Experts’ by experience perspectives of music therapy in mental health care: A multimodal evaluation through art, song and words.

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Submitted for the award of PhD

University of Limerick, Ireland

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Submitted to the University of Limerick, October 2014.
Declaration

This thesis is presented in partial fulfilment of the requirements for the degree of Doctor of Philosophy. The substance of this thesis is my own work and due reference and acknowledgement has been made, when necessary, to the work of others. No part of this thesis has previously been accepted for any degree nor has it been submitted for any other award.

Signed: _______________________ Date: ___________

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Abstract

The recovery approach in mental health advocates for the involvement of service users at each stage of healthcare delivery and planning. Service user evaluation provides one pathway to enhance mental health provision. Based upon principles of inclusive design, this doctoral research commenced with two main aims: 1) to develop high quality processes for service user evaluation of music therapy in mental health, and 2) to reflect upon the feedback elicited from such processes in order to gain a deeper understanding of how music therapy is received among those who have attended sessions in mental health. Two pathways of service user evaluation were designed to include the perspectives of nine service users who have attended music therapy in statutory mental health services. The first involved verbal inquiry through individual interviews with six service users. An additional means of evaluation involved arts-based focus groups with three service users who created one visual image and three songs about their lived experience in music therapy. Following interpretative phenomenological analysis of the interviews and arts-based reflection upon the arts-materials, the combined findings and insights illuminated service user experience in music therapy. Findings revealed: that music therapy is attended because of a love or interest in music; there is not always a distinction between music therapy and other music activities; music therapy is a health-promoting resource; the music therapy environment is person-centred; and music therapy can provide many sensory experiences. Unfamiliar findings highlighted: the circumstances that surround attendance of service users’ first session; the challenges that are involved in music therapy; feelings of tension and frustration in relation to musical expectancy; and that musical contribution is fostered in a group setting. While some input was received from a service user consultant in this study, it is recommended that similar future research expands stakeholder involvement in all stages of the research process.
Dedication

To Michael
Acknowledgements

I clearly recall the day that the idea for this study first emerged as a couple of key words scribbled onto a white board in my office at the Irish World Academy of Music and Dance. On that occasion my supervisor Professor Jane Edwards and I discussed the potential for this research topic. Ever since that day Jane has encouraged me to bring this study to fruition. She generously gave of her time, knowledge and expertise while reminding me of my abilities as a researcher even on difficult days when I wondered if completion of this study would be possible. She has been a wonderful mentor and advisor over the years.

Inspiration for this research arose from my experience of practising as a music therapist at Mayo Mental Health Services where I worked with a fantastic group of service users and practitioners who were committed to the concept of mental health recovery—at many points during this research I thought of you all. This project would be nothing more than an idea were it not for the nine mental health service users who generously gave of their time and knowledge to partake in the research interviews and focus groups—sincere thanks to you all for having shared your personal experiences of music therapy with me and for opening up my mind to the possibilities that such services can offer. There were a number of people who worked behind the scenes to make this research possible. My thanks are due to Hilary Moss (Arts Officer), Catherina Brady (Art Therapist) and Rory Adams (Music Therapist) of the National Centre for Arts and Health, Tallaght Hospital. Thanks also to Tommy Hayes (Music Therapist), Dr Séamus O’Flaithbheartaigh (Consultant Psychiatrist), Sally Howard (Advanced Nurse Practitioner), Ailbhe Dunne and Pat Croker (Nurse Managers) at Inis Cara Day Centre, Limerick Mental Health Services.

Along this journey I spent time with some inspiring individuals including Paddy McGowan (Dublin City University), Dr Alison Ledger (Leeds Institute of Medical
Education), and Professor Randi Rolvsjord (University of Bergen, Norway). Each one’s encouraging words and insightfulness all seemed to come at various points when it was needed most. Your helpful signposts were much appreciated along this journey.

My thanks are due to the Irish World Academy of Music & Dance and the University of Limerick who provided financial support for this research. I am very lucky to work within such a creative environment that I share with an encouraging group of colleagues, particularly my fellow members of the *Music & Health Research Group* who have supported me along this endeavour. During the final leg of this journey, my friends at *Go-Tri Racing Team* were there to cheer me on as I sprinted for the finish line. I heartily looked forward to our early morning swims and club breakfasts that always put a smile on my face before sitting down to a long day’s work at the desk. *Tri-ing* does not only apply to sport but also to many things we do in life.

Last of all, heartfelt thanks go to my family and friends for all their encouragement, particularly during my period of hibernation when their texts and calls of moral support always managed to motivate me to keep on going. I particularly wish to thank my brother-in-law Eoin who agreed to proof-read this thesis for me. My parents, Marie & Frank, have provided unwavering support to me over the years—you both have made many sacrifices for me that I will never forget and always appreciate. Finally, thanks to my darling Mark, who became my husband along this journey and who is a tower of support and patience. I love you all very much.
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Chapter 1

Introduction

Overview of the Research

Service user evaluation in mental health recognises the value of capturing the lived experience of health care participants based on inclusive approaches to health service provision. Recovery-oriented practice has influenced mental health provision internationally; promoting the meaningful inclusion of service users’ perspectives at all stages of health care delivery and planning. Inclusive principles of recovery-oriented practice were fundamental to this doctoral research study which focussed on how service user evaluation can inform the practice and development of music therapy in mental health.

This doctoral research was commenced with two main aims: 1) to develop high quality processes for service user evaluation of music therapy in mental health, and 2) to reflect upon the feedback elicited from such processes in order to gain a deeper understanding of how music therapy is received among those who have attended sessions in mental health. Service user evaluation processes were developed and based upon the principles of inclusive design (Clarkson, Coleman, Keates, & Lebbon, 2003). Investigating nine participants’ lived experience of music therapy in mental health was undertaken while considering how such information can be used to improve mental health provision. These aims informed the development of service user evaluation of music therapy in statutory mental health services. Individual interviews were conducted with six service users, four of whom participated in a follow-up interview. These interviews were analysed using interpretative phenomenological analysis (J. A. Smith, Flowers, & Larkin, 2009). Creative service user evaluation was engaged with three service users who participated in a series of arts-based focus groups in
which one visual image and three songs were created. These materials were the focus of an
arts-based reflexive process undertaken by the researcher to gain a deeper understanding of
how these service users’ visual image and songs were representative of lived experience of
music therapy services. The inclusion of both verbal narrative methods and creative arts
pathways for service user evaluation of music therapy is a unique contribution to the field.

The interview and arts-based processes aimed to optimally include the perspectives of
nine people who have lived experience of music therapy in mental health and to report these.
Super-ordinate themes were found across ten interviews with six participants who described
their experiences of individual or group music therapy in mental health. These included; ‘The
music therapy context makes a difference’; ‘Music therapy brings challenge’; ‘Music therapy
makes a positive impact’; ‘Group music therapy fosters contribution’; ‘Music therapy is
person-centred’; ‘Music therapy creates a sensory world’; ‘Music is bound in meaning’; and
‘Frustrations and tensions can occur in music therapy’.

The arts-based reflexive process undertaken in relation to the visual image and songs
created by service users in the focus groups revealed that some service users commence
music therapy from a perspective of enjoyment and love of music rather than with the view to
receiving a form of mental health treatment. This process also illuminated the interpersonal
nature of the therapeutic relationship where reciprocity, humour and friendship featured.
Other insights gained from the arts-based reflexive process included that music and music
therapy can be indistinct for some service users and that there are positive aspects of
engaging with music that service users can experience within sessions.

Together the findings and insights from the interviews and arts-based focus groups
revealed both familiar and unfamiliar aspects of service user experience in music therapy
with reference to wider reporting of changes and challenges in the literature. Familiar
findings included that attendance of music therapy can stem from an interest in music or wish
for meaningful occupation. For some service users there is no clear distinction between musical experiences within and outside therapy, instead music therapy is experienced within a much more holistic framework of lifelong music experience. This complemented a further finding about the health-promoting role of music therapy wherein all service users described positive outcomes as a result of their participation within sessions. The music therapy environment was portrayed as person-centred. Service users felt supported and encouraged within an equal relationship with their therapist. Steps leading into and processes involved in music improvisation were also described, extending a further understanding of experiential and stimulatory aspects of improvisation.

Service user participants also revealed new and unfamiliar findings about their experiences in music therapy. These highlighted the steps that participants take before arriving at their first session and the challenges that can arise from the following: the many unknowns about the processes involved; their past experiences with music which may cause ambivalent feelings to arise; and interpersonal aspects of being part of a music therapy group. The findings also revealed that when service user expectancies of music are unrealised in sessions, feelings of tension and frustration can occur, particularly in relation to engagement in improvisation. A final finding highlighted how through the act of musical contribution within a group context, service users can promote their own wellness as well as the wellness of fellow group members.

The descriptions elicited through the research process enabled the presentation of an in-depth understanding of the life-world in music therapy in mental health. Theoretical consideration of how service users conceptualise their involvement in music therapy was undertaken, and important aspects of participation within sessions were highlighted.

As the first research study to undertake service user evaluation of music therapy through verbal and creative means, this doctoral research has sought to increase
representation of service user voices in music therapy and mental health. These findings can inform music therapy programme developments in mental health, and to contribute to the ongoing development of evaluation processes.

**Structure of the Thesis**

The structure of the thesis follows traditional research reporting procedures in introducing the topic and reviewing relevant literature, elaborating the aims and methods and presenting the findings which are then discussed. The introductory chapter provides an overview and background of this research that is followed by a review of literature relevant to the ideas of: recovery in mental health; service user involvement and; music therapy in mental health (Chapter 2). The research paradigm and methodology (Chapter 3) precede a description of the methods employed (Chapter 4). The findings from each of the individual interviews with six service user participants are presented in one chapter (Chapters 5), followed by presentation of the overall interview findings (Chapter 6) and the arts-based processes and outcomes (Chapter 7). The final chapters include a discussion of the research outcomes (Chapter 8) and a reflection including recommendations and conclusions (Chapter 9). Material in the form of: song recordings; interview and focus group transcripts; ethical clearance applications; ethical and risk management approvals; indemnity cover; and memoranda of understanding with data-collection sites have been uploaded to the website Dropbox [https://www.dropbox.com/login](https://www.dropbox.com/login) for confidential review by the examiners.

**Background to the Research**

The concept for this research arose from a formative period in my music therapy career when working in a mental health service in transition from delivery of a traditional model of practice –within the medical or rehabilitative model– towards one that embraced the principles of mental health *recovery*. This was an exciting and yet volatile time as there were
some mental health professionals in the service who readily embraced the inclusive and collaborative philosophy of recovery while others clung to a familiar medical psychiatric discourse in which service users were kept at a distance. As discussion ensued around how the service could be delivered within a recovery-oriented ethos, so too did my awareness of the power differentials that existed between mental health service users and professionals. As the inaugural and sole music therapist within the team and a minority voice within this dynamic debate, I could empathise with the service user perspective that often seemed voiceless or unnoticed within the discussions concerning changes to mental health provision. Furthermore I felt somewhat torn as a professional who had undergone clinical training and yet whose music therapy practice was sometimes diluted and disregarded as entertainment or activity when considered within a traditional clinical model of care. As the critical mass of stakeholders committed to developing a recovery-oriented service increased so too did my opportunities to witness and partake in increased collaborative working with service users and their families. Although often experienced as complex and sometimes occurring within unchartered territory, this collaborative way of working was built upon mutual respect for professional and experiential views in contrast to the patriarchal and medically dominated approach that had once exemplified the service. I entered into this research with the hope to develop inclusive mechanisms of evaluation in a way that would elicit and honour the experiential knowledge of service users. Although this research focussed specifically on music therapy services in mental health, it is also intended that the evaluation pathways designed and employed in this study be informative for the wider mental health community.

One of the first steps in developing this research involved gaining an understanding of the place of service user evaluation within the contemporary mental health landscape. I considered the reasons for inclusion of service user perspectives and how these might successfully be used to inform mental health provision. Embarking on research that aimed to
enhance mental health services from an inclusive perspective was undertaken at a time when the World Health Organisation (2013) recognised the central role of good mental health in overall human well-being. This resonates with the overarching aim of music therapy as a practice that promotes well-being and positive mental health through the use of musical processes (McCaffrey, in press-a).

Increased prioritization has been given to prevention and promotion in the field of mental health (World Health Organisation, 2002). This aims to increase awareness of the importance of good mental health which “enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities” (World Health Organisation, 2013, p. 5). Prevention and promotion in mental health is also vital in reducing the increasing burden of mental ill health as the latest figures of the global disease burden show that rates of mental illness have surpassed those of cancer and cardiovascular disease (Collins et al., 2011). This has resulted in a struggle among health systems to respond to the epidemic of psychosocial distress and mental illness (World Health Organisation, 2005, 2013). Therefore, improvement in the planning and delivery of mental health services is essential.

The Mental Health Action Plan: 2013-2020 outlines the importance of empowerment and involvement of persons with mental health needs in terms of advocacy, planning, policy, legislation, service provision, monitoring, research and evaluation of mental health provision (World Health Organisation, 2013). Mental health recovery provides a framework for inclusion, in addition to underpinning mental health policy in many countries internationally (Slade, Leamy, et al., 2012). Recovery amplifies concepts of empowerment and activism among service users as they overcome the limitations of mental illness to lead satisfying and meaningful lives (Shepherd, Boardman, & Slade, 2008). Partnership working is an essential component of recovery-oriented practice where the acquisition of service users’ knowledge
through lived experience is recognised alongside practitioner knowledge that has been acquired through skill and/or training (Le Boutillier et al., 2011). Such meaningful collaboration between service users and practitioners provides a way of moving beyond professional dominance in mental health care service towards a person-centred approach to health provision (Department of Health, 2012b).

Having considered the relevance of recovery in mental health in terms of this research, a further literature review explored the outcomes, challenges and reasons for service user inclusion in the development of mental health services. This highlighted the complexities of inclusion from the perspective of service users and providers while illustrating power differentials in the mental health arena which can be overcome through meaningful dialogue between all parties (Beresford, 2012). Through reading this literature the benefits of service user involvement in mental health became apparent. However, there were a small number of examples of service user evaluation as a specific form of involvement in mental health and a need to develop innovative forms of service user evaluation became apparent.

The final piece of preparatory work for this research involved a review of music therapy practice in mental health. This highlighted the influence of the medical and psychiatric models upon development of music therapy, particularly in terms of the principles of evidence-based practice (EBP) and the measures employed to determine its efficacy and effectiveness. Many studies designed in accordance to the principles of EBP have shown positive outcomes for people who have attended music therapy in mental health (Edwards, 2006; Gold, Assmus, et al., 2013; Gold, Solli, Krüger, & Lie, 2009; Grocke, Bloch, & Castle, 2008; Lee & Thyer, 2013; Lin et al., 2011). However, research conducted within the EBP rubric has been criticised for neglecting the expertise of service users acquired through their involvement with mental health services (Anthony, Rogers, & Farkas, 2003; Stickley, 2006).
Emerging discussion of the role of music therapy as a recovery-oriented practice because of its promotion of collaboration and partnership within therapeutic relating moves away from an emphasis on EBP (Chhina, 2004; Eyre, 2013; Kaser, 2011; Kooij, 2009; McCaffrey, Edwards, & Fannon, 2011).

In-depth examination of the music therapy literature revealed a relatively recent trend towards the greater inclusion of the voices of music therapy service users (Ansdell & Meehan, 2010; Hammel-Gormley, 1995; Rolvsjord, 2010; Solli, 2014; Solli & Rolvsjord, 2014; Stige, 2012). This emerging literature base provided unique and valuable insights into participation within sessions, providing a deeper understanding of this practice for the music therapy and wider mental health communities.

The inclusion of service user perspectives in research and evaluation in music therapy practice in mental health is a small but growing area of research through which awareness of the experiences of participation in sessions and programmes can be increased. This provides valuable information for future developments within music therapy. Service user evaluations of music therapy have relied upon verbal (interview) or text based (questionnaire) methods of data collection (Baines, 2003; Baines & Danko, 2010; Carr et al., 2011; Dye, 1994; Heaney, 1992). The role of creative arts-based evaluation in evaluating service user perspectives requires further elaboration and reflection.

In the research carried out for this doctoral thesis interviews and arts-based methods provided meaningful ways by which the perspectives of nine service users who have attended music therapy while receiving treatment in the mental health services in Ireland could be accessed. Service user views of music therapy have been elicited through interviews in previous mental health research (Ansdell & Meehan, 2010; Rolvsjord, 2010; Solli, 2014; Solli & Rolvsjord, 2014; Stige, 2012). The additional use of an arts-based focus group reported in this thesis marks a unique research contribution to the field. The further arts-based
reflections in which I engaged through song composition required me to be open to others’ experience, and to tolerate the ambiguity of only being able to know in imprecise terms the participants’ experiences of music therapy. The interviews, arts-based focus groups and musical reflections offered a new way to listen to the voices of service users in mental health. These methods and techniques honoured the subjective nature of service user experience while acknowledging how such experiences imparted a form of expertise that could be used to inform the delivery of mental health services.

Reflection upon the emancipatory framework in which this research was conducted revealed that service users played a crucial and highly valuable role in relaying their experiences of music therapy in mental health. While input was received from a service user consultant before the collection of data commenced, it is recommended that future emancipatory research in music therapy could aim to involve service users at all stages of the research process, including in decisions regarding the initial design.

Summary

As recovery-oriented practice increasingly underpins the provision of many mental health services around the world, it is an opportune time to reflect upon how service user perspectives can optimally be included in the development of music therapy practice in this field. This research was commenced with two main aims: a) to develop high quality processes for service user evaluation of music therapy in mental health, and b) to reflect upon the feedback elicited from such processes in order to gain a deeper understanding of how music therapy is received among those who have attended sessions in mental health. It is hoped that this work is not only of interest to music therapy practitioners but also other mental health stakeholders who seek insight into contemporary means of service user evaluation in health care.
Chapter 2

Literature Review: Recovery, Service User Involvement and Music Therapy

The three key themes on which the research is based are presented and discussed in this chapter. These are: 1) recovery in mental health, 2) service user involvement and, 3) music therapy in mental health. The recovery approach in mental health provides the substantial theoretical and practical framework for the research undertaken for this PhD. Service user involvement is a central principle of recovery, and is a concept widely promoted in mental health policy in many countries, including in Ireland (Department of Health and Children, 2006) where this research was conducted. Further development of service user programme evaluation is needed in order to enable the voices of people with lived experience of services to be heard. Music therapy fosters recovery through the promotion of well-being in a collaborative, empowering process (Solli, Rolvsjord, & Borg, 2013). Despite the obvious alignment between the central principles of both music therapy and recovery in mental health, music therapy processes have traditionally been described from the practitioner perspective with the voices of service users underrepresented in the research and practice literature. Tuning in to the voices of those who have lived experience of attending music therapy is needed to inform the future development and delivery of this allied health practice. Ultimately evaluation procedures that include service users in their design, development and implementation are needed.

A literature search was conducted using the terms “music therapy in mental health”, “recovery in mental health”, “service user experience” and “service user evaluation” in healthcare databases including: Academic Search Complete, the Cochrane Library, CINAHL, Google Scholar, Medline, PsycArticles, PsycINFO, and PubMed. These yielded many useful
articles providing information about how topics relevant to the proposed research have been conceptualised in the service user literature as well as in disciplines such as nursing, psychiatry, psychology and social work. A range of books on music therapy, recovery and service user involvement were also consulted in addition to a review of mental health policy and guidance documents by the Health Service Executive, Department of Health, Department of Health and Children, and the Mental Health Commission in Ireland. Professor Jane Edwards also pointed out many useful articles that added to the depth and breadth of my knowledge around the notion of service user evaluation of music therapy in mental health.

**Recovery in Mental Health**

**Introducing Recovery**

*Recovery* denotes an evolving approach within mental health services defined as a “deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles” in order to live “a satisfying, hopeful, and contributing life” (Anthony, 1993, p. 7). Recovery is based on principles such as: 1) self-help to promote personal responsibility, 2) empowerment to strengthen marginalised groups and, 3) advocacy that aims to politically influence mental health provision for the benefit of service users. Recovery marks a new way of thinking about and living life beyond the confines of a diagnosis of mental illness (Shepherd et al., 2008). It is considered a leading approach in the delivery of modern mental health services (Slade, Leamy, et al., 2012). This section of the thesis primarily presents recovery literature that focusses upon mental health provision in Ireland and its neighbour country of the UK. Therefore, it is not the purpose of this literature review to explain the recovery approach internationally but instead present how recovery has impacted the services where this research was undertaken.
Recovery and Psychiatry

Recovery provides a response to the dominance of medical psychiatry in the definition and treatment of mental illness. The underpinning biomedical model within psychiatry has been criticised for viewing patients through a narrow lens that fails to encompass a holistic view of the individual (Fox, 2012). In psychiatry the neurobiological, behavioural and social dimensions of disorders are stratified hierarchically (Priebe, Burns, & Craig 2013). Priebe, Burns and Craig (2013) explained that psychiatric research:

regards neurobiological aspects as the basis of disorders, which are then expressed in psychological symptoms influenced and managed within a social context. Neurobiological findings tend to be taken as the explanations for disorders. Neurobiological processes have been proposed as explanations for how and why interventions work (p. 319).

As a discipline that is concerned with the assessment, diagnosis and treatment of disorders of the mind (College of Psychiatry of Ireland, 2013), it is the role of the psychiatric practitioner to establish mechanisms of change that can be activated by a specific intervention (Wampold, 2001). Curing a diagnosed disorder within this schema uses a clinical definition of recovery involving the reduction or eradication of the symptoms experienced (Davidson & Roe, 2007).

Management of the symptoms of mental disorders as the focus of psychiatry has been bolstered by the growth of the pharmacological industry, neuro-scientific discoveries and behaviour-based therapy interventions (Priebe et al., 2013; Unkefer & Thaut, 2005). Criteria-based diagnostic systems such as the DSM-V (American Psychiatric Association, 2013) and the ICD-10 (World Health Organisation, 1992) support the use of diagnostic systems of symptom identification to manage treatment and clinical recovery goals. Since many disorders occur co-morbidly, diagnostic processes “disentangle the complex and holistic experience of an individual in their biographical and social context” (Priebe et al., 2013, p. 320). This can create a sense of alienation for service users who use holistic, biographical and social terms to describe their experiences of overcoming a mental disorder and embarking
upon their recovery journey (Fox, 2012). Therefore multiple practitioners, advocates and service users adopting a recovery ethos have increasingly called for consideration of a wider range of factors, apart from symptoms alone, as to what makes a mental disorder debilitating (Davidson & Roe, 2007).

Many scientific advances have contributed to the practice of psychiatry. However, it has been noted within the field that no new breakthrough treatments have emerged in the past thirty years (Priebe et al., 2013; Priebe, Omer, Giacco, & Slade, 2014). Practitioners’ focus on chemical imbalances and neurology have attributed to feelings of depersonalisation and frustration among patients (Davidson & Roe, 2007). Central to this dissatisfaction is the deficit focus in mental health treatments that are viewed as problematic in the pursuit of wellness (Davidson & Roe, 2007). Based on assumptions of deficiency and pathology this may offer an explanation of physical disease but with regard to mental illness a diagnosis “can only provide an understanding of its symptoms and causation” (Fox, 2012, p. 50). These different conceptualisations of mental illness between the medical and service user communities are challenged through the recovery approach which acknowledges the expertise of all people engaged in mental health services.

Political Change in Mental Health

Anthony (1993) wrote that the seeds of mental health recovery were first sown as a repercussion of deinstitutionalisation that occurred in many countries in the later decades of the 20th century. This recognised the value of assuming a social approach in the promotion of mental health and independent living (Fakhoury & Priebe, 2002), acknowledging that people with mental illness had far more hopes and ambitions beyond being free of symptoms (Anthony, 1993). This era witnessed the replacement of many long-stay psychiatric hospitals with community mental health services for people with a mental health diagnosis so as to encourage independence and agency (Cohen, 2008; Fakhoury & Priebe, 2002). Although it is
beyond a comprehensive analysis here, deinstitutionalisation has been viewed by some as a process that fostered ideas of normalisation and socialisation (Fox, 2012). Turner (2004) stated that the intention of deinstitutionalisation “was that mental illness would be treated in acute units, like any other medical illness, with continuing care provided by social services, supported accommodation and a notion of normalization of a stigmatized population” (p. 1). Case examples from different countries have illustrated both the successes and failures of deinstitutionalisation (Stubnya, Nagy, Lammers, Rihmer, & Bitter, 2010). While some have welcomed the encouragement of providing active rehabilitation, community involvement and closure of large psychiatric hospitals (Turner, 2004), others have accused deinstitutionalisation of simply changing the locus of treatment provision and creating mini-institutions in social settings (Lamb & Bachrach, 2001). Other criticisms have regarded lack of consensus surrounding its philosophic ideas (Talbott, 2004).

Psychiatric rehabilitation and community care sought to treat both illness and consequences of illness in order to aid people to meet the challenges of disability (Anthony, 1993). The focus of rehabilitation, still practiced today, is to improve an individual’s quality of life and social inclusion by encouraging their skills and promoting autonomy in order to help lead a successful life in the community (Killaspy, Harden, Holloway, & King, 2005). Rehabilitation refers to the application of services and technologies that are made available to support functioning of the individual (Kowlessar & Corbett, 2009). This social approach to the promotion of mental health undoubtedly provided a supportive backdrop to the ethos of the current recovery approach (Anthony, 1993). However, both concepts differ as rehabilitation implies providing services for a person whereas recovery refers to the lived or real life experience of people as they overcome the challenge of the disability and “recover a new and valued sense of self and of purpose” (Deegan, 1988, p. 11).
With an ideology premised on concepts of empowerment, self-help and advocacy, the consumer/survivor movement of the 1980s and 1990s, challenged “traditional notions of professional power and expertise which pervaded mental health services” (Shepherd et al., 2008, p. 2). This was inspired by self-help groups such as Alcoholics Anonymous who adopted a mental health recovery approach rooted in the action and protest of the Civil Rights movements, which resulted in calls for social justice and equality (Shepherd et al., 2008; Turner-Crowson & Wallcraft, 2002). Through the sharing of personal testimonies or stories by those who had survived the psychiatric system, a type of organised resistance was founded that gradually began to promote change both inside and outside of the institution (Costa et al., 2012).

**Recovery Narratives**

The mental health and related literature has provided many first-hand accounts of people overcoming the limitations of mental illness (Chadwick, 2007; Davidson, 2003; Deegan, 1988; Everett, 2000; Hayne & Yonge, 1997; Repper, 2000; Ridgway, 2001). These offer alternative narratives within the mental health landscape, ones in which human diversity and personal experiences of service users are relayed. There has also been momentous growth of the service user perspective within the *grey* literature of informally published material as referred to by Crawford et al. (2002). These efforts have contributed to broadened and *alternative* readings of mental health services compared to those which have featured in within the more scholarly literature. This body of work is briefly reviewed here as it supports the endeavour of the research undertaken for this thesis to show the value, along with the disruptive yet restorative potential, of first-hand accounts from people who have lived experience of events and situations.

Patricia Deegan (1988) provided an account of her recovery from schizophrenia in a peer reviewed mental health journal. Her writing described how she moved beyond the
catastrophic event of being diagnosed with a mental illness. She recounted her experience of being told schizophrenia was an incurable condition, with the best possible outcome being that she would *cope* and *adjust* to her illness. After years of despair and personal anguish she recalled how she slowly began to experience hope, recognising that “when one lives without hope (when one has given up) the willingness to ‘do’ is paralyzed as well” (Deegan, 1988, p. 13). Little by little she changed from being a passive participant to an active participant who began to recover a new sense of self. Deegan (1988) emphasised that her recovery was not about achieving an end product or result but rather was concerned with meeting the challenges and limitations of her disability in order to find the means to lead a satisfying, meaningful life.

Leete (1989) described her efforts to recover her life despite meeting constant struggles which were only compounded by the way in which others viewed her through the lens of illness:

> Life is hard with a diagnosis of schizophrenia. I can talk, but I may not be heard. I can make suggestions, but they may not be taken seriously. I can report my thoughts, but they may be seen as delusions. I can recite experiences, but they may be interpreted as fantasies. To be a patient or even ex-client is to be discounted. Your label is a reality that never leaves you; it gradually shapes an identity that is hard to shed (p.199).

These words highlight how service user voices have sometimes been dismissed due to the diagnosis of mental illness. The diagnosis leads to their marginalisation within the established care system. Repper and Perkins have described the “gulf between lived experiences and the accounts of mental health professionals” (2003, p. 4). Such narratives and those of others who have also provided early accounts of recovery (for example, Lovejoy, 1982; Unzicker, 1989), have made a distinguished contribution to the mental health field. These recovery narratives exemplify the efforts that service users have made to survive and overcome the limitations of mental health treatment and the systems in which this is delivered, even in cases where a poor prognosis was relayed by mental health professionals (Turner-Crowson &
Wallcraft, 2002). These accounts reveal how the quality of daily life can impact upon mental state and how with committed efforts and a dedication to return to wellness, people can and have overcome the impact of mental illness (Chadwick, 2007). Mosher, Menn, and Matthews (1975) have advocated for service users’ role in educating fellow survivors by asking “who can tell us better how to get over the illness than its recovered victims?” (pp. 455-456).

Honouring the wealth of knowledge to be found in lived experience is respectful and humanising. However, while the benefits of peer-support among service users have been acknowledged, so too have the costs of this, in some situations, to the well-being of participants due to the stressful nature of collaborating with multiple stakeholders (Mowbray, Moxley, & Collins, 1998).

Collective considerations of recovery narratives help identify some of the basic key ingredients that may be part of a highly personal process. They can enhance practitioners understanding of the personal experience of living with illness and of the diversity that exists with regard to values, beliefs, culture and context of those with whom they serve (Ridgway, 2001). Therefore, the project of storytelling or re-authoring one’s life may be regarded as a social act that can be used as an important resource in mobilizing mental health professionals towards recovery-oriented practice (Ridgway, 2001). It is also a means of altering the language of mental health in a way that empowers those who were once thought of as passive agents in what Foucault (1961/2001, p. xii) derided as “a monologue of reason about madness”. It has been noted that the 1990s and 2000s has seen more literature appear on narrative approaches to psychiatry and associated fields, signalling the increased significance of service user narratives (Cohen, 2008). Of course the use of this approach is not particularly new to the field of psychoanalysis, as Freud believed in the importance of narrative whereby in principle, clients were encouraged to tell their stories, thus being the primary author of their own text (Cohen, 2008). However, it is important to note that these narratives were
treated somewhat idiosyncratically, for example that where adults described their sexual abuse as children Freud did not counter that these events could have literally happened (Plummer, 1995).

Research involving analysis of personal narratives has determined the dimensions involved in recovery. Jacobson (2001) used symbolic interactionism to analyse thirty recovery narratives to find that the central dimensions involved in recovery are: the self; others; the system; and the problem. It was concluded that successful recovery practice involves the avoidance of assumptions by health professionals about the substance of each of these dimensions (Jacobson, 2001). Practitioners are encouraged to be open-minded as they explore the meaning of each of these dimensions with the service users with whom they work so that the uniqueness of each service user’s recovery narrative can be honoured.

Ridgway (2001) analysed four recovery narratives and identified a number of themes that described recovery as: the reawakening of hope after a time of despair; moving from withdrawal to active participation in life; actively coping rather than passively adjusting; and reclaiming a positive sense of self rather than viewing oneself as a person with a mental illness. Other shared elements of recovery were also described such as the non-linear nature of the recovery journey, the importance of personal meaning and purpose in one’s life alongside the importance of one’s social network in which support and partnership are given (Ridgway, 2001). These findings reveal shared characteristics of recovery which can serve as reminders for reflection for service users who are beginning to embark upon their journey towards wellness.

The value of recovery narratives in educating and inspiring mental health stakeholders has been recognized (Ridgway, 2001), but concern has also been expressed about their self-disclosing nature whereby “mad stories have become a kind of pornography” (Costa et al.,
In some instances these have been shown to be elicited by service systems that hold “neoliberalist mental health agendas in order to support and sustain the validity of health service systems” (Costa et al., 2012, p. 99). The author of a service user narrative may not always be aware of the purposes for which their story will be used. Therefore, a series of precautionary tips have been devised so as to protect the service user before they agree to publicly recount their story (Costa et al., 2012). These remind service users of the voluntary nature of participation in addition to increasing their awareness that the story is readily accessible and will most likely be on record for a very long time. They encourage service users to think about: who will profit from their story; the purpose for which their story is told; how these may be used to elicit change in large organisations; and the issue of payment for completing this work.

In spite of the unintended consequences that may arise when exposing peoples’ lives and experiences to others through narrative text, the above research and processes indicate that as long as certain safeguards are in place there is a key role for narrative in contributing to the emancipation of the service user, the mental health system, and its practitioners.

Conceptualising Recovery

Mental health recovery encompasses many meanings, in part due to the heterogeneous nature of outcomes of mental illness (Davidson, O’Connell, Tondora, Styron, & Kangas, 2006; Turner-Crowson & Wallcraft, 2002), but also because of variations in its developments and applications within and between countries. Scholarly conventions of research require definitions of main concepts and terms which are then used consistently. However, recovery is not easy to define with completeness and certainty. It is a term that has evolved and continues to change through practice and research elaborations. In order for recovery to be presented in a meaningful way in this section of the thesis it is important to point to a currently incomplete consensus regarding the current scope and values within recovery. In
the broadest terms recovery can function as a guiding ethos within service delivery in which the foundation principles are consideration and inclusion of service users in all aspects of the development and implementation of services, and at the same time recovery can be conceptualised as a significant concept in the lived experience of people who need support because of a range of mental experiences relating to perceptions or moods that create difficulties in their lives. Tensions emerging in the following elaboration of the current approaches to recovery in mental health practice and research include the lack of attention to the collective and social in some iterations, and the criticisms of the neglect of the individual within a more socially oriented approach.

The term *recovery* can encompass notions of *clinical recovery* and what Slade (2009b) described as *personal recovery*, each originating from different models of theory and practice (Davidson & Roe, 2007; Fox, 2012). The former emerged from the expertise of mental health practitioners and is simply described as a biomedical model whereby symptoms are eliminated and social functioning is restored in order to declare that one has *cured* the individual (Harrison et al., 2001). From a clinical perspective, recovery is conceptualised as operating within the principles of social disability, resource utilisation and the absence of symptoms. In the 1980s evidence, such as that from Ciompi (1980), emerged to support this understanding of clinical recovery among people with serious mental illness such as schizophrenia, thus challenging the bleak notion that such a diagnosis determined ongoing deterioration and decline (Shepherd et al., 2008). Davidson and McGlashan (1997) produced research to show that at least one quarter, and even up to two-thirds of people experiencing psychosis will achieve partial or full *clinical recovery*. These more optimistic developments with regards to prognosis resulted in calls for clinical recovery to be evaluated in the framework of evidence-based medicine (Bellack, 2006; Liberman & Kopelowicz, 2005). However, this evidence-based approach was enshrined within the practice and discourse of
health professionals which although premised on using the best available evidence to inform
treatment decisions (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996), can promote
the primacy of the professional view at the cost of excluding a service user perspective
(Davidson et al., 2006).

Davidson and Roe (2007) have differentiated recovery from mental illness and
recovery in mental illness. Recovery from mental illness involves being free of symptoms and
restoration of one’s “normal condition that existed prior to the onset of illness” (Davidson &
Roe, 2007, p. 462), that is clinical recovery. For people who do not return to this premorbid
state of functioning, recovery in mental illness refers to a process “of minimizing the
destructive impact of the illness while simultaneously identifying and building on a person’s
strengths and interests in order for the person to have an identity and a life beyond that of
‘mental patient’” (Davidson & Roe, 2007, p. 462). This does not suggest that the amelioration
or reduction of symptoms is dismissed in personal recovery, but rather these aspects are de-
amplified to become a subordinate issue to the consideration of how one wishes to belong in
the world (Repper & Perkins, 2003). Personal recovery engenders an approach whereby by
the needs, preferences and wishes of the individual are the map from which the journey
towards wellness begins (Davidson, Rowe, Tondora, O’Connell, & Staeheli Lawless, 2009).
Recovery is not something that services do to a person but rather something that services can
encourage (Turner-Crowson & Wallcraft, 2002). This involves mental health services
adopting practices that are recovery-oriented (Anthony, 1993).

The many definitions of personal recovery found in the literature point to theoretical
variance around this topic which has led to call for increased clarity and consensus about
recovery among the mental health community (Bonney & Stickley, 2008; Davidson & Roe,
2007). As the idea of recovery emerged from the writings of people who “face the challenge
of life with mental health problems” (Repper & Perkins, 2003, p. 46), it would seem plausible
that it is from such accounts that the principles of recovery have been ascertained (Turner-Crowson & Wallcraft, 2002). Many research studies have exclusively looked to service user descriptions of recovery to define its central principles (Bird et al., 2014; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011),

Leamy et al. (2011) undertook a narrative synthesis of 97 papers that described or developed an intellection of personal recovery from mental illness in order to inform and develop a conceptual framework of recovery. The findings of this review were used to produce a CHIME framework that represented the processes of recovery to include: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment. The main characteristics of the recovery journey were also identified. These described recovery as: 1) an active process; 2) individual and unique to the individual; 3) non-linear; and 4) a journey of stages. Members of the Black and minority ethnic communities in this study indicated a greater emphasis on the themes of spirituality and stigma indicating that recovery facilitation may require attention to culturally specific factors (Leamy et al., 2011).

The CHIME framework described above has since been tested for validity and relevance (Bird et al., 2014). Following a series of focus groups with current mental health consumers about the meaning and experience of recovery it was found that inductive and deductive analysis validated this conceptual framework where connectedness, empowerment, identity and meaning in life, in addition to hope and optimism are the main features (Bird et al., 2014; Leamy et al., 2011). However, in comparing the findings of both studies, differences relating to medication and diagnosis, practical support and scepticism were found (Bird et al., 2014). These not only indicated the idiosyncratic nature of the recovery journey but also a need to gain a further understanding of recovery from specific cultural and contextual points of view. Bonney and Stickley (2008) extended their review of recovery
conceptualisations in the British literature beyond those of service users so as to also include
the perspectives of policy makers and service providers. Of 170 papers reviewed, the central
themes of recovery were found that related to: 1) identity; 2) power and control; 3) hope and
optimism; 4) risk and responsibility; 5) the social domain; and 6) the service provision
agenda.

In considering the themes and categories derived from the reviews of the recovery
literature, it would appear that recovery is not only personal but also social (Repper &
Perkins, 2003; Tew et al., 2012). This relates to the social model of disability that considers
the systemic barriers of societal organisation that disable people and leads to exclusion from
society (Shakespeare, 2013). Tew et al. (2012) recognised the possible societal dimension of
recovery and therefore examined the evidence relating to the social factors of this process.
Findings showed that the negotiation of positive social identities, the establishment of
supportive personal relationships, empowerment, and social inclusion may be regarded as
social agents of change in the recovery process (Tew et al., 2012). These conclusions are
particularly relevant in refuting criticisms that the recovery approach emphasises an
individualistic approach that overlooks the strength that one can gain from others and the role
of community in promoting wellness (Mind, 2008). It is also important to recognise that the
majority of descriptions of recovery have originated from papers written in the USA and UK
(Slade, Leamy, et al., 2012) reflecting the influence of Western ideas and values.

CHIME offers a conceptual framework that recognizes the cultural variance that can
exist in understandings of recovery (Leamy et al., 2011). As a leading conceptual framework
that has been validated and updated (Bird et al., 2014; Slade, Leamy, et al., 2012), it seems
plausible to consider characteristics of CHIME in relation to those derived from other
aforementioned studies (Bonney & Stickley, 2008; Ridgway, 2001; Tew et al., 2012). See:
‘Table 1: Comparison of CHIME (Leamy et al., 2011) to other Recovery Themes’ (p.26).
The findings from each of these studies originated from different groups of mental health stakeholders. Despite the variance in terminology across the papers presented, there is agreement as to the relevance of the CHIME conceptual framework (Leamy et al., 2011). Each study recognized the role of social connectedness and positive identity in the recovery process. All but one study identified themes relating to the concepts of power and/or empowerment, and hope. The concept of meaning was corroborated to a later extent.

Findings by Tew et al. (2012) were generated from a primarily social perspective and individual components of recovery were therefore not addressed. Therefore, the CHIME model by Leamy et al. (2011) appears to offer a framework around which there is some consensus about the underlying processes of recovery.

Systematic and empirical means of investigation have increasingly been used to elaborate the recovery approach (Slade, 2012). For example, a systematic review of 105 conceptualisations of recovery carried out by Slade, Leamy, et al. (2012) found that over half of these were garnered from qualitative research, non-systematic literature reviews (24%), position papers (12%), systematic reviews (2%) and quantitative empirical studies (1%). The current understanding of recovery has been primarily derived from qualitative research and expert opinion, despite these sources being placed at the lower end of the hierarchal model of evidence-based medicine (Slade, Leamy, et al., 2012). Some recovery stakeholders have called for further quantitative studies to be conducted in order to develop the evidence-base (Slade & Hayward, 2007). However, an alternative view has been advocated by others, for example the statement “don't tell me that recovery is not evidence-based. I'm the evidence” (Davidson et al., 2006, p. 640).

Opposition to increasing the evidence for recovery using quantitative means has also been expressed by J. Campbell (2009) who is of the opinion that principles of evidence-based practice are not congruent with those of recovery due to the paternalistic framework from
which these are derived. These efforts to engender the “appliance of science”, the famously used slogan of the Zanussi electrical company, indicate mixed reactions to framing recovery within an evidence-based paradigm (McGowan, 2012, October).

Although the concept of recovery in mental health can encompass many different meanings, it is clear that personal recovery is an idea that has emerged from a service user perspective. While efforts have been made to further define and conceptualise personal recovery, the notion of building an evidence-base to support this concept has been met with resistance on behalf of some service users. Reason for such resistance is due to the professional hegemony that evidence-based practice can be viewed to espouse, but also resistance due to a disagreement around what constitutes as evidence. Therefore, there is a need for agreement among service users and practitioners as to how conceptualisations of recovery can continue to be developed in a language and manner that is satisfactory to all parties concerned.
Table 1: Comparison of 'CHIME' (Leamy et al., 2011) to other Recovery Themes

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<thead>
<tr>
<th></th>
<th>Connectedness</th>
<th>Hope and optimism</th>
<th>Identity</th>
<th>Meaning in life</th>
<th>Empowerment</th>
<th>Other themes identified</th>
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<tbody>
<tr>
<td>Leamy et al. (2011)</td>
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<td>Bonney and Stickley (2008)</td>
<td>The social domain</td>
<td>Hope and optimism</td>
<td>Identity</td>
<td></td>
<td>Empowerment</td>
<td>a) Risk and responsibility</td>
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<td></td>
<td>b) Service provision agenda</td>
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<tr>
<td>Ridgway (2001)</td>
<td>Importance of social network for support and partnership</td>
<td>Reawakening of hope</td>
<td>Reclaiming a positive sense of self</td>
<td>Importance of meaning and purpose</td>
<td>Power and control</td>
<td>a) Actively coping</td>
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<td>b) Non-linear process</td>
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<td>c) Withdrawal to active participation</td>
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<tr>
<td>Tew et al. (2012)</td>
<td>a) Social inclusion</td>
<td>The negotiation of positive social identities</td>
<td>Empowerment</td>
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<td></td>
<td>b) establishment of supportive personal relationships</td>
<td>(This study only considered social processes of recovery, and regarded hope as a personal characteristic)</td>
<td>(This study only considered social processes of recovery, and regarded meaning as a personal characteristic)</td>
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Realising Recovery

The further elaboration of recovery undertaken here allows the revelation of the expansive and incomplete, even anti-consensus, context in which recovery is growing as an approach within mental health care. In Ireland the first sparks of a future blaze of recovery services are emerging but the implementation of a rich and nuanced policy around recovery is frustratingly slow. For Ireland’s near neighbours in the UK the recovery approach has been elaborated and implemented in various ways. Reflection on these contexts allows for the development and expansion of the concept of recovery and at the same time point to the ways in which its full implementation across all services is hampered. The discussion of policy and health care literature that follows seeks to amplify some of the current key tensions and opportunities in pursuing a service user orientation in mental health services.

Described as an idea “whose time has come” (Shepherd, Boardman, & Slade, 2008, p. 1), personal and social understandings of recovery have grown among mental health service providers internationally (Slade et al., 2014). Recovery has been described variously as an approach (Mental Health Commission, 2008), concept (Fox, 2012; G. Stacey & Stickley, 2012), model (Eyre, 2013; Oades, Crowe, & Nguyen, 2009), movement (Slade, 2009b), orientation (Williams et al., 2012), paradigm (Mind, 2008), process (Lovejoy, 1982; Young, Green, & Estroff, 2008), vision (Turner-Crowson & Wallcraft, 2002), that has been embraced as a “harbinger of progress” as it provides an overarching framework for mental health provision (Pilgrim, 2008, p. 295). Recovery is emphasised in the Mental Health Action Plan 2013- 2020 by the World Health Organisation (2013), and underpins mental health policy in many countries such as the United States, United Kingdom, Canada, Australia, New Zealand, Ireland, Norway, Sweden, Taiwan, South Korea and Iceland (Slade, Leamy, et al., 2012).
A Vision for Change (AVFC) is the current policy for mental health services in Ireland (Department of Health and Children, 2006). The concept of recovery is promoted at every level of service provision in this policy. Collaboration and partnership between service users and professionals is inherent to realising *the vision*. This mission is emphasised by the Mental Health Commission (2007, 2008) who have also promoted a recovery approach to service provision. However, the roll-out of AVFC is notably slow and inconsistent (Department of Health, 2012b; Faedo & Normand, 2013). Observations of an independent monitoring group highlighted a number of barriers that have impeded AVFC’s progress including issues related to resources, staffing, organisational structure and the lack of an implementation plan (Department of Health, 2012b). The need for cultural change has also been included to promote a shift from “professional dominance towards a person-centred, partnership approach” (Department of Health, 2012b, p. 4). However, despite these challenges in realising recovery in mental health services in Ireland, there still remains a strong commitment to embrace this approach (Health Service Executive, 2014).

Realising a recovery philosophy in mental health services requires the adoption of *recovery-oriented* practices that offer a “supportive and healing environment” (Leamy et al., 2011, p. 448). This requires a shift in practice away from a clinical model towards a holistic approach that focusses on strengths and abilities of the individual. Recovery-oriented practice has been described as “eliciting, fleshing out, and cultivating the positive elements of a person’s life- such as his or her assets, aspirations, hopes, and interests” (Davidson et al., 2006). However, the realisation of recovery-oriented practice in mental health has been described as a complex and multi-faceted affair (Slade, Adams, & O'Hagan, 2012), because of the lack of clarity about the pragmatics of practice that are involved (Bonney & Stickley, 2008; Davidson et al., 2006; Davidson & Roe, 2007; Le Boutillier et al., 2011). This has created feelings of uneasiness and tension among service providers (Pilgrim, 2008).
In an effort to define the central ingredients of recovery-oriented practice, Le Boutillier et al. (2011) conducted a synthesis of 30 practice guideline papers and extracted 16 themes. These included: 1) seeing beyond the service user; 2) service user rights; 3) social inclusion; 4) meaningful occupation; 5) recovery vision; 6) workplace support structures; 7) quality improvement; 8) care pathway; 9) workforce planning; 10) individuality; 11) informed choice; 12) peer support; 13) strengths focus; 14) holistic approach; 15) partnerships; and 16) inspiring hope. From these themes four overall conceptual practice domains were identified including practices which supported personally defined recovery, a working relationship, organisational commitment and the promotion of citizenship. Together these elements are constructed to create a framework that can be used to realise the delivery of recovery-oriented practise as a “transformational ideology” (Le Boutillier et al., 2011, p. 1470). However, this ideology has been met with scepticism accusing recovery-oriented practices of raising false hopes among service users (Pilgrim & McCranie, 2013). Others have viewed recovery as an invitation for failure (Roberts & Wolfson, 2004). However, one of the main concerns in adopting recovery in mental health services has been that new rhetoric rather than changed practice is adopted (Ridgway, 2001; Slade, Adams, et al., 2012).

With an awareness that mental health services do not easily or readily adopt changes in practice, Davidson et al. (2006) specifically focussed on domains of organisational commitment and the promotion of citizenship in mental health in relation to recovery. Generated from discussions, presentations and training events, concerns highlighted about recovery-oriented practice were that:

Recovery is old news, recovery-oriented care adds to the burden of already stretched providers, recovery involves cure, recovery happens to very few people, recovery represents an irresponsible fad, recovery happens only after and as a result of active treatment, recovery-oriented care is implemented only through the addition of new resources, recovery-oriented care is neither reimbursable nor evidence based, recovery-oriented care devalues the role of professional intervention, and recovery-
oriented care increases providers’ exposure to risk and liability. (Davidson et al., 2006, p. 640)

The concerns identified were grouped into two overarching challenges that relate to the issues of risk and resources that have also been discussed by Pilgrim (2008). These issues can therefore offer a concrete grounding from which healthcare providers can begin to consider how to implement a recovery philosophy in mental health. The proposed shift in practice is informed from a strengths-based model that encourages active and meaningful citizenship among service users. Davidson et al. (2006) discussed the challenges involved in this changeover, particularly at the juncture where recovery-oriented practices and more traditional means of psychiatric treatment and rehabilitative practices are concurrently offered. This is a point at which paradigms may conflict. A question of context has also arisen around the suitability of particular environments to implementation of recovery-oriented practice. Solli (2014) suggested that community settings may offer environments that are more conducive to citizenship and inclusiveness in comparison to inpatient settings where risk-taking is less inclined.

Tew et al. (2012) highlighted the need for socially-oriented recovery practice which is premised on the idea of connecting people with their social world. Rather than pursuing an individualistic treatment pathway, professionals are urged to collaborate with both the person with mental health difficulties and other parties in their social setting so as to promote inclusion and help maintain as much of their “ordinary life” as possible (Tew et al., 2012, p. 455). The role of social workers and other socially-oriented professionals is emphasised in this regard which can not only help realise recovery by promoting social inclusion, but also address issues of discrimination and stigma against people who are trying to overcome societal barriers towards wellness. Harnessing opportunities for empowerment is also encouraged through the use of self-directed support models that diminish reliance upon mental health services (Tew et al., 2012). However, the enormity of this task has been
considered as Slade, Adams, et al. (2012) questioned whether mental health workers should be expected to become agents of social change while O'Hagan (2001) queried whether the current workforce has the ability to adopt the necessary competencies to do this role in the first instance.

There have been numerous calls to further develop the evidence-base for recovery-oriented practice (Anthony et al., 2003; Farkas, Gagne, Anthony, & Chamberlin, 2005; Slade, 2012; Slade, Adams, et al., 2012). In response Slade et al. (2014) described ten empirically supported pro-recovery interventions related to areas such as peer support, action planning, education, housing and vocation. However, a question of congruency has arisen therein whereby evidence-based practice has allegedly failed to speak or recognise the language of mental health recovery (Anthony et al., 2003). In acknowledgment that evidence-based practice will inform mental health for the foreseeable future, Anthony et al. (2003) suggested that future practice should focus on outcomes that are relevant to people’s recovery. Among Anthony and colleagues’ eight points of consideration for mental health researchers and policy makers were that increased recognition be given to qualitative and non-traditional measures of inquiry so that recovery and evidence-based practice can engage in more meaningful discussion in order to implement effective, positive change in service delivery (Anthony et al., 2003). A follow on from this is the contribution by Farkas et al. (2005) who defined a recovery-oriented mental health program that is compatible with principles of evidence-based practice. They suggested that values underlying recovery such as self-determination/choice, personal involvement, person orientation and growth potential can be fostered through dimensions such as mission, policies, procedures, record keeping and quality assurance that all correspond with evidence-based practice. This is an example of what Wilcoxon, Magnuson, and Norem (2008) have described as using culturally derived values as a reference point for the process of acculturation. Therefore, a change in the style of working
is not only required to deliver recovery-oriented practice but also a change in the culture from which these services are provided (Slade et al., 2014).

Mental health policy in many countries has pledged commitment to realising recovery-oriented practice. While this practice is ideologically attractive for both service users and professionals, there is a yearning for further description around how such practice can be realised, particularly in the cases of more traditional mental health services where there is uncertainty around how to realise the recovery vision. While it is acknowledged that the fruition of recovery-oriented practice may require a marked cultural shift for some mental health services, it may also be the case that such services require clear and detailed guidance along such a developmental trajectory.

**Working in Partnership**

At the heart of successful recovery-oriented practice is collaborative, respectful, and mutually trusting relationships between those who receive and deliver services (Slade, 2009a). These relationships are inherent to breaking down barriers that have solidified notions of *them* and *us* between service users and professionals. Instead, recovery-oriented practice encourages that both parties work in partnership (Slade, 2009b). Hope, shared power, availability, openness and stretching boundaries have been identified by service users as important ingredients of helpful relationships where recovery-oriented professionals have been described as courageous individuals who are willing to address the complexities and uniqueness of the change process in a collaborative manner (Borg & Kristiansen, 2004). These research findings are similar to those of Young et al. (2008) who showed that personal growth in recovery may be attributed to relationships in which discussions about new activities, roles and responsibilities occur. Repper and Perkins (2003) outlined the simplest and yet most essential part of the relationship between service user and professional is the acknowledgement of shared humanity:
The ability to recognize the humanity of those with whom we work, value them and recognize the importance of their lives forms the essential bedrock upon which supportive, hope-inspiring relationships are based. An individual is much more likely to begin to value himself/herself if others value him/her (p. 78).

Roberts and Wolfson (2004) proposed that professionals act in the role of a coach or personal trainer who imparts skill and knowledge while they in turn learn from the service user who is an *expert by experience* (Greenhalgh, 2009; Shepherd et al., 2008; Telford & Faulkner, 2004). This idea has also informed discussion in the psychotherapy literature (Casement, 1985). Understanding the experiences of people with mental health difficulties in this way provides a means by which the power differential that features in the traditional doctor-patient relationship can be ameliorated (Kaminskiy, Ramon, & Morant, 2012). Acknowledging that expertise can be acquired through skill and/or training and lived experience is a way of fostering collaborative working during the recovery journey. *Wellness Recovery Action Planning* (WRAP) as devised by Mary Ellen Copeland (1997), is an example of how both parties can work in partnership in order to identify strategies and wellness skills in recovery.

Personal or social recovery is conceptualised within these various proposals for the implementation of a recovery approach as requiring trusting and encouraging relationships that surround people as they overcome the difficulties that are created in their lives by having a mental disorder. Realising such relationships does not require monetary input alone but instead the embracement of a belief system that nurtures connection, hope, identity, meaning, and empowerment so that people can be encouraged to discover their own special formula for their recovery (Leamy et al., 2011).

The current status of recovery is both an emerging concept for effective service delivery and yet a difficult and complex idea. While there is a willingness among many mental health providers to adopt this ideologically seductive approach it must also be
recognised that it is pragmatically elusive. It demands a high degree of flexibility in service provision where a shared sense of responsibility can be fostered between service users and practitioners whom together work in partnership.

**Service User Involvement**

Recovery underpins the provision and development of mental health in many countries around the world. Therefore, it is not only necessary to reflect upon individual journeys but also upon the context in which these occur (Slade, Leamy, et al., 2012). Successful embrace of recovery in mental health systems demands acknowledgement and inclusion of expertise from those who have faced mental health problems (Repper & Perkins, 2003). Such people “should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation” (World Health Organisation, 2013, p. 10). Yet this requires radical cultural change and organisational transformation so that the voices of *experts by experience* can directly inform mental health delivery and planning.

The need for successful inclusion of service user perspectives has been highlighted in statutory health services in Ireland (Department of Health, 2012a; Department of Health and Children, 2008; Health Service Executive, 2010). National policies and guidance documents recognise the central role of service users in the positive reform of mental health systems (Department of Health, 2012b; Department of Health and Children, 2006; Health Service Executive, 2012, 2014; Mental Health Commission, 2005; National Service Users Executive, 2012). While there are some examples of willingness on behalf of statutory service providers to include user perspectives (Mental Health Commission, 2012), such efforts are still in their infancy (National Service Users Executive, 2012; Thornicroft & Tansella, 2005). It has been agreed that the main way of meeting this need for inclusion of service users in the
development and delivery of care systems will only come as a result of reform in mental health services so that they are committed to the “genuine engagement of service users, family members and carers in the planning and delivery of care both at the individual level and at the service level” (Health Service Executive, 2014, p. 15).

Moral justifications with nods to equity are on public record from many areas as indicating support for a recovery orientation, but the realisation of service user opinions in the everyday operations of services presents a challenge involving redistribution of power (McDaid, 2010). The following section will discuss the perceived and practical complexities of service user involvement and the varying ways in which service user perspectives can be included in development of programmes and systems of support and care.

**Considering Involvement**

User involvement is influenced by many factors and refers to a broad spectrum of activities on individual and operational levels (Repper & Perkins, 2003). While the notion of user involvement at all stages of mental health service development and planning may initially present as a simple and realisable idea, consultation of the literature indicates that involvement is quite a complex process. This is due to the differing consumerist but also social and liberatory models from which concepts of service user involvement have emerged. As a result, there is much variance in the discourse that surrounds the idea of service user involvement and this relies upon the ideals from which such discourse has emanated.

A number of countries including Ireland, the UK, the USA, Australia, New Zealand and Canada have engaged a recovery vision underpinned by the values of involvement and partnership in mental health by all (Wallcraft et al., 2011). Including users in the development of health provision is no longer considered optional, and services are challenged to create forums for meaningful inclusiveness (Crawford, 2001). This initiative is rooted in a
number of wider social and political developments that occurred in the later decades of the twentieth century related to “disciplines and discourses of politics and political philosophy; of democracy and power; [and] of citizenship and responsibilities” (Beresford, 2012, p. 21).

Notions of involvement and participation in mental health have been accompanied by differing types of terminology which depends upon the belief and value system of the stakeholder group concerned (Wallcraft et al., 2011). This has led to differing opinions around the concept of involvement that impacts how recipients of mental health services see themselves and their respective roles. An example of this relates to how such people refer to themselves in the mental health literature which has featured varying terms such as ‘consumers’, ‘patients’, ‘clients’, ‘survivors’, ‘users’, ‘experts by experience, or ‘service users’ (McLaughlin, 2009; Wallcraft, Schrank, & Amering, 2009). While acknowledging that it is unlikely that agreement will be reached around the use of one term of reference, that of service user is chosen in the case of this research because (at the time of writing this thesis), it is the preferred term of the National Service Users Executive who represent the views of people who use mental health services in Ireland.

According to Wallcraft and Nettle (2009), the impetus for user involvement in mental health was due the determination of those with mental health difficulties who spoke out about their experiences of illness. In the USA since the late 1970s, these advocates provided information and support to other people with mental health difficulties in addition to campaigning for better services and public understanding of mental health issues (Wallcraft & Nettle, 2009). Croft and Beresford (1992) traced user involvement in the UK back to the 1980s as a time of great social and political change. This era was seen to provide a fertile landscape from which the agenda for involvement in social policy arose and this subsequently contributed to the development of service user involvement in mental health services. Service user groups in the UK, seen to align with a reformist user/consumer
movement, shared a similar mission to those in the US by calling for better facilitation of recovery (Repper & Perkins, 2003). A further contributing factor to user involvement in mental health in the UK was the radical, anti-psychiatry movement that became vocal during the 1980s which resulted in the creation of user-run services that were set apart from traditional mental health systems (Repper & Perkins, 2003). Each of the above accounts of user involvement in mental health indicate that there have been many contributing factors to this movement which has arisen within various contexts. Beresford (2002) has advised caution in this regard, suggesting that these varying factors may delineate very different meanings across various service user groups. Therefore, involvement is a rather complex concept that has been poorly defined in the past due to its connotation with goodness when instead it is something that is far from being value-free and neutral (Beresford, 2012; McDaid, 2009).

One major influence upon user involvement in mental health has come from a consumerist model that arose in the 1980s and 1990s as a result of in market-led approaches to public provision and policy that lead a devaluing of state input (Beresford, 2002). The fundamental premise for this model is that consumers should have a choice as to which services they receive. However, Beresford suggested that an irony existed within such consumerist ideology as it held a belief that solutions lay in market-led approaches yet when such solutions were found the state, in many cases, had then to intervene to “counter the inequalities and inadequacies of market-led economies” (2012, p. 27). Notions of consumerism have since evolved into a stakeholder model which opines the view that “public services are best planned and delivered when the views of key parties, including those of service users, professionals, the general public and government, are actively sought and taken into account” (Rush, 2004, p. 314).
Another instigator of user involvement in mental health can be traced back to social and liberatory movements that embrace involvement in terms of political values. According to Beresford (2012) these have been some of the most powerful influences on the user involvement initiative. Often representing people with disabilities and being characterised as having a tendency to be located on the periphery of political systems, the social and liberatory movements speak out about service user issues internationally while also offering a critical evaluation of society’s role therein (Oliver, 1990). Based on democratic or empowerment models of participation as referred to by Beresford (2002), these are unlike the notion of consumerism as they address issues concerning inequality and civil rights whereby the primary motive is to influence health services that impact upon society as a whole (Rush, 2004). In the context of mental health, catalysts of such initiatives stemmed from the process of deinstitutionalisation and subsequent discontentment with aspects of community care (Beresford, 2002). This led to a call for public participation from service user movements and organisations who wished to have more of a direct influence on health provision (P. Campbell, 1996).

It is clear that the consumerist and social user involvement movements are different to each other by offering varying understandings and ideologies about how health services should develop. This makes development of user involvement a complex affair where confusion is likely to arise between service users and providers as a result of sharing a common language of participation that is founded upon differing approaches (Beresford, 2012). Rush (2004) suggested that a way of overcoming such confusion may be through meaningful dialogue between all parties concerned.

**Rationale for Involvement**

There is both an ethical and evidence-based argument to be made for inclusion of service user perspectives in mental health (Thornicroft & Tansella, 2005) and this can be
considered on individual, operational, strategic and research levels (Repper & Perkins, 2003). On an ethical standing it is believed that people have vital contributions to make in relation to the services they use (Thorncroft & Tansella, 2005). Crawford supports this ethical viewpoint and has suggested that involvement should be based on the “understanding that someone who has experienced services has developed an informed view that is of value to those developing and assessing services” (2001, p. 85). From an evidence-based perspective a systematic review by Crawford et al. (2002) concluded that user involvement can bring about change in the planning and development of mental health services in terms of providing better information to service users, simplifying appointment processes or extending opening hours, and improving transport for those with mobility issues. It was also found that some service users may experience increased self-esteem as a result of being able to make a contribution while others were satisfied to have an opportunity to air dissatisfaction. Although these findings support some of the positive impacts as a result of user involvement, the need for a better evidence-base has been emphasised, yet Crawford et al. (2002) suggested that “this absence of evidence should not be mistaken for an absence of effect” (p. 1267).

**Challenges of Involvement**

The inclusion of service user perspectives in mental health is no longer discretionary but instead compulsory (Crawford et al., 2002). Ensuring that the collaboration between service users and professionals is meaningful involves overcoming problems relating to such engagement. Staff who already feel the weight of burgeoning job descriptions have reported difficulties with user involvement (Wallcraft et al., 2011) and this is perhaps not particularly surprising given that mental health is a field of practice where compassion fatigue is common (Sprang, Clark, & Whitt-Woosley, 2007). Some psychiatrists have voiced their reluctance towards user involvement arguing that the purpose of the medical skillset should be measured
in relation to the treatment of symptoms rather than with regard to how patients experience or feel about such treatment (Crawford, 2001). Concern has also been expressed about the extent to which a patient may be regarded as a consumer of healthcare in instances when their insight is diminished because of their mental health problems (Crawford, 2001). A lack of participation skills on behalf of service users has also been cited where concern about capacity has been a central feature within the resistive discourse to such involvement (McDaid, 2009). It has been suggested that this reluctance stems from a view within psychiatry that the role of the profession is to balance the needs of service users with a wider responsibility to society at large (Crawford, 2001). Some have interpreted this as an attempt to discredit the role of mental health service users in enhancing systems of healthcare in society (Crawford & Rutter, 2004).

A further question has arisen as to whether members of mental health service user groups are actually representative of ‘ordinary patients’ (Crawford et al., 2003; Crawford & Rutter, 2004). This question of accountability has originated from mental health providers who expressed the opinion that because there is a lack of consensus among service user views therefore these views should not carry weight or influence service delivery (Rutter, Manley, Weaver, Crawford, & Fulop, 2004). Differing objectives among service users can pose a challenge in creating successful partnerships with professionals (Rush, 2004; Rutter et al., 2004). It is possible that this stems from an expectation that service users are an homogenous group (Lammers & Happell, 2003). However, a comparison of perspectives from mental health user groups and those of a sample of patients showed that there can be much in common with regard to priorities for mental health service development (Crawford & Rutter, 2004). This can be strengthened when on-going links are maintained between representatives and those whom they serve so that collective rather than individual perspectives of impacting issues are held (Crawford & Rutter, 2004). Furthermore, it is important that service providers
are aware that there is no absolute way of obtaining an accurate picture of service user perspectives. Instead it may be possible to find ways of eliciting the views of those who are not active members of representative groups using alternative methods of inquiry (Crawford & Rutter, 2004). Such initiatives may provide a way of gleaning new perspectives of relevant issues.

Another aspect of challenge in terms of user involvement relates to how service users engage with mental health systems. Mitigating factors against service user involvement with health provider groups have been attributed to: a haphazard selection of representatives; a lack of means in tapping into the views of the groups they represent; reticence about contributing at a committee level; feelings of being outnumbered by senior professionals; a lack of knowledge about the remit of the group they serve and how this relates to the overall health system and organisational structure; having little influence over the agenda of meetings; and finding that their contributions are ignored (Health Service Executive, 2012). Service users who took part in participatory action research in Ireland also attributed challenges of involvement to unequal physical, mental, cultural and economic resources in addition to identifying issues around power, time, stigma and lack of respect for their lived experience (McDaid, 2009). This points to the need for service users to discern their own participation in terms of their level of functioning, personal choice and what they feel they are able to contribute (Lammers & Happell, 2003). Other barriers reported in the literature include devaluing attitudes on behalf of providers in addition to inadequate support and direction with regards to consumer-run programmes in times of personal crisis (Lammers & Happell, 2003). Collective consideration of all of these obstacles indicate that ‘tokenism’ may take place under the guise of ‘involvement’ which unfortunately only disempowers and undermines service user perspectives (K. Stacey & Herron, 2002).
It would appear that service user representatives may face structural disadvantages as they engage with mental health systems that have been traditionally designed and delivered by health professionals. This has been hindered by a lack of defined mechanisms of inclusion in service delivery and policy (Lammers & Happell, 2003; Wallcraft et al., 2011). The consequence of this is that terms of involvement are often set on an unequal playing field to the disadvantage of the service user (McDaid, 2009). J. Baker, Lynch, Cantillon, and Walsh (2004) have put forward a framework that aids the analysis of such inequality in accordance to the dimensions of: resources; power relations; love, care and solidarity; and respect and recognition.

The multiple challenges described above can be used to identify solutions for successful involvement in terms of staff attitudes, participant and structural supports, and the need to define involvement on a basis of equality. In recognition of the value of service user involvement in mental health, the World Psychiatric Association (WPA), in consultation with the international mental health community, created a set of ten recommendations outlined below for best practice in collaborative working with service users and carers:

1. Respecting human rights is the basis of successful partnerships for mental health.
2. Legislation, policy and clinical practice relevant to the lives and care of people with mental disorders need to be developed in collaboration with users and carers.
3. The international mental health community should promote and support the development of users’ organizations and carers’ organizations.
4. Improving the mental health of the community should be a fundamental condition for formulating policies to support economic and social development.
5. International and local professional organizations, including WPA through its programs and member societies, should seek the involvement of consumers and carers in their own activities.
6. The best clinical care of any person in acute or rehabilitation situations is done in collaboration between the user, the carers and the clinicians.
7. Education, research and quality improvement in mental health care require collaboration between users, carers and clinicians.
8. The path to recovery of mental health should include attention to economic and social inclusion.
9. WPA Member Societies and other professional groups should collaborate with users’ organizations, carers’ organizations and other community organizations to lobby
governments for political will and action for better funding of services, community education and fighting stigma.

10. Enhancing user and carer empowerment includes the development of self-help groups, participation in service planning and management boards, employment of people with mental health disabilities in mental health service provision, user-run community centres and psychosocial clubhouses, speakers bureaux and local anti-stigma programs.

(Wallcraft et al., 2011, pp. 232-234)

These recommendations indicate how the involvement of stakeholders is supported by the international mental health community which includes the College of Psychiatry in Ireland (World Psychiatric Association, 2014, September 10). While these are helpful in providing guidance to this developing movement, further work is needed to realise genuine and meaningful inclusion.

**Service User Involvement in Service Evaluation and Research**

Traditionally, people with mental health difficulties have been involved in research as subjects where participation is typically controlled and monitored by health professionals (Repper & Perkins, 2003). However, as the consumerist and democratic approaches to service user involvement gathered momentum so too did the idea of active citizenship along with government and public bodies’ awareness of the need for service improvement (Beresford, 2002; Wallcraft & Nettle, 2009; Ward et al., 2010). Individual small-scale studies by service users, consumer research by service user/survivor groups in addition to studies by service users who were also mental health professionals and reformers of healthcare, all played crucial roles in developing user involvement in research (Wallcraft et al., 2011). It has since been recognised that service users have a valuable contribution to make to mental health research by raising important research questions, ensuring the user friendliness of interventions, and deciding upon outcome measures (Trivedi & Wykes, 2002). Today service users may be involved in a broad array of research activities from the initial conceptualisation of a research question to dissemination and follow-up of findings (Beresford, 2007). This
may relate to different categories of research such as: 1) user involvement research; 2) collaborative research between service users, their organisations, researchers and service providers; and 3) user-led research which is typically initiated and ran by service users (Beresford, 2007). Therefore, service user involvement in research can vary between the dimensions of consultation, partnership and control (Minogue, 2009).

Consultation has been described as a way of considering a particular issue between individuals and is often used as a means of hearing views and opinions (Minogue, 2009). Although often limited to information receiving that does not promote as active involvement or empowerment as that involved in user-led research, consultation has been thought of as a way of influencing the agenda for user involvement in research (Sweeney & Morgan, 2009). For these to be meaningful and high-quality, service user participants should be “adequately informed, prepared and provided with opportunities for deliberation and discussion” (Sweeney & Morgan, 2009, p. 28). Although consultation is rated at a low level on the ladder of participation as designed by Arnstein (1969), this model has been criticised for its linear nature that does not recognise the thought processes of those involved or the complex nature of engagement (Beresford, 2002). Another way of conceptualising consultation for the purposes of user involvement has been to clearly communicate its link in relation to the decision outcome (Abelson & Forest, 2004). This can encompass varying degrees of engagement, motivation, and investment on the part of the researcher and participant. It has been viewed as “a step in the direction of making research accessible to those people who experience mental health services and allowing service improvement to be shaped by the experience of those who receive services” (Minogue, 2009, pp. 159-162).

Premised on principles of consultation, this research also considers the growing idea of service user evaluation that values the experiences of those who are consumers of mental health care (Beresford, 2002; Thornicroft & Tansella, 2005). This concept has been promoted
in health policy in Ireland (Department of Health and Children, 2006; Health Service Executive, 2010) and in other jurisdictions such as the UK (HM Government, 2009). However, evaluation by service users appears to be inadequately defined in such policies, and although service user evaluation features in AVFC as the guiding document for development of mental health services in Ireland, it received no mention in the most recent operational plan of the Health Service Executive (2014). Therefore, evaluation requires further definition as it has received inconsistent attention in mental health provision in Ireland. In a report for mental health services complied by Barrett (2008), evaluation was described as a process of asking questions which focus on the impact of care on the individual. This is similar to evaluation as a form of gaining perspective through open dialogue as described by Fortune et al. (2010), but different to other understandings of the word that relate to measuring performance (Barrett, 2008).

The mental health literature provides examples of service user evaluation as a form of inquiry that focusses on a particular service or intervention (Fortune et al., 2010; Furness, Armitage, & Pitt, 2011; Simpson, Reynolds, Light, & Attenborough, 2008). These show that service users are competently able to comment on their experiences (Fortune et al., 2010) and that they wish to pass on such experiential knowledge in order to improve mental health programmes and their relationships with practitioners therein (Furness et al., 2011). However, the issue of involving service users with greater needs has been raised (Furness et al., 2011) which points to the need on behalf of researchers to engage in more novel means of inquiry.

Service user evaluation in mental health research recognises the value of lived experience of mental health provision. It not only aims to listen to service user perspectives but also considers how this information can be used to improve various aspects of service delivery as promoted by the recovery approach in mental health. Although not specifically related to a mental health context, evaluation has been suggested as a way of empowering as
it provides a “respectful invitation” for people to voice their views (Tsiris, Pavlicevic, & Farrant, 2014, p. 19). In order to further develop the area of service user evaluation it is necessary to identify meaningful methods of inquiry so as to address the varying needs of a heterogeneous service user population as they relay their views. This may require the use of innovative feedback mechanisms so that multiple perspectives can be accounted for and that meaningful changes for all can be embarked upon in mental health provision.

**Music Therapy in Mental Health**

The promotion of psychological well-being is central to the practice of music therapy in mental health. Music therapy is a relational therapy in which the mental well-being of service users is nurtured through music. This way of communicating can foster one’s capacity to further develop and maintain relationships outside of the therapeutic work and is therefore “characterized by its relational and social capacities that foster improved mental well-being and quality of life of service users” (McCaffrey, in press-a). Music therapy may be offered on an individual or group basis and in mental health, can serve as an adjunct to standard pharmacological treatment or as a stand-alone therapeutic process depending on client needs.

Historical accounts of music therapy’s emergence as a practice in mental health produce a complex myriad of intersecting agents and ideas related to music, medicine, culture and society (McCaffrey, in press-b). An ensuing debate among music therapists includes the question as to whether the history of music therapy is part of a grander narrative of music and medicine (Ruud, 2001), or whether the music in a hospital context, and as a post war initiative is a way of understanding the backdrop from which music therapy developed (Edwards, 2008). The recreational value of music and music-making became recognised in psychiatry during the 19th century which led to a popular practice in hospitals and asylums across Britain and the USA whereby choirs, bands and orchestras performed to various
patient groups (Tyler, 2000). Other uses of music in psychiatry included its role as a form of moral therapy that was premised on a belief that mental illness was caused by the individual’s failure to observe moral laws established by God and nature (Davis, 2003). The use of music for spiritual purposes can be traced in psychiatric practice in Germany where music was systematically used to treat the soul (Kramer, 2000). The application of music in psychiatry followed a more distinctive trajectory when professionalization of music therapy occurred during the post war period in many English speaking countries (Edwards, 2008). One of the earliest definitions of music therapy described it as “the carefully prescribed dosage of music, either by listening or participation, given under a psychiatrist’s supervision and closely watched and controlled” (Gilliland, 1945, p. 24). This definition suggested that early professional practice of music therapy in psychiatry was closely governed and aligned to a medical model of care. Although music therapy has since developed an extensive theoretical base that not only relates to psychiatry but also to the domain of mental health, the developmental trajectory of the profession has been greatly influenced by central principles and practices of a medical model which require further discussion in the context of this research (McCaffrey, in press-b).

The Evidence-base for Music Therapy in Mental Health

The emergence of music therapy as an allied health profession in mental health is due to the ground-breaking efforts of its early practitioners but also due to research that has demonstrated its efficacy and effectiveness. Since the establishment of evidence-based medicine (EBM) in the late 1990s (Sackett et al., 1996), music therapy has been challenged by but also challenged the application of EBM in healthcare (Edwards, 2005). The EBM movement has influenced music therapy research along with other allied health areas so that the discipline is regarded as an evidence-based practice (EBP) that selects “optimal treatment
techniques based on best-possible assessment data and the selection of optimal treatment based on best-possible outcome data” (Unkefer & Thaut, 2005, p. v).

There is a strong and growing research base supporting music therapy as an evidence-based practice in mental health. In accordance to the hierarchal levels of EBM, the most conclusive evidence is that produced by systematic reviews that synthesise research evidence of high quality randomized controlled trials (RCTs) (Haynes, 2002). At the time of writing this thesis, there are two high quality systematic reviews supporting music therapy in the treatment of schizophrenia and schizophrenia-like illness (Mössler, Chen, Heldal, & Gold, 2011) and depression (Maratos, Gold, Wang, & Crawford, 2008). In addition to these systematic reviews there have also been a number of RCTs carried out to investigate the outcomes of music therapy with a specific population or patient group. Erkkilä et al. (2011) carried out an RCT for people with depression and concluded that individual music therapy, combined with usual care, is effective for people of working age in terms of symptoms of depression, anxiety and general functioning. These results are similar to earlier findings of the aforementioned systematic review by Maratos et al. (2008) who also concluded that music therapy can bring about a reduction in symptoms of depression. An RCT conducted by Fachner, Gold, and Erkkilä (2013) also supports the premise that music therapy reduces symptoms of depression and anxiety. Results suggested that verbal reflection and improvising on emotional experiences during music therapy encouraged neural reorganisation and cortical activity. Albornoz (2011) also carried out an RCT to find that within a group context, improvisational music therapy can lead to improvements in reducing depressive symptoms in adolescents and adults with depression and substance abuse. In a study that examined the feasibility of an RCT of music therapy groups for people with schizophrenia, those randomized to music therapy showed improved symptom scores, particularly in general symptoms of schizophrenia (Talwar et al., 2006). These and earlier research findings by
Tang, Yao, and Zheng (1994) provide support for the treatment guidelines in schizophrenia which state that arts therapies are “the only interventions both psychological and pharmacological, to demonstrate consistent efficacy in the reduction of negative symptoms” (National Institute for Health and Clinical Excellence, 2009, p. 205).

Carr et al. (2011) carried out an exploratory RCT to investigate the effects of music therapy among people with persistent post-traumatic stress disorder (PTSD) who did not respond to cognitive behavioural therapy. Results showed that group music therapy helped reduce both symptoms of PTSD and those of depression (Carr et al., 2011). These results echo earlier observations of Bensimon, Amir, and Wolf (2008) who concluded that Israeli soldiers experienced a reduction in their PTSD symptoms following participation in drumming during group music therapy.

Other clinical outcomes of music therapy with certain service user groups have also been investigated. Carr, Odell-Miller, and Priebe (2013) reviewed 98 papers relating to music therapy in the treatment of adult psychiatric inpatients receiving acute care. They found 35 papers that reported specific outcomes of therapy with this population, concluding that music therapy is often practiced within an open group setting in which there is emphasis on active music for non-verbal expression for the purposes of engagement, communication and interpersonal relationships. However, the need for a clearly defined model of practice in working with inpatients was highlighted.

More recent quantitative investigations in music therapy have shifted the focus beyond the application of a specific intervention to target a certain diagnosis. This to some is a welcomed initiative as Budd and Hughes (2009) have argued that it is impossible to isolate effects that are specific to a certain type of psychological therapy. Rather than focusing on a diagnosis, the effects of a specific type of music therapy upon those who have a shared
characteristic has been investigated (Gold, Mößler, et al., 2013). This pragmatic parallel trial employed individual resource-oriented music therapy (ROMT) as a model of practice that involves the nurturing of strengths, resources and potentials in a manner that emphasises collaboration rather than intervention (Rolvsjord, 2010). ROMT was offered in addition to standard treatment to people with mental disorders with low motivation for therapy. When compared with those who received only usual care it was found that ROMT was superior in terms of negative symptoms, functioning, clinical global impressions, social avoidance through music and vitality (Gold, Mößler, et al., 2013). Such efforts to move beyond the formulation of diagnosis-specific treatment models has been considered by Pedersen (2014) who has called for further collaboration between nature science and humanistic science in order to understand “why music therapy works and which qualities and resources it promotes in the treatment process” (p. 190).

Overall, research has shown that music therapy is a promising practice which can support the needs of adults with mental health problems (Edwards, 2006; Gold, Assmus, et al., 2013; Gold et al., 2009; Grocke et al., 2008; Lee & Thyer, 2013; Lin et al., 2011; Odell-Miller, 1999). In a review of almost 100 studies on the topic of music in mental health, music as used by music therapists was effective in bringing about clinical improvement (Lin et al., 2011). These support the views of Grocke et al. (2008) who reported the benefits of music therapy for people with enduring mental illness including improved social functioning, global state and mental state. In an another review of music therapy studies with people who have a mental health diagnosis it was concluded that music therapy is “a structured interaction that patients are able to use to participate successfully, manage some of their symptoms, and express feeling relating to their experiences” (Edwards, 2006, p. 33).

While the findings from the studies described above undoubtedly support the role of music therapy in mental health, some researchers have called for further methodological
rigor, clearer outcomes and larger sample sizes in future research in this area (Carr et al., 2013; Erkkilä et al., 2011; Lee & Thyer, 2013; Maratos et al., 2008). Defined models of music therapy practice in working with people with mental health difficulties have also been called for (Carr et al., 2013). Although results indicate the lasting effects of music therapy (Gold et al., 2009), it has been suggested by researchers in social work that further investigation is required to ensure that claims of ongoing effects can be substantiated (Lee & Thyer, 2013). This is similar to the view that “advancement in scientific understanding and more methodically sound research is still required to establish [music therapy] … as a sole quantified therapy” (Solanki, Zafar, & Rastogi, 2013, p. 198). Although it is unclear to what exactly a ‘sole quantified therapy’ refers, some confusion has prevailed among certain members of the mental health community (Puig Llobet & Lluch Canut, 2012), who have continually failed to distinguish between applications of music by allied health practitioners, artists, or volunteers from the endeavours of qualified music therapists. These various issues point to the need for continued development of the evidence-base for music therapy in mental health particularly to enhance growth of the profession within a clinical context. However, the discourse and rules of engagement related to evidence-based medicine are governed by a dominant medical model that has been criticised for giving little credence to the expertise of service users as a result of their involvement with mental health services (Anthony et al., 2003; Stickley, 2006). This is problematic given the rising international recognition of recovery in mental health which promotes the involvement of service users at each and every stage of service provision (World Health Organisation, 2013). Therefore, there is an anomaly at play where service user involvement is discouraged in some sectors of mental health and encouraged in others. A way for healthcare providers to address this anomaly is by embracing a broader understanding of the term evidence which is inclusive and respectful of service user expertise that has been gained through lived experience. Such a broadened conception of
evidence would ensure that the evidence-base for mental health practice is informed by both those who use and those who provide services. Odell-Miller (1999) suggested that further mixed-methods studies are required to achieve a broader understanding of therapy where quantitative tools of measurement can be employed alongside qualitative approaches which consider service users’ expectations and outcomes of therapy. If service user voices are to be heard, and to contribute to service development and evaluation, the RCT will need to be relegated to only one way of evidence building for good practice. Such relegation will be needed if the value of service users’ lived-experience is to be recognised. Without such reconfiguration of the various levels of evidence, service users will continue to be denied the possibility of being true partners in mental health research and development.

**Music Therapy and Recovery in Mental Health**

A growing awareness of recovery in mental health is evident in the music therapy literature. An emerging discussion about the potential role of music therapy as a recovery-oriented practice has appeared (Chhina, 2004; Eyre, 2013; Kaser, 2011; Kooij, 2009; McCaffrey et al., 2011), looking beyond a psychiatric model of care towards broader conceptualizations of practice in modern mental health provision. McCaffrey et al. (2011) proposed that music therapy “can realise some of the central themes of recovery by responding to the individual wishes and requests of people with enduring mental illness in a way that realises their personal choices, strengths and potentials so that they can reclaim control over their lives” (2011, p. 187). In order to gain a further understanding of possible resonances between music therapy and recovery-oriented practice, Solli et al. (2013) conducted a meta-analysis of 14 studies that described service users’ experiences in sessions. Themes arising from this analysis included ‘having a good time’, ‘being together’, ‘feeling’ and ‘being someone’ which led to the conclusion that “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” (Solli et al., 2013, p. 244). However, although resonance between music therapy practice and that related to recovery is gaining increased attention, this does not necessarily mean that all models of music therapy practice in mental health are recovery-oriented. Some models of music therapy in mental health might conflict (McCaffrey, in press-a). This points to the need to further define recovery-oriented practice in music therapy which Solli (2014) has described as an environment where the patient is clearly in the “driver’s seat” (p.16).

Common theoretical ground between recovery-oriented practice and defined models of music therapy in mental health has been explored (Grocke et al., 2008; McCaffrey et al., 2011; Solli, 2014; Solli & Rolvsjord, 2014; Solli et al., 2013). Similar to some of the characteristics of recovery-oriented practice (Le Boutillier et al., 2011), it has been suggested that music therapy has the capacity to promote social inclusion (Stige, 2012), meaningful occupation (McCaffrey et al., 2011), a strengths focus (Priebe et al., 2014), agency (DeNora, 2000), empowerment (Rolvsjord, 2004) and hope (Kooij, 2009). Overarching each of these characteristics is the notion of well-being which also has been a germane feature of music therapy in mental health practice in recent years (Ansdell, 2014; DeNora, 2013). Closer consultation of the literature suggests that certain models of music therapy in mental health align with recovery-oriented practice. ROMT (Rolvsjord, 2004, 2010) has been closely aligned to recovery-oriented practice because of its aim to amplify service users strengths, potentials and resources in which music is regarded as a health resource. This has been likened to the Nordoff Robbins creative music therapy approach because of its promotion to utilise various types of resources within the individual (Priebe et al., 2014). Community music therapy (CoMT) (Pavlicevic & Ansdell, 2004a; Stige, 2002, 2012) has also been associated with recovery-oriented practice for reasons of its social and cultural emphases in
working with individuals. Having reflected upon these various likenesses, a rather encompassing view is taken by Solli (2014) who suggested that the theoretical foundation of recovery resonates with humanistic, resource-oriented and community-oriented approaches in music therapy. These threads are woven around a framework in which social inclusion, culture, individuality and wellness feature. These ideas extend far beyond the scope of traditional mental health practice to which the discipline of music therapy initially aligned as it sought to become professionalised. However, recasting a wider net upon practice is necessary if music therapy is to evolve in relation to contemporary practices and concepts in mental health.

**Service User Perspectives of Music Therapy**

Central to the establishment of music therapy as a recovery-oriented practice is the meaningful involvement of service users in development of music therapy practice in mental health. There is a relatively small body of literature relating to service user feedback about music therapy in mental health and this is not terribly surprising given the fervent interest that has occupied many researchers in building the evidence-base of the profession. Indeed, Stige (1999) has highlighted “the need to understand – as well as possible – what the client understands, what his [her] perspective on what is going on in therapy is” (p.61).

It appears that there are distinctive yet related areas of investigation pertaining to service user perspectives of music therapy. The first concerns service user experience of music therapy elicited through interviews, and in some cases these have been carried out between therapists and their clients (Hammel-Gormley, 1995; Rolvsjord, 2010; Solli, 2014; Solli & Rolvsjord, 2014; Stige, 2012). These provided rich examples of how music therapy can be experienced in an idiosyncratic manner but also how it has the capacity to engender changes in the lives of service users both within and outside of the therapy context. Stige (2012) recounted how his client Ramona described music therapy as a “dressing room”
(p.326) in which she could prepare for life in the world outside. Similarly, other interviews have also illuminated how previous music experiences can impact upon those in music therapy (Rolvsjord, 2010). A larger scale study was carried out by Ansdell and Meehan (2010) who interviewed 19 patients and found that they do not necessarily experience or value music therapy in the same way as professionals within mental health may anticipate. This is particularly thought-provoking and is suggestive of possible disparities between the service user and provider perspective. It is also interesting to note that patients involved in this study described music therapy’s benefits as being broader than simply symptomatic change, thus positioning music therapy more within a wellness rather than illness paradigm (Ansdell & Meehan, 2010). These findings are similar to those of Solli and Rolvsjord (2014) who interviewed nine patients with psychosis about their experience of music therapy to find that in many ways music therapy is the opposite of treatment. Although symptom reduction featured as a central theme in these interviews, this was accompanied by themes relating to freedom, contact and wellbeing which again situate music therapy more closely to a wellness paradigm (Solli & Rolvsjord, 2014).

A second avenue to gaining service user perspectives in music therapy has been through processes of evaluation as described by Tsiris et al. (2014). An early example of this process was carried out by Reker (1991) who gave questionnaires to people with schizophrenia who were asked to evaluate their experiences of music therapy. Shortly after this Heaney (1992) recommended the use of evaluation scales in order to deliver valuable therapeutic services and highlighted the “poverty of research in patient’s regard for music therapy” (p. 83). Dye (1994) also undertook a client evaluation of music therapy concluding that the feedback from questionnaires indicated increased insight about the therapeutic process as gained by participants who had taken part. Another example of service user evaluation of music therapy is provided by Carr et al. (2011) who reported that people with
PTSD found group music therapy to play a helpful role in their treatment. Other evaluations have also been carried out in the context of community mental health in which those who attend music therapy have reported the effectiveness of a consumer-initiated song-based programme (Baines, 2003; Baines & Danko, 2010).

The examples described above suggest that mental health service users provide valuable information because of their experiences of music therapy. This not only provides rich learning as to how music therapy can impact upon the individual but also insight into the personal processes as one journeys towards wellness. If the increasing calls for service user involvement are to be realized in mental health provision then it is essential that mechanisms for service user feedback are developed. This research aims to embrace the recovery approach in mental health that emphasises the importance of service user involvement by conducting individual interviews with service users who have lived experience of music therapy. This will serve as a means of evaluation that aims to gain a perspective of a particular service through open dialogue (Barrett, 2008), but also a way of eliciting detailed information “that provides a rich narrative source of opinions, feelings and ideas” (Tsiris et al., 2014, p. 87).

Mindful that some service users encounter difficulties with such processes because of communication challenges (Furness et al., 2011), the research conducted for this thesis promotes the expansion of existing evaluation processes (Baines, 2003; Baines & Danko, 2010; Carr et al, 2011; Dye, 1994; Heaney, 1992; Reker, 1991); looking beyond questionnaires, surveys and interviews to other non-verbal and creative means of inquiry. Many service users attend music therapy because of its capacity to offer a non-verbal way of relating with others through music. Providing creative arts-based evaluation processes may also be useful to mental health providers who wish to move beyond more traditional processes of attaining service user feedback for the purposes of service enhancement. Arts-
based evaluation processes would seem to offer a way of attaining respectful, meaningful, and inclusive feedback in a manner that can honour a diverse range of human expression and communication. Therefore, such feedback processes may present mental health providers with a means of acknowledging and respecting diversity among those who use their services.

Summary

This chapter has presented a review of the literature in three main areas: 1) recovery in mental health; 2) service user involvement, and; 3) music therapy in mental health. An exploration of the literature on recovery in mental health provided a description of the central framework of this research that underpins mental health provision in many countries around the world. Evolving from the service user movement in mental health, recovery encompasses a holistic view of the individual where ideas of self-help, advocacy and empowerment feature. Recovery emerged from the writings of people who have overcome the limitations of mental illness and shown that it is possible to live a meaningful, satisfying life beyond a diagnosis. Central to this is the notion of partnership where service users’ expertise by experience and professional’s expertise by training and/or skill combine in an egalitarian manner in fostering one’s journey towards wellness.

A key feature of recovery in mental health is the inclusion of service users at all stages of healthcare delivery and planning. This recognises that service users are valuable sources of information because of their expertise acquired through direct contact with healthcare systems. Service user inclusion has been advocated in many statutory mental health systems internationally including that in Ireland. However, the inclusion of such perspectives is a complex concept that engenders many meanings due to differing roots in consumerist, liberatory and social movements. The need for suitable mechanisms of meaningful service user involvement has been highlighted not only in the planning and
delivery of mental health provision but also in research that informs how such services are
offered. Service user evaluation offers a means of enabling service improvement through the
inclusion of stakeholder voices who have lived experience of engaging with and using such
forms of healthcare. Such evaluation can be carried out through open dialogue with service
users in research. However, this may be at the cost of excluding those who equally have
valuable perspectives to share but who also have additional needs. Creative and inclusive
feedback mechanisms are needed that can encompass multiple perspectives so as to inform
and enhance current mental health provision.

The practice of music therapy in mental health is grounded upon the notion of
promoting wellness among participants. Evidence to support such practices is needed. This
has traditionally been carried out by healthcare professionals in accordance to principles of a
medical model of care that examine efficacy and effectiveness of treatments. While this has
successfully resulted in establishing a developing evidence-base to support music therapy
practice, it has perhaps unintentionally resulted in the under-representation of service user
voices in music therapy and mental health research.

Service user inclusion in music therapy and mental health research requires some new
thinking and action. Experiential expertise of service users can provide valuable feedback to
inform the delivery of music therapy in mental health. Although revealing about service
users’ lived experience of music therapy, to date such research has primarily relied upon
verbal methods of inquiry through use of questionnaires, surveys and interviews. Many
people attend music therapy in mental health because it offers creative means of expression
that extend beyond verbal reliance. As service user evaluation becomes increasingly
recognised by health providers as means to ensure quality services, it is crucial that
meaningful feedback mechanisms are utilised in eliciting the perspectives of those who attend
music therapy in mental health. Developing service user evaluation of music therapy in
mental health is crucial if this practice is to realise the inclusive ethos of recovery. To date, music therapy practice in mental health has predominantly been informed by inquiry carried out from the perspectives of practitioners and researchers. Although such research has been integral to building the professional identity of music therapy, this has perhaps unintentionally come at the cost of disregarding the voices of those who have lived experience of attending music therapy programmes. The guiding vision of mental health recovery now presents a challenge to music therapy to meaningfully incorporate service users’ expertise by experience into practice. Service user evaluation presents one way of rising to such a challenge.
Chapter 3

Research Paradigm and Methodology

Choosing a Research Paradigm

This research aimed to: 1) develop high quality processes for service user evaluation of music therapy in mental health, and 2) reflect upon the feedback elicited from such processes in order to gain a deeper understanding of how music therapy is received among those who have attended sessions in mental health. The methodology chosen for this study explicitly references the phenomenological tradition of research that is committed to exploration and illumination of lived experience. As this means of inquiry progressed it became apparent that ethos of the overall project was situated within a critical paradigm (Kincheloe & McLaren, 2002a). This seeks to promote the emancipation of marginal groups that is imperative to social justice approaches to mental health care as advocated by the recovery approach in mental health.

A Qualitative Framework

Denzin and Lincoln (2005a) defined a paradigm as a net within which the researcher’s epistemological, ontological and methodological principles are held. It has also been described as “a basic set of beliefs that guides action” (Guba, 1990, p. 17). This interpretive framework shapes how a researcher perceives and interprets the world, in addition to how it should be studied and understood (Denzin & Lincoln, 2005a). Lloyd and Carson (2012) wrote that the relationship between research practice and the paradigm holding and defining the research process are intertwined. These are constitutive meaning that one only makes sense in relation to the other. The paradigm serves as a lens through which the researcher perceives a phenomenon, and is a framework which provides information about the assumptions of differing research practices and orientations (Edwards, 1999; Guba &
Lincoln, 2005). It is a means of distinguishing between “positivist and postpositivist ways of thinking and naturalist or constructivist ways of knowing” (Wheeler & Kenny, p.62).

This research was carried out within a qualitative tradition, one where researchers may “delve into questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change, and discover the reasons for the success or failure of interventions” (Starks & Trinidad, 2007, p. 1372). Ruud (1998) has characterized qualitative research as empathic, holistic, empirical, naturalistic, descriptive and interpretative. This tradition of inquiry is concerned with subjectivity and understanding the lived experience of those who participate in research. According to Griffiths (2009), qualitative approaches are particularly suited when the topic of investigation is complex, novel or under-researched as it allows for the possibility of new or unexpected findings to emerge. It is surrounded by “a complex, interconnected family of terms, concepts, and assumptions” (Denzin & Lincoln, 2005a, p.2).

**Valuing Service User’s Expertise by Experience**

Phenomenology is an approach to qualitative inquiry that has influenced music therapy research practice over the past thirty years (Wheeler & Kenny, 2005). It is concerned with rich and in-depth description of phenomena in a way that provides description of “the lived world of everyday experience” (Finlay, 2011, p.10). Phenomenological research can provide insights into the human condition. This can reveal in-depth articulation of aspects of human experience that are tacitly familiar but also those that may be surprising or unfamiliar. Phenomenology offers a way of witnessing individuals in their experience but also gives voice to individuals as they relay such experience (Finlay, 2011).

Phenomenology’s commitment to the exploration of lived human experience resonated with the concept for this study that is rooted within the recovery approach in
mental health that promotes the term *expert by experience*, acknowledging that those who use mental health services are experts by virtue of their own experiences (Shepherd et al., 2008; Telford & Faulkner, 2004). In terms of recovery, experience is regarded to be a source of valuable knowledge that can contribute to the delivery and planning of services in a way that promotes collaboration between recipients and providers of mental health care. Providers of healthcare or professionals are often termed *experts by profession* within the recovery approach, thus broadening the concept of expertise in a way that mirrors the collective knowledge of multiple stakeholders (Dillon & Hornstein, 2013). Therefore, this research embraces a broadened notion of expertise and focuses upon service users’ expertise in music therapy in mental health as a result of their personal and lived experiences therein.

Employment of a phenomenological approach offered a means of acknowledging the value of such lived experience as promoted in mental health recovery.

Although the methodology chosen for this study explicitly references the phenomenological tradition of research, a later discovery along this trajectory highlighted that the ethos for the overall project is situated within a critical paradigm (Kincheloe & McLaren, 2002a). Research conducted with such critical influences takes into account dimensions of power, reciprocity in relationships, social and personal values, while interrogating and valuing the roles of researchers and participants in shaping new knowledge. Therefore, the agenda for this study not only focussed upon illumination of lived experience in music therapy in mental health but also upon carrying out inquiry based upon principles of inclusive design (Clarkson at al., 2003) so that the perspectives of service users could be amplified within the music therapy and mental health evidence-base. This aligned with the recovery approach in mental health that advocates for the emancipation of service users in the mental health arena.
Bearing in mind that music therapy has the capacity to offer both verbal and non-verbal means of communication, the research design incorporated both verbal and arts-based means of evaluation. This not only reflected the creative domain in which music therapy is rooted but also honoured the concept that meaning making systems are not exclusive to words, meaning that communication of human experience can take many forms (McCaffrey, 2013). Therefore, two processes of evaluation were designed. One incorporated verbal methods while the other used arts-based methods. Both mechanisms of evaluation were concerned with the research question: ‘what are service users’ experiences of music therapy in mental health?’ The feedback elicited from these processes was reflected upon in order to gain a deeper understanding of how music therapy is received among those who have attended sessions in mental health.

**Interpretative Phenomenological Analysis**

The chosen methodology for this research is Interpretative Phenomenological Analysis (J. A. Smith, 1996, 2004; J. A. Smith, et al., 2009). Interpretative Phenomenological Analysis or ‘IPA’ is “an approach to qualitative, experiential and psychological research which has been informed by concepts and debates from three key areas of philosophy of knowledge: phenomenology, hermeneutics and idiography” (J. A. Smith et al., 2009, p. 11). IPA was developed through the mid-1990s and is described as a qualitative approach that offers a specialised type of content analysis (O’Toole et al., 2004). According to Finlay (2011), it is a methodology that has burgeoned over the last decade.

Developed by Jonathan A. Smith, IPA is a research methodology that is committed to the study of human experience. J. A. Smith (1996) argued that human psychology research has benefitted from experimental as well as experiential findings, and therefore proposed IPA as a way that researchers could capture qualitative aspects of human existence. This idea was initially met with some resistance by mainstream psychology whereby IPA was rejected
because of its subjective pursuit that was deemed at that time to have been very different to
the field’s predominantly quantitative agenda (J. A. Smith, 1996). IPA was met with a
warmer welcome within sociology and this was perhaps due to its familiarity with analysis of
the qualitative kind (J. A. Smith, 1996). IPA has since developed as a research methodology
that is not only practiced in psychology but also across many other fields related to health and
social care (J. A. Smith & Osborn, 2008).

Many of the topics that have been explored using IPA have come from the area of
health psychology that deal with momentous existential issues such as life transforming or
threatening events, conditions or decisions (J. A. Smith, 2004). Interestingly, identity seems
to be a superordinate construct that emerges from many of these studies, indicating its
fundamentality in human existence (J. A. Smith, 2004). Findings from such research are often
targeted to an audience of clinicians and practitioners who wish to gain further insight into
experiences relating to illness or disability so as to enhance treatment delivery. It has been
suggested that when considering the IPA approach, the researcher should check the match
between the epistemological underpinnings of IPA and the research question posited;

if a researcher is interested in exploring participants’ personal and lived experiences,
in looking at how they make sense and meaning from those experiences, and in
pursuing a detailed idiographic case study examination, then IPA is a likely candidate
for consideration as a research approach (J. A. Smith, 2004, p. 48).

IPA seemed appropriate for this research study due to its assumption that rich,
detailed personal accounts can provide insight into people’s involvement in and orientation
towards the world (J. A. Smith et al., 2009). These can reveal to the audience the experiential
claims and key objects of concern in the participant’s world thus involving exploration of
perceptions or accounts of an experience as opposed to producing an objective record
(O’Toole et al., 2004). Mindful that sometimes the credibility of service user voices can be
questioned because of their mental health diagnosis (Happell, Manias, & Roper, 2004), the
choice of IPA seemed to offer a means of listening carefully to what participants have to say
without enforcing explanations on what is being said. This resonated with a constructivist view of knowledge as promoted in recovery that emphasises knowledge from the perspective of the person experiencing the phenomenon (Loveland, Weaver Randall, & Corrigan, 2005).

As a qualitative research approach IPA also offered a way of giving voice to the experiences of participants (Larkin, Watts, & Clifton, 2006), while also identifying their key concerns and priorities (Hammell, 2001). This was important given that perspectives of those who have attended music therapy in mental health are underrepresented in the research base despite music therapy being espoused as a client-centred practice. These political expressions as understood through lived experience (Langdridge, 2008), provided a means of addressing the power imbalance that exists between service users and professionals within the evidence-base for music therapy in mental health. Langdridge (2008) said that “through this teleological – rather than archaeological – process, we may find ways of understanding that disrupt the status quo and open up new possibilities for living (p. 1137). Therefore, the choice of IPA enabled participants’ accounts of music therapy to be revealed to others so that these can be considered in future development of the profession.

**Epistemological Underpinnings of IPA**

Edwards (2012) has encouraged music therapy and healthcare researchers to more clearly identify and describe the epistemological stance of their chosen research methodology. According to Shinebourne (2011), IPA has a distinctive epistemological framework that features theoretical underpinnings in phenomenology and hermeneutics while it also takes an idiographic perspective. Shinebourne (2011) viewed this methodology as being congruent with the existential phenomenological paradigm that is linked to a wider research literature in psychology. The following sections will discuss key concepts of each of the three major philosophical influences on IPA, namely: phenomenology, hermeneutics and idiography. Together these elements conceptualise lived experience in a way that
Phenomenology & IPA

A key value of phenomenological philosophy is that it offers a way to comprehend and explore lived experience (J. A. Smith et al., 2009). In its simplest sense, phenomenology tries to devise a method for the detailed and accurate description of phenomena (Macquarrie, 1972). The word phenomenology has a long history in philosophy and is concerned with the in-depth description of human experience by illuminating the way things appear to us in our consciousness (Macquarrie, 1972). Groenewald (2004) described this field as the science of pure phenomena. Phenomenology begins with acknowledging something and then describing its essence, core commonality and structure (Starks & Trinidad, 2007). Yet on the other hand phenomenology is concerned with the relative subjective value of human experience, whereby perception of the world is gained through engagement in it and its meaning is regarded as a function of our relationship to it (Finlay, 2009).

Phenomenological methods are concerned with questions such as: ‘what is this experience like?’ and, ‘what does this experience mean?’ (Finlay, 2011; Laverty, 2003). Description is at its core as it aims to describe phenomena exactly how they appear in the individual’s consciousness, thus bringing the inquirer’s eye back to the things themselves as argued by Edmund Husserl, a German philosopher, who many regard to be the father or fountainhead of phenomenology (Groenewald, 2004; Laverty, 2003).

Husserlian Influence

From an epistemological viewpoint Husserl regarded experience to be the principle source of knowledge (Dowling, 2007). This resonates with the perspective of IPA where phenomenological research is viewed as a means to systematically and attentively reflect on
everyday lived experience (J. A. Smith et al., 2009, p. 33). Husserl devised a method to accurately describe the essence of a phenomenon as it appears to the consciousness (Macquarrie, 1972). Emerging at a time when there was growing dissatisfaction within the field of psychology, Husserl first termed the epistemology of his phenomenology as descriptive psychology but he later thought this to be misleading as it solely focussed on subjective conditions of objective knowledge (Drummond, 2007). He later introduced it as belonging to a “descriptive, philosophical method” that established both an “a priori psychological discipline” and a universal philosophy (Husserl, 1927, p. 2). Hence, phenomenology references a philosophical in addition to a method of inquiry in social sciences as employed in this research.

Husserl openly criticised empiricist dominance and deemed psychology as a science that had gone wrong (Husserl, 1999; Laverty, 2003). He introduced natural science methods as a means of investigating human issues, arguing science to be a second-tier system that ultimately depended upon first-order personal experience of the life-world. Therefore, he was of the view that science is essentially based on what is immediately given to us, yet he did acknowledge that people are not accustomed to concentrating on the physical act of experience but instead on thoughts, matters and values of the moment (Husserl, 1927). Husserl strove to develop a science that focused upon reflecting upon the act of experience. This was philosophically informed and yet also based on sound perceptions, ideas and judgements so that it would be a forerunner to any further scientific explanation (Husserl, 1954/1970).

Husserl’s phenomenology is premised on the idea that the only thing we know for certain ‘is’ consciousness which appears before us yet it acknowledges that various obstacles can get in the way of this given human beings’ predilection for order and categorisation (Husserl, 1927). Thus the role of consciousness in phenomenological inquiry is a key
construct, laden in relatedness to the world. Consciousness always relates to or is towards something and therefore contributes to the very meaning of objects and people in the world (Husserl, 1954/1970). Husserl was curious to find a means by which someone comes to know their own experiences so that each particular thing could be focussed upon in its own right (Husserl, 1927).

*Intentionality* is a key concept of the phenomenological approach. It is used to define the process whereby the individual focusses in their consciousness on that which is being experienced (Finlay, 2011). Langdriddle (2008) stated that within phenomenology:

> intentionality is not being used in its usual sense of intending to do something like go to work. Instead, it refers to the fact that whenever we are conscious, we are always conscious of something. There is always an object of consciousness, whether that is another person or an idea (p.1127).

Husserl (1927) viewed intentionality as a key feature of coming to know one’s experience and believed that it was necessary to reduce back experience to its core and essential structures. Once the researcher stepped outside of everyday human experience they could describe essential structures which would transcend the particular circumstance of their appearance and perhaps then illuminate a given experience for others (Husserl, 1927).

The life-world or *Lebenswelt* is a central focus of phenomenological inquiry (Husserl, 1954/1970). It “is how our body and relationships are lived in time and space” (Finlay, 2011, p. 125). Husserl understood this as what is experienced pre-reflectively, without alternating to categorisation or conceptualisation, often comprising of what is taken for granted or things that are common sense (Husserl, 1954/1970). It is the world that is lived and experienced that meaningfully appears to the consciousness (Finlay, 2011). It is not based upon an introspective inner world but rather one that is lived and is highly relational and social (Finlay, 2011). In the words of Merleau-Ponty (1996): “man is in the world, and only in the world does he know himself” (p. xi).
In order to illuminate subjective human experience it is necessary that the researcher be able to manage pre-understandings as to enable one to be free of previous beliefs and knowledge about a phenomenon. This was what Husserl called the *phenomenological attitude* (Husserl, 1954/1970). This has been defined as the “process of retaining wonder and openness to the world while reflexively restraining pre-understanding, as it applies to psychological research” (Finlay, 2008, p. 11). Holding a phenomenological attitude is often mistakenly regarded as a straightforward process by the novice researcher who seeks to be merely unbiased and objective (Finlay, 2011). However, maintaining such a stance involves great complexity, discipline and radicality (Finlay, 2008). It involves the researcher not only suspending their presuppositions but perhaps more importantly, opening themselves to be moved by an *Other* where evolving understandings emerge in a relational context (Finlay, 2008). This is what Finlay (2008) describes below as the dance that occurs in the mind of the researcher:

> in this process, something of a dance occurs—a tango in which the researcher twists and glides through a series of improvised steps. In a context of tension and contradictory motions, the researcher slides between striving for reductive focus and reflexive self-awareness; between bracketing pre-understandings and exploiting them as a source of insight. Caught up in the dance, researchers must wage a continuous, iterative struggle to become aware of, and then manage, pre-understandings and habitualities that inevitably linger. Persistence will reward the researcher with special, if fleeting, moments of disclosure in which the phenomenon reveals something of itself in a fresh way (p. 3).

Thus the phenomenological attitude is complex. It is continuous and on-going as one engages with the data. It involves a dual process whereby the researcher is required to connect directly and immediately with the world as he/she experiences it while also being open to whatever may emerge and this is a continuous on-going process (Finlay, 2008).

*Bracketing* refers to the method of suspending or holding ones taken for granted assumptions and perceptions (Husserl, 1927). This process of reduction involves laying aside one’s everyday perceptions or previous knowledge of the phenomenon so as to enable a fresh
understanding of it. Bracketing originates from mathematical roots whereby the contents of brackets within equations are treated separately. Sometimes referred to as the process of reduction, it is an effort to move away from the distractions of the world so that the essence or eidos or idea of the experience could be illuminated (J. A. Smith et al., 2009), and is a way of coming to know things from within and in their own right as they are presented to the consciousness (Dowling, 2007).

Each of these processes that aim to illuminate conscious experience through systematic and attentive examination have influenced the development of IPA. (J. A. Smith et al., 2009). However, rather than sharing Husserl’s concern to find the essence of experience, IPA focusses on capturing particular experiences as experienced by particular people (J. A. Smith et al., 2009).

**Other Phenomenological Influences on IPA**

Later theorists of the phenomenological project began to move away from Husserl’s philosophical phenomenology that focused on consciousness and essences of phenomena. According to Groenewald (2004), this resulted in a move towards existential and hermeneutic (interpretive) dimensions by those such as Martin Heidegger (1889 - 1976), Maurice Merleau-Ponty (1908 - 1961) and Jean-Paul Sartre (1905 - 1980). Husserl’s student Heidegger was in many ways responsible for these developments (J. A. Smith et al., 2009) by emphasising the importance of meaning, and questioning the notion of knowledge outside of an interpretative stance (Heidegger, 1927/1996).

Heidegger’s major work, *Being and Time* featured the term *Dasein*, which literally means *there-being or being there*, as the uniquely positioned feature of *human being* whereby there is a dialogue between a person and his/her world (Heidegger, 1927/1996). Where Husserl was concerned with perception, awareness and consciousness, Heidegger focussed upon the ontology of existence itself in which the world appears meaningful and where
being-in-the-world is temporal and always in-relation-to something (Heidegger, 1927/1996). Therefore it has been suggested that Heidegger took a worldly perspective to his work (J. A. Smith et al., 2009).

Heidegger believed that humans are thrown into a world of objects, language and relationships yet our being-in-the-world is always situated from a unique perspective (Heidegger, 1927/1996). He was concerned with the person’s context in the world and how this impacted their understanding of it. This relatedness with the world is termed intersubjectivity, that describes how people communicate with and make sense of each other (Todres, Galvin, & Dahlberg, 2007). Heidegger (1927/1996) also took on an existentialist approach in his writings, discussing the significance of death which added a temporal dimension to the concept of being-in-the-world. According to J. A. Smith et al. (2009, p. 17):

By the end of Being and Time, one gets a sense of how our being-in-the-world can be understood to be multi-modal. As well as practical engagement with the world, it involves self-reflection and sociality, affective concern, and a temporal existential location.

Heidegger’s concepts have made a marked contribution to the development of IPA. Its authors embrace the notion of thrownness (J. A. Smith et al., 2009). Consequently, this places significance on the interpretation of people’s meaning making activities which is a key concern of IPA.

Like Heidegger, the French philosopher Merleau-Ponty, shared many understandings with Husserl about being-in-the-world yet he wished to enlist more of a contextualised phenomenological pursuit (J. A. Smith et al., 2009). Merleau-Ponty expanded the influences of both earlier phenomenologists (Groenewald, 2004) but regarded the taking on-board of a detached position in which prior assumptions are suspended as problematic (Merleau-Ponty, 1996). Whereas Heidegger was interested in the worldliness of existence, Merleau-Ponty (1996) was concerned with how one’s relationship with the world is experienced through the
human body. Therefore, the *embodied* nature of our existence or the body-in-the-world is also a focus of IPA.

It is also important to acknowledge Sartre’s influence on IPA whose existential ideas related to the self as an on-going project as opposed to the self as a pre-existing entity (J. A. Smith et al., 2009). This focus on *becoming* rather than on *what one is* connects with the concept of *nothingness* (Sartre, 1956). For Sartre this meant that both the absence and presence of other things and people were equally important in defining who one is and how one sees the world. He stressed the complexity of being-in-the-world amongst others and shared with Heidegger and Merleau-Ponty the importance of taking a contextual view of one’s existence (J. A. Smith et al., 2009).

Each of the philosophers of phenomenology discussed above were committed to inquiry into the *life-world* as a relational world full of meanings (Todres et al., 2007). Despite the differing approaches to inquiry of the life-world, what has remained constant is that phenomenological investigation can offer a humanising form of inquiry (Todres et al., 2007). This humanising aspect was attractive as I sought to find a way of considering lived experience in music therapy in a way that was personally relevant and meaningful to those who participated in this research.

**Hermeneutics**

IPA is also underpinned by *hermeneutics* as the theory of interpretation. Hermeneutics is an entirely separate body of thought from phenomenology but yet these intersect when considering the work of Heidegger who is regarded as a hermeneutic phenomenologist (J. A. Smith et al., 2009). As a student of Husserl’s, Heidegger (1927/1996) believed that hermeneutics was a pre-requisite to phenomenology as phenomenology involves the uncovering of meanings hidden by the phenomenon’s mode of appearing. According to Moran (2002, p. 229):
Phenomenology is seeking after a meaning which is perhaps hidden by the entity’s mode of appearing. In that case the proper model for seeking meaning is the interpretation of a text and for this reason Heidegger links phenomenology with hermeneutics. How things appear or are covered up must be explicitly studied. The things themselves always present themselves in a manner which is at the same time self-concealing.

Heidegger emphasised that in phenomenology existence preceded essence. This was unlike Husserl who suggested phenomenology as an eidetic science whereby emphasis was placed on essence (Macquarrie, 1972). Heidegger acknowledged that the in-depth description offered by phenomenology could illuminate features of the life-world that otherwise would be unnoticed. He rejected Husserl’s idea that consciousness is always intentional and towards something and instead suggested that behind a phenomenon there is an utterly inaccessible thing in itself (Macquarrie, 1972). Heidegger highlighted the importance of meaning and questioned the idea of knowledge outside of an interpretative stance. He viewed consciousness as something that makes possible a significant world, rather than making possible the existence of the world (Drummond, 2007).

Taking an etymological approach, Heidegger (1927/1996) observed that phenomenology was made up of two words *phenomenon* and *logos*. Translating phenomenon as to *show or appear*, he dissected the various meanings that pertain to these terms and took the opinion that when something appears, it is entering into a new state or *coming forth*. Therefore, Heidegger was interested in how things reveal themselves to the world and how such appearances can be uncovered (Shinebourne, 2011). Heidegger (1927/1996) also translated *logos* as meaning *discourse, reason, or judgement*. This understanding of the term in an analytical sense, refers to “a primordial human capacity which enables people to communicate with others” (Shinebourne, 2011, p. 19). Discourse was viewed as a way of articulating intelligibility which therefore underpinned processes of interpretation and assertion- “the analytical thinking required by *logos* aspect then helps us to facilitate, and grasp, this showing” (J. A. Smith et al., 2009, p. 24). For Heidegger, such showing or
disclosure of an object was already immersed in the context of being-in-the-world as discourse refers to a primordial human capacity, whereby every interpretation is grounded in previous experience (Shinebourne, 2011).

It is this very understanding of interpretation that is based on fore-having, fore-sight and fore-conception that has set apart the work of Heidegger and others from that of Husserl, who believed that rigorous description could make it possible to reveal the essence of an object (Shinebourne, 2011). Merleau-Ponty (1996) also suggested that eidetic knowledge was unattainable given our historicity and personal take on the world, and was of the opinion that the best that one can do is interpret. He saw our engagement in the world preventing us from stepping into an objective realm outside, arguing that both person and world are mutually constitutive.

IPA has also been influenced by other hermeneutic theorists such as Schleiermacher who offered a holistic view of the interpretative process, suggesting that there is something unique about the intentions and techniques of an author, which will impress a particular form of meaning on the text that is produced (Schleiermacher, 1998). According to J. A. Smith et al. (2009): “this meaning is available for the interpretations of a reader, but those interpretations must also be accommodated to the wider context in which the text was originally produced” (p. 22). Opining interpretation as a craft that not only seeks to understand the text but also the writer of the text, indicates that IPA can offer meaningful insights that exceed the explicit claims of participants (J. A. Smith et al., 2009). Therefore the interpretative analyst can offer a perspective to a text which the author is not able to bring, meaning that there can be an added-value at play during the process of interpretation.

Like Schleiermacher, Gadamer (2004) also influenced the development of IPA with reference to the complex relationship between the interpreter and the interpreted, where fore-conceptions are continually revised and shifting during the interpretative process. Gadamer
emphasised the historicity of our existence and how this impacts upon the ability to experience, adding that that one’s fore-groundings or prejudices are situated on an evolving horizon that are constantly fusing with those of others during interpretation. This process requires a degree of openness on behalf of the interpreter, whereby understanding the content rather than the author is the primary focus involving constant movement between past and present (J. A. Smith et al., 2009). According to Dowling, “inquiry using Gadamerian hermeneutics becomes dialogue rather than individual phenomenology and interpretation permeates every activity” (2007, p. 134). Therefore in IPA interpretation focuses on the meaning of the text that is “strongly influenced by the moment at which the interpretation is made” (J. A. Smith et al., 2009, p. 27). According to Dowling (2007), this is related to the notion of universality whereby those who express themselves and those who understand them are interlinked by a human consciousness that makes understanding possible.

IPA embraces phenomenology as an interpretative pursuit. J. A. Smith et al. (2009) wrote: “without phenomenology; there would be nothing to interpret; without the hermeneutics; the phenomenon would not be seen” (p. 37). IPA is also influenced by Heidegger’s unpacking of the relationship between interpretative work and the fore-structure of our understandings, thus prompting a re-evaluation of Husserl’s views of bracketing and taking a Godly view of the world. IPA shares Heidegger’s and Merleau-Ponty’s views that bracketing is a much more enlivened and complex process whereby one’s preconceptions cannot be put up-front before interpretation but rather got to know as the interpretative process is underway (J. A. Smith et al., 2009). Therefore in IPA bracketing can only ever be partially achieved and this is more closely connected to reflexive practice that is seen across qualitative psychology (J. A. Smith et al., 2009).

IPA engages the concept of the hermeneutic circle that is concerned with the dynamic interplay between the part and the whole at many levels: “to understand any given part, you

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look to the whole; to understand the whole, you look to the parts” (J. A. Smith et al., 2009, p. 28). This provides researchers with a useful concept of method as it not only presents analysis as a series of linear steps but also one that is iterative, whereby one may move back and forth through a range of different ways and steps when thinking about the data (J. A. Smith et al., 2009). This engages the hermeneutic circle where fore-structures are continually adjusted (Finlay, 2011).

It is the interpretative process that allows the phenomenological appearing of the object to shine through in IPA (J. A. Smith et al., 2009). This involves engaging with the participant more so than bracketing prior concerns and preconceptions. This is where the double hermeneutic comes into play in the research process with “the participant is trying to make sense of their personal and social world; [and] the researcher is trying to make sense of the participant trying to make sense of their personal and social world” (J. A. Smith, 2004, p. 40). Both researcher and participant draw on everyday resources to make sense of the world, yet the researcher’s access to the phenomena under investigation is through the participant’s reporting of it. Therefore, the participant’s meaning making is first order while the researcher’s sense making is second-order (J. A. Smith et al., 2009).

J. A. Smith et al. (2009) proposed that there is a second example of a double hermeneutic involved in IPA as the researcher attempts to reconstruct the participant’s original experience in its own terms while also using outside theoretical perspectives to shed light on the phenomenon. This interpretative work involves a hermeneutic of empathy and a hermeneutic of questioning whereby the notion of ‘understanding’ has put forward as a neat descriptor of what constitutes successful interpretation in research employing IPA (J. A. Smith et al., 2009). According to Shinebourne (2011), interpretation can be descriptive and empathic while also being critical and questioning. These varying thoughts on interpretation resonated with this research that on one hand aimed to be empathic towards the views of
those who experienced music therapy. On the other hand it sought to question what such perspectives meant and how these would compare with the pre-existing body of knowledge surrounding service user experience in music therapy.

**Idiography**

IPA is idiographic in the sense that it aims to discover the particulars of what makes people unique in opposed to taking a nomothetic view that employs aggregated data concerned with making claims at a group or population level (J. A. Smith, 2004; J. A. Smith et al., 2009). According to Shinebourne (2011), the terms *idiographic* and *nomothetic* were first used by Gordon Allport around the mid twentieth century. Allport (1946) described nomothetic knowledge as knowledge of general laws whereas idiographic knowledge related to unique events, entities, and trends.

IPA’s idiographic commitment is evidenced through detailed finely-textured analysis of the individual’s unique perspective of a given phenomenon. The individual is recognised as a complete unit of study in opposed to being part of a general group from which general meanings are generated (Shinebourne, 2011). This is closely linked to a rationale for case-studies (J. A. Smith et al., 2009). Implications for such a commitment are that sample sizes are usually small and purposive, with a possibility to push this logic even further by conducting analysis on a single case when it is rich or compelling (Eatough & Smith, 2006; J. A. Smith, 2004).

Convergence and divergence across multiple cases is not considered in IPA until closure or gestalt has been achieved in each individual case as it is integral that the idiosyncratic nature of each is firstly addressed (J. A. Smith, 2004). When this is achieved an examination of similarities and differences may commence across cases in order to produce “detailed accounts of patterns of meaning and reflections on shared experience”
Therefore IPA does not avoid generalisations but instead offers a different way of establishing those generalisations (Harré as cited in J. A. Smith et al., 2009). The notion of idiography does not solely concern the individual. More complexity is at play as although experience is uniquely embodied, situated and perspectival, it is also a worldly and in-relation-to phenomenon that is not the property of the individual per se (J. A. Smith et al., 2009). However, each person can give their own unique and situated perspective about their shared experience of the phenomena of interest (J. A. Smith et al., 2009). IPA promotes this position as when considering the particulars of each individual case it acknowledges that a sense of shared aspects of humanity may arise whereby each case contains somewhat of an essence of an experience (Giorgi & Giorgi, 2008). Therefore an insightful study will touch on the essential human features that make people unique individuals while also linking aspects that are shared and communal (J. A. Smith et al., 2009). This in turn can be used to illuminate existing nomothetic research.

IPA’s commitment to an idiographic perspective influenced my decision to employ this approach to analysis in this research. It offered a means of analysing individual participant’s personal perspectives of music therapy in a way that could carefully consider unique voices while also considering differences and similarities across multiple cases against a large corpus of studies that have taken a nomothetic approach to music therapy research. Furthermore, in taking such an idiographic stance it was thought that this project would remain true to the recovery philosophy of closely listening to the service user’s voice, recognising that one size does not fit all.

**Symbolic Interactionism**

*Symbolic interactionism* has also been identified as another theoretical touchstone of IPA (J. A. Smith, 1996). Symbolic interactionism emerged in the 1930s, representing a resistance to the positivist paradigm that was becoming increasingly popular in social science...
research (J. A. Smith, 1996). Rather than measuring observable data, the symbolic interactionism proponents argued that individual’s meanings ascribed to events were of central concern in social science and that such meanings were gained as a result of interpretation (J. A. Smith, 1996). At the core of this concept is the notion that meanings occur as a result of social interactions (J. A. Smith, 1996). IPA has adopted characteristics of symbolic interactionism through its commitment to adopt the insider perspective of the phenomenon being explored while at the same time recognising the dynamic nature of the research process. This has been summed up as an inter-personal process by J. A. Smith (1996) who said: “access is both dependant on, and complicated by, the researcher’s own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity” (p. 264). This highlights that there are both social and personal aspects of meaning-making involved in IPA.

IPA in Practice

The IPA methodology has been employed to examine a wide range of different human experiences such as: the nature of empathy (Baillie, 1996); fear of falling (Mahler & Sarvimäki, 2011); patients’ use of long-term oxygen therapy (Ring & Danielson, 1997); lived experience of Parkinson’s disease (Bramley & Eatough, 2005); childhood experience of cancer (Griffiths, 2009; Griffiths, Schweitzer, & Yates, 2011); and mental health service user experience of community rehabilitation services (Kowlessar & Corbett, 2009). IPA has also been used in studies that address people’s personal experiences with music relating to topics such as: the benefits of choir singing amongst people with a disability (Dingle, Brander, Ballantyne, & Baker, 2013); experiences of choir participation amongst members of the homeless community (Bailey & Davidson, 2003); and men’s experience of singing in a male-only vocal choir (R. Faulkner & Davidson, 2006). A number of music therapy studies have also employed IPA. These pertain to therapists’ experience of self in improvisation
(McCaffrey, 2013), patients’ experiences of improvisation in music therapy as part of cancer care (Pothoulaki, MacDonald, & Flowers, 2012) and music therapy process and affect modulation (Ansdell, Davidson, Magee, Meehan, & Procter, 2010). Particularly pertinent to this research are studies that have used IPA in the investigation of patients’ experiences of music therapy in mental health (Ansdell & Meehan, 2010; Solli & Rolvsjord, 2014). In choosing their method of analysis, Ansdell and Meehan (2010) concluded that IPA offered a subjective form of inquiry that helped develop an understanding of patient experiences while also providing a rigorous procedure for approaching their open-ended research question. Solli and Rolvsjord also employed IPA as a way of understanding the meaning of content because it presented as a way of “engaging in an interpretative relationship with the text” (2014, para. 3). These conclusions about the use of IPA in qualitative research resonated with the agenda of this study. This aimed to carry out inquiry into service user experience of music therapy in a way that could honour subjective experience and engage with an-open ended question while participating in both a structured and flexible approach to an interpretative process. IPA offered an inductive approach that could allow unforeseen themes to emerge. This gave participants the opportunity to reveal unexpected aspects of their experiences in music therapy that might not be expected or previously encountered in previous research. Therefore, IPA is data-driven rather than theory driven and focusses on what is relayed by participants about their world instead of confirming or refuting a researcher’s preconceived hypotheses.

**IPA: Discussions & Debates**

IPA has been the focus of discussion and debate in the qualitative research literature. Of particular interest is a lively discussion that has occurred between J. A. Smith (2010) and Amedeo Giorgi (2010, 2011) who criticised IPA for its lack of scientific grounding. Giorgi (2010) claimed that IPA is unscientific because it fosters a personalised style of working instead of an interpersonal or intersubjective approach as expected in scientific, qualitative
inquiry. In response, J. A. Smith (2010) has insisted that IPA is scientific but suggested that this difference in opinion is as a result of both parties holding different meanings of *science*. Giorgi later rejected J. A. Smith’s (2010) rebuttal arguing that his scientific concern for IPA arose not from a misunderstanding of the term but rather from his wish that qualitative methods and methodologies “be able to defend themselves in terms of generic scientific criteria” (Giorgi, 2011, p. 198).

J. A. Smith (2010) hastened to add that Giorgi’s (2010) accusations had been based on consultation of only two IPA studies when a much larger corpus of work on the subject had been published. Yet Giorgi (2011) contended that although premised on two studies, these were featured in handbooks that related to the presentation of qualitative methods and that neither study detailed the hermeneutic and phenomenological sensibilities supposedly employed by IPA. In Giorgi’s (2011) opinion this appeared to be an example of J. A. Smith over-simplifying the IPA approach at the cost of misleading the reader.

Giorgi (2010) also claimed that there is a contradiction to be found within IPA as on one hand it advocates that it is not prescriptive yet on the other it offers step by step instructions in conducting analysis. In response, J. A. Smith (2010) asserted that in IPA these steps are suggestions not prescriptions, adding that it is the quality of the intellectual and intuitive work that produces good qualitative research. Many researchers in phenomenological research have been reluctant to prescribe techniques (Groenewald, 2004), and have proposed that imposing a certain approach on a phenomenon would do injustice to that very phenomenon (Hycner as cited in Groenewald, 2004). Giorgi’s (2010) binary construct that one has either a prescription or freedom in the research method makes it difficult to imagine a solution that could be satisfactory to both parties.

Giorgi (2010) criticised IPA for its lack of rules which in turn creates a highly subjective mode of analysis that fails to support the novice researcher. J. A. Smith (2010)
claimed that there cannot be total freedom in IPA as there is a threshold of proficiency required to carry out the work and a set of sequential research steps to be followed as previously discussed by Groenewald (2004). Therefore IPA features a balance between structure and flexibility:

One cannot do good qualitative research by following a cookbook. The suggestions I make are only that – suggestions to be adapted and developed by researchers, and what determines the quality of the outcome is the personal analytic work done at each stage of the procedure (J. A. Smith, 2004, p. 40).

Giorgi (2010) also raised concerns that there is no rule that all raw data need be accounted for in IPA. In his opinion this fosters unaccountable selectivity and increases the chances of biased reporting of the findings, but it was countered that ‘checking’ the data is a means of addressing this issue (J. A. Smith, 2010). This may be completed at numerous levels and stages through supervision, independent audit and also by the reader who should carefully consider whether each presented theme is sufficiently supported by extracts from participants.

Giorgi (2011) has taken issue with a number of the features of IPA including: 1) use of the term bracketing; 2) identification of the assumption of the phenomenological attitude with an act of reflection; and 3); failure to refer to the phenomenological psychological reduction or epoché when this is the very entrée to the phenomenological sphere as also identified by Chamberlain (2011). Giorgi (2011) emphasised the importance that IPA meets the demand characteristics if it claims to follow a phenomenological pursuit and pointed out several examples of how this is not the case. He claimed that: 1) IPA is not inductive but rather intuitive and descriptive; 2) IPA researchers offered narrowed and generalised definitions of phenomenology; 3) descriptive steps about the eidetic reduction are not given; and 4) no indication is given of the phenomenological reduction practiced. These claims, coupled with a further accusation that replication of IPA studies are not possible, in addition
to the suggestion that hermeneutic argument is generally and loosely applied, prompted Giorgi (2011) to once again state that: “IPA has little to do with 21st Century phenomenological philosophy and its methodical procedures do not meet the criteria of good scientific practices” (p. 26).

At the time of writing J. A. Smith has yet to explicitly respond in the literature to Giorgi’s most recent criticisms about the IPA approach. This leaves the IPA researcher to seek alternative viewpoints which can elaborate the outlined issues. Pringle, Drummond, McLaafferty, and Hendry (2011) helpfully pointed out that these varying perspectives may be due to differing emphases in the analytic process. Giorgi may be assumed to take a descriptive approach while J. A. Smith et al. (2009) stressed the importance of hermeneutics and interpretation that seek to “capture examples of convergence and divergence, rather than focusing solely on commonalities which Giorgi’s approach prioritises” (Pringle et al., 2011, p. 22). In their evaluation of the use of IPA in nursing studies, Pringle et al. (2011) concluded that IPA is an adaptable and accessible approach that can offer an in-depth account that privileges the individual. They suggested that IPA seeks to firmly root analysis directly in the words of participants. If these accounts are rich and descriptive enough, they can be can be used to directly influence and contribute to nursing practice (Pringle et al., 2011). Therefore there may be politically motivated reasons for the employment of IPA.

Brocki and Wearden (2006) conducted a systematic literature review of published papers in health psychology that employed IPA. This resulted in the review of 52 articles in terms of methods, sampling, research applicability and theoretical adherence to the IPA process. It was concluded that IPA is highly accessible meaning that in contrast to other qualitative methodologies, it features comprehensible language and straightforward guidelines but that not all researchers explicitly recognize their own role in the interpretive process, therefore more clarity is needed in future IPA studies (Brocki & Wearden, 2006).
Guidelines by Yardley (2000) have been used to assess validity and quality in qualitative research regardless of the theoretical orientation undertaken. There are four domains of assessment in which qualitative methods are assessed. These are: sensitivity and context; commitment and rigour; transparency and coherence; and impact and importance (Yardley, 2000). Shinebourne (2011) concluded that IPA can operate within each of these guidelines, adding that this methodology can adhere to criteria for validity and quality within qualitative research.

Considering the multiple viewpoints on IPA in the research literature was a useful place to explore the decisions about use of IPA for this project. There is general consensus among many healthcare researchers that IPA is a useful means of inquiry about lived experience. At the same time it was helpful to note debates concerning IPA’s theoretical underpinnings which are yet to be satisfactorily rebutted. Data collection for this project commenced with Yardley’s (2000) guidelines for validity and quality in mind coupled with a sustained wish to honour subjective experiences of those who attend music therapy in mental health care.

**Critical Theory**

Denzin and Lincoln (2005b) have described that the critical paradigm is based on an ontology of critical realism whereby virtual reality is shaped by cultural, economic, ethnic, gender, social and political values that are shaped over time. Therefore, a central tenet of this type of research is that knowledge is derived within a social context (Edwards, 1999). According to Guba and Lincoln (2005) Critical Theory’s epistemology is transactional while its methodology is both dialogic and dialectical.

Critical Theory has its origins in the Frankfurt School in Germany which was established to study the works of Karl Marx. However, during the 1960s this theory came to
have a prominent place in academic scholarship and thinking in many other countries, in part due to the many German Jewish philosophers (Wyn Jones, 1999). University communities were at the same time being radicalised, and many in society were seeking alternative ways to create social and community life (Kincheloe & McLaren, 2002a). Critical Theory offered a method of freeing academic work from dominant research methods that arose from a post-enlightenment culture nurtured by capitalism (Kincheloe & McLaren, 2002a) and it brought with it an approach to social change that was both democratic and inclusive (McGowan, Mac Gabhann, Stevenson, & Walsh, 2009).

Critical Theory considers the influential social and historical forces in the construction of beliefs and identity of individuals and groups, as well as revealing the unequal relations of power across and between social groups. Research is used to disrupt and challenge the status quo intending to evoke strong emotions from its opponents and proponents (Kincheloe & McLaren, 2002a). Kincheloe and McLaren (2002b) differentiated traditional researchers from critical researchers where the former are concerned with description, interpretation or reanimation of a segment of reality whereas the later often regard their work as an initial step towards political action that can redress the injustices that may occur in the research process itself. Critical Theory is concerned with the intersections that occur between: race; ideologies; class and gender; education; discourses; religion and other social institutions; and cultural dynamics in the construction of a social system (Kincheloe & McLaren, 2002b). Therefore, Critical Theory has been employed in research which studies marginalised groups of society such as indigenous peoples, women, gay and lesbian communities and ethnic minorities (L. T. Smith, 2005).

According to Kincheloe and McLaren (2002b), critical research can best be understood as examining the contexts in which the empowering of others can occur. It confronts the political unconscious and social injustices of a particular society or public
domain and endeavours to be “unembarrassed by the label political and unaafraid to consummate a relationship with emancipatory consciousness” (Kincheloe & McLaren, 2002b, p. 305). Therefore, critical researchers frequently voice their struggle for a better world as shared by the Brazilian educator Paulo Friere who promoted inclusivity and encouraged research participants to be thinking about their own thinking (Kincheloe & McLaren, 2002b).

Denzin and Lincoln (2005b) have pointed out that multiple critical theories can be found within the discourses of qualitative research and that these are all the while changing and evolving. Kincheloe and McLaren (2002b) added that Critical Theory has a tendency to avoid too much specificity so the authors address the implied issues of complexity and the need for clarity by defining and describing their own idiosyncratic approach to Critical Theory. This begins with the premise that Western society is more distanced from notions of democracy and freedom due to people’s acculturation to feeling comfortable within structures of subordination and domination. Kincheloe and McLaren (2002b) referred to their version of Critical Theory as critical humility which rejects economic determinism and instrumental or technical reality. Instead it focuses on critical enlightenment, critical emancipation, immanence, culture, domination and cultural pedagogy while reconceptualising Critical Theory of power in relation to linguistic, ideological and hegemonic terms (Kincheloe & McLaren, 2002b). It has been suggested that this framework pertains to critical hermeneutics meaning that all research is regarded as an act of interpretation regardless of how vociferously numerous researchers argue that facts can, and should, speak for themselves (Kincheloe & McLaren, 2002b).
An Emancipatory Framework

The critical paradigm has been described as being ideologically oriented (Guba, 1990). This is possibly because it views research as a way of leading to emancipation and social justice for oppressed groups. This paradigm has been applied to mental health research that considers relational power pertaining to the service user position (Lloyd & Carson, 2012; McGowan et al., 2009). This may be viewed as a way of questioning social reality and exposing the dominant forces that exist within it. Such research can be regarded as a way of offering a counterhegemonic struggle that encourages the repositioning of service users from passive participants to active agents in the research process (L. T. Smith, 2005). It is a way of challenging the scientific paradigm that has traditionally dominated mental health research whereby critical researchers “inherit a forceful criticism of the positivist conception of science and instrumental rationality” (Kincheloe & McLaren, 2002b, p. 304). Such efforts to disrupt the dominance of a unitary scientific position are emancipatory in nature as they support the empowerment of service users and the initiation of broader social change (Beresford, 2002). Stickley (2006) has called for caution around use of the term empowerment, pointing out that this has become a buzzword in psychiatric and mental health practice. In this research it is used acknowledging that “the production of all knowledge needs itself to become increasingly a socially distributed process by taking much more seriously the experiential knowledge that oppressed groups produce themselves” (Oliver, 2002, p. 15). This can lead to greater degrees of autonomy and human agency among service users while also breaking down barriers between differing groups of mental health stakeholders.

Power

Discussion of emancipation and empowerment of service users cannot take place without considering the dimensions of power that operate to define who can speak, who must
be silent, and where action towards change is permitted to occur. According to McGowan et al. (2009) power may take many forms in mental health care through power over, empowerment, disempowerment or power struggles. Michel Foucault, examined and analysed power structures and concluded that power and knowledge were inseparable, leading him to question the dominant assumptions underlying psychiatry. One of Foucault’s major works *Madness and civilization* highlighted the organisation of relationships between people and knowledge in a way that is provocative and challenging (1961/2001). This reflection on the social history and meaning of madness was critical of the manner in which patients were confined and excluded because they did not fit within societal norms. Psychiatry’s objectification of those who experienced distress resulted in them being regarded as subjects that led to dehumanising and depersonalising practices (Foucault, 1961/2001). Such subjectification also meant that dominant forms of knowledge held a hierarchal position over those that were synonymous with the patient group which also led to further exclusion. This prompted Foucault to question whether madness was a disease or instead an invention of civilization serving to support the marginalisation of those who did not fit the dominant social structures. According to Besley (2002), Foucault suggested that there are two types of subjugated knowledges: one that pertains to erudite and previously established knowledge that is masked, hidden or buried; the other is popular, local or indigenous knowledge that is marginalised. In Foucault’s opinion, the intertwined topics of power and knowledge were complex in nature and he assumed an archaeological orientation towards this topic by attempting to “make visible what is invisible only because it’s too much on the surface of things” (Foucault, 1989, p. 46).

Caution is warranted around the term *emancipation* as it can imply an arrogance on behalf of researchers or practitioners holding the capacity to emancipate others (Kincheloe & McLaren, 2002b). According to Costa et al. (2012), critical researchers investigating the
service user perspective in the qualitative paradigm may often think of themselves as “the
good guys” (p. 90). They may draw on methodologies that focus on purpose and meaning
while being empathic and sensitive to power. These increased efforts towards social justice
have led to a trend in mental health research whereby the personal narratives and stories of
service users are elicited in a way that counters the objectivising of this group in the same
way that has occurred in other research approaches. However, Costa et al. (2012) have traced
the ways in which such efforts have sometimes became misconstrued with personal stories
used to sustain the validity of health service systems which ultimately can diminish the social
justice agenda.

Lloyd and Carson (2012) proposed the idea of critical conversations between
stakeholders in mental health care. Carried out from the perspective of mental health nursing,
they emphasised the importance of equality within such conversations, in a way that is far
more than simply getting information out of participants but instead is focussed upon the
sharing of valuable information in a collaborative manner. This proposes a respectful way of
listening to service user experiences in a way that honours authenticity and recognition of the
other. Lloyd and Carson (2012) argued that engagement in critical conversations can lead to
greater involvement of stakeholders in mental health, offering a bottom-up approach to
transforming care using a shared language.

**Bricolage**

*Bricolage* has been described as a key innovation that is used within an evolving
criticality (Denzin & Lincoln, 2005b). It is a term that arose from the work of French
anthropologist Claude Levi-Strauss in the 1966 publication of *The Savage Mind* (Maxwell,
2012). It pertains to employing whatever strategies, materials and methods that are at hand in
the qualitative research process, arising from a research climate of blurred disciplinary
boundaries (Denzin & Lincoln, 2005a). Kincheloe (2001) wrote about the dialectical nature of the disciplinary and interdisciplinary relationship in bricolage that promotes a synergistic interaction between these two concepts. This can be a way of confronting disciplinary differences by using divergent methods of inquiry, diverse theoretical and different philosophical understandings which can spark researcher creativity (Kincheloe, 2001).

Critical theorists have been described as bricoleurs, as they seek to produce practical, pragmatic knowledge that is cultural, structural, and judged in terms of its historical situatedness and ability to initiate action (Denzin & Lincoln, 2005b; Kincheloe & McLaren, 2002b). This inter/cross-disciplinary pursuit is grounded in an epistemology of complexity where the critical qualitative researcher:

must abandon the quest for some naïve concept of realism, focusing instead on the clarification of his or her position in the web of reality and the social locations of other researchers and the way they shape the production and interpretation of knowledge (Kincheloe & McLaren, 2002b, p. 316).

Bricolage is employed in this research as it actively constructs “research methods from the tools at hand instead of passively receiving the correct universally applicable methodologies” (Kincheloe & McLaren, 2002b, p. 317). Rather than exclusively employing verbal and textual means in generating knowledge as promoted in IPA, this research moves across methodological domains by employing arts-based methods as a mode of meaning making in asking service users about their experiences of music therapy in mental health.

Although the crossing of disciplinary boundaries from IPA to arts-based methodologies may serve “as a magnet for controversy” (Kincheloe, 2001, p. 680), it was informed by a rationale rooted in an ethos of inclusivity towards the mental health service user group. As music therapy is often offered to service users because of its capacity for non-verbal relating (McCaffrey, 2013), it seemed hypocritical to solely rely upon verbal methods to evaluate music therapy. Furthermore, taking such a singular approach to the research
question could be regarded as excluding service users who wished to share their perspectives through non-verbal means.

The transition between IPA and arts-based methods offered some epistemological similarity as they both placed importance upon the value of personal, lived experience of those who attend music therapy. However, from an ontological perspective there was a marked shift in the means employed to elicit and interpret such experience and this involved further hermeneutic or interpretative consideration which is a feature of bricolage (Kincheloe, 2001). The following section will focus on arts-based methods and provide a rationale for their use in asking service users ‘what is your experience of music therapy?’

**Arts-based Research**

**Historical Overview of ABR**

The *shift or adjustment* to present new ways of knowing through alternative and creative means of representation marked an era of change in qualitative healthcare research, particularly in health sciences, social sciences and humanities (Boydell et al., 2012; Lafrenière et al., 2012). According to Finley (2005), arts-based inquiry developed in postmodern and postcolonial contexts, “woven from complex threads of social, political, and philosophical changes in perspectives and practices across multiple discourse communities” (p. 682). Postmodern foundational shifts resulted in new imaginings of how research operates and what social purposes research might aid with researchers calling for new, diverse approaches to address the many questions that more traditional research trajectories had failed to answer (Finley, 2005). As far back as 1967, Guba (as cited in Finley, 2005) appreciated that there was need to ask new questions in social research and foresaw a reformist program that would bring art to the foreground of inquiry.

Lafrenière et al. (2012) wrote that ABR practices slowly entered the health realm at the turn of the last century. However, Finley (2005) traced this further back to the 1970s.
when new questions and new ways of looking at the social world began to emerge. In Australia, the UK and the USA, ABR practices were founded out of a concern for evaluating art-based programs in healthcare settings that aimed to produce evidence to support the uses of arts in health (Lafrenière et al., 2012). Yet in Canada, the picture differed with arts-based methods first being used to represent people’s experiences of illness, with particular interest in what it is like to live with illnesses such as cancer (Lafrenière et al., 2012).

**ABR & Social Justice**

Arts-based initiatives in research are viewed as a way of making scholarship accessible to a wider audience (Knowles & Cole, 2008). Such investigative practices have been aligned with a broader agenda to increase public involvement in healthcare research, perhaps offering reason for arts-based methods rise in popularity in social science research since the 1990s. Leavy (2011) attributed the increasing utilisation of arts-based practices, not only to the social justice movement but also to the growth of autobiographical data, critical theoretical perspectives, developments in embodiment theory and initiatives towards public scholarships (Leavy, 2011).

The emergence of ABR practices brought about new ways of working between participants and researchers in addition to offering alternative ways of accessing experiential knowing (Liamputtong & Rumbold, 2008). No longer were participants research *subjects* but instead co-creators of knowledge who collaborated with researchers (Finley, 2005). This paradigm presented a different way of working that was thought to influence a new quality standard for social science research, one that was quite removed from a traditional scientific model of objectivity (Finley, 2005). Furthermore, Finley (2005) also suggested that it promoted equality and collaboration in a way that emphasised the importance of interpersonal, ethical, moral, political and emotional skills between all parties involved in the research process.
The issue of accessibility is central to justification for using such methods and techniques. Ledger and Edwards (2011) considered that one of the benefits in using ABR practices is that it can increase access to aspects of human experiences that do not require use of narrative or linguistic terms. They pointed to research by Panhofer, Payne, Meekums, and Parke (2011) suggesting that over-emphasis on verbalisation among participants in the research process can risk neglect of other experiences that have stored in the body and which may be accessed through other sensory modalities.

By offering a broadened array of possibilities for accessing human knowledge, ABR practices have been increasingly used to access the experiences and views of marginalised voices in healthcare research (Ledger & Edwards, 2011). Such marginalised voices belong to groups where more narrative, traditional forms of inquiry have not been appropriate. Previous employment of such narrative methods of inquiry has meant that qualitative research concerning experiences of patients and service users has been privileged to those who supposedly readily utilise a verbal domain. This has perhaps resulted in a rather narrowed view of the patient or service user population that fails to acknowledge people who have valuable and meaningful contributions to offer about their experiences of healthcare through alternative and creative means.

**ABR in Practice**

The decision to employ arts-based methods to elicit perspectives about music therapy in mental health is premised on the notion that they can provide meaningful opportunities for reflections and contributions from service users through non-verbal means of expression; capturing meanings that cannot be elicited through the methods of empirical or positivist traditions (Barone & Eisner, 2011). This supports findings by Boydell et al. (2012), who from their review of 71 arts-based health research studies concluded that these forms of inquiry are often used to overcome limitations and find alternatives to traditional qualitative research.
Boydell et al. (2012) also found that the most common rationale for using arts-based methods was to highlight subjective and detailed experiences of illness in ways that can: enhance understanding; empower and engage participants; account for the skills and abilities of vulnerable groups; address, challenge and rebalance power relationships; and create critical awareness among participants and audiences of health-related issues. Arts-based modes of knowledge translation have been suggested to have a powerful and unique emotional characteristic that engages target audiences and promotes discussion (Parsons & Boydell, 2012).

Arts-based practices have been used for a number of different purposes in a mental health context. Often used within recreational and therapeutic programmes, the role of the arts has long been recognised for its capacity to promote social and emotional well-being (Dyer & Hunter, 2009; Edwards, 2008; Guerin, Guerin, Tedmanson, & Clark, 2011; Lipe et al., 2012; Van Lith, Schofield, & Fenner, 2013). Reported outcomes for such artistic engagement are improved general health, increased self-esteem and self-worth, feeling valued, facilitating the development of interpersonal relationships and widening social networks (Van Lith et al., 2013). In addition, arts-based practices have also been employed to promote mental health recovery as they promote a person-centred approach (Dyer & Hunter, 2009; Van Lith et al., 2013). Chambala (2008) suggested that participation in arts experiences might contribute to one’s identity as an artist rather than as someone who has a mental illness.

Arts-based practices in mental health contexts have been utilised to expand beyond the aim of promoting wellness whereby creative forms are employed to create and disseminate knowledge (Boydell et al., 2012; Clarke, Febbraro, Hatzipantelis, & Nelson, 2005; Koh, 2014). In a review of arts-based health research, Boydell et al. (2012) found that six of 71 studies were concerned with people’s experiences of mental health and each of
these studies featured a different arts-based means of inquiry including: poetry; photography; drama-theatre; and drawing-photography. One of these studies utilised poetry as a method of inquiry that moved beyond traditional literary convention so as to capture experience of mental illness in terms of personal facets such as emotions, feelings and moods (Clarke et al., 2005).

Upon consulting the literature, one may postulate on how the role of the arts has evolved in relation to mental health. An interesting example is that of The Cunningham Dax Collection in Melbourne, Australia, as one of the largest collections of art by people with an experience of mental illness and psychological trauma in the world (Koh, 2014). Assemblage of this collection began in 1946 by the psychiatrist Professor Dax. It was originally curated to illustrate personal experience of different classifications of mental illness. Today it continues to depict such experiences but is also used to tackle stigma of mental illness in addition to promoting the creative abilities of those whose work is exhibited (Koh, 2014). This is perhaps an example of how the agenda of arts-based initiatives that have grown in mental health contexts in ways that historically may not have been envisaged.

An ABR literature review revealed that few arts-based research studies have been carried out in music therapy (Ledger and Edwards, 2011). Many researchers have used processes within research studies that involved creating art responses but not explicitly referred to ABR (Ledger & Edwards, 2011). They suggested that this may be because music therapy researchers are reluctant to explicitly utilise arts-based research practices when they are undertaking research. This merits the question as to what constitutes as arts-based research. Austin and Forinash (2005) distinguished art-based research from research that uses artistic processes by describing the former as research that utilises the arts in response to raw data or to create new data or, lifts the analysis of findings to a another level or to gain access to otherwise unavailable material. This is exemplified in doctoral research by Ledger (2010a)
who wrote a series of poems to reflect upon the experiences of music therapists in relation to service development. Of the few music therapy studies that are classified under this description of arts-based research (Gilbertson, 2013; Ledger, 2010a; Schenstead, 2012; Vaillancourt, 2009, 2011), none relate to music therapy in mental health. However, there are examples of music therapy studies in mental health whereby arts-based processes have been employed without describing the research as being *arts-based* in nature (Grocke, Bloch, & Castle, 2009; Trondalen, 2007).

**ABR Methods**

Arts-based practices may draw upon, but are not limited to literary writing, performance, dance, visual art, music, film or other creative media (Leavy, 2011). Given the multitude of choice, it is surprising to find that arts-based researchers rarely explicitly state their reason for selecting an art genre (Boydell et al., 2012). In the project undertaken for this thesis visual art and music were chosen as creative means of inquiry into human experience of music therapy mental health. As one of the most commonly used methods in arts-based inquiry (Fraser & al Sayah, 2011), visual art was chosen because of its capacity to facilitate inquiry of human consciousness that might not be found through words (Bagnoli, 2009; González-Rivera & Bauermeister, 2007; Henare, Hocking, & Smythe, 2003; Ogina & Nieuwenhuis, 2010; Woolford, Patterson, Macleod, Hobbs, & Hayne, 2013; Yuen, 2004), but also because it can offer a way of expressing matters that are personal to the individual (Fleury, 2011), or clarifying one’s thoughts about a certain phenomenon (Henare et al., 2003). An example of using the visual arts to provide access to sensitive personal issues can be found in the work of Canadian researchers Bone, Dell, Koskie, Kushniruk, and Shorting (2011) who used this method to elicit indigenous knowledge and overcome literacy issues in order to understand and address substance misuse in First Nation communities. Similarly,
visual art has been used to elicit sensitive information from vulnerable groups (Ogina & Nieuwenhuis, 2010; Woolford et al., 2013).

Despite the popularity and use of music in everyday life (Ansdell, 2014), it is interesting to note that none of the 71 arts-based research studies reviewed by Boydell et al. (2012) employed music as a means of inquiry. However, some examples can be found beyond their review that present music as a valuable method of inquiry in arts-based healthcare research. Aldridge (2008) used music as a medium to gain further insight into his clinical work in music therapy and suggested that behind one’s chosen discourse is a one’s persona, thus suggestive of how music can access the personal world of the individual. Similarly, song writing has also been used to provide a meaningful and effective forum in which to portray multiple perspectives of mental health service users (Grocke et al., 2009).

The choice of both arts-based genres in this study was also influenced by Barone and Eisner (2011) who recommended that the researcher exhibits artistry in their chosen method of engagement. Having considered a number of different arts-based genres in relation to my own skill-set as encouraged through my participation in ‘Qualitative Methods in Healthcare’ summer school organised by fellow members of the Music & Health Research Group, the mediums of visual art and song writing were selected. These were chosen due to my previous experiences of using visual art in previous educational contexts, and my background as professional musician and music therapist.

**ABR: Discussions and Debates**

ABR practices present multiple challenges as they advocate for a broadened conception of knowledge, ascertain that their chosen methods produce representative data and also demonstrate that such practices are effective (Boydell et al., 2012; Dyer & Hunter, 2009; Lafrenière et al., 2012; Ledger & Edwards, 2011; Van Lith et al., 2013). Despite their
growing popularity in recent years in healthcare research and their potential to offer innovative sets of techniques to researchers, it is clear that ABR is an area of inquiry that warrants further development. Boydell et al. (2012) wrote that the increased utilisation of ABR in healthcare research has brought about questioning of whether or not there is a paradigmatic shift occurring in qualitative research. This is dependent upon how researchers using ABR can rise to the challenges that have arisen.

According to Boydell et al. (2012), there is a need for critical discussion around the impact of arts-based health research addressing issues of representation, effectiveness and validity. Dyer and Hunter (2009) have identified a lack of robust approaches to evaluation of arts in health projects and called for the development and validation of an evaluation tool to measure such projects. Van Lith et al. (2013) has also recognised the need to develop the evidence-base to support such practices in mental health and has suggested well-designed, mixed-methods studies, employing both quantitative and qualitative approaches as a means of addressing the issue of validation. However, these issues, featuring terms such as robustness, validation and evidence-base, relate to positivist language that does not necessarily resonate with the qualitative tradition aligned with arts-based practices. Therefore, it may be more helpful to look more closely at issues that have arisen within the course of arts-based research as reported by researchers, rather than becoming burdened with satisfying outside calls that emanate from a different paradigmatic locus.

Insider agreement points to the need to further develop the field methodologically (Fraser & al Sayah, 2011; Lafrenière et al., 2012; Ledger & Edwards, 2011). Piirto (2002), a qualitative researcher and literary writer, has questioned the required qualifications of arts-based researchers. There seems to be somewhat of an irony at play when one considers that it is recommended that an arts-based researcher practice artistry in their chosen method while at the same time the rationale behind using arts-based methods with participants in the first
instance is that they do not necessarily require pre-requisite skill (Barone & Eisner, 2011). This could be regarded as problematic from a viewpoint of Critical Theory as it raises issues relating to skill and power in the knowledge creation process, particularly as arts-based methods are often used to capture the perspectives of marginal groups.

The question of how to judge the quality of arts-based materials has also been raised (Piirto, 2002). Dewey (1934/2005) considered that art has traditionally been viewed and judged in terms of aesthetic purpose, overlooking the experiential qualities of such materials as representations of human experience. Similarly, Boydell et al. (2012) have reminded researchers that they need to think about ABR as a different way of doing research that escapes more dominant and traditional schools of thought. A more contemporary view of arts-based materials is that they speak for themselves and can elicit multi-faceted viewpoints when presented to others (Leavy, 2011). This potential to reach out to and resonate with an audience in many different ways is testament to their humanness and acts as a reminder of the tradition from which arts-based research emerged (Leavy, 2011).

In Lafrenière et al.’s (2012) review of 72 ABR studies, 24 of these described ethical issues pertaining to the knowledge creation phase of ABR. These related to the protection of participants’ autonomy, anonymity, and their input into the use and purpose of the materials generated; questioning the location of authorship. However, the discussion about the ethics of engaging in arts-based health research needs further elaboration (Lafrenière et al., 2012), with some researchers in the field stating that ethical considerations are needed but currently often neglected (Boydell et al., 2012). Reporting ethical issues and dilemmas encountered in carrying out ABR are therefore necessary. In the commentary about their systematic review of 30 arts-based studies, Fraser and al Sayah (2011) also pointed to the need for inclusion of a rationale for using arts-based methods in future studies, including a clear description of how these are used in research.
ABR is undergoing a stage of growth and development. Arts-based practices were therefore utilised in this research because of the novel possibilities they could offer into lived experience of service users in music therapy. These practices were chosen because they present an alternative means of contributing human knowledge to science (Willis, 2008) and because they offer a means of further humanising research methods (Gerstenblatt, 2013).

Given the role of ABR in the promotion of social justice, alongside the research being about experiences in a creative arts therapy, arts-based practices are relevant to the inquiry undertaken for this thesis. Resonances with the critical paradigm are evident in the ways in which arts experiences can promote inclusiveness for service users. From a pragmatic point of view, ABR offered a way to overcome some of the possible communication challenges that service users of music therapy might encounter when sharing their experiences solely through words. These offered novel ways of representing human experience through collaborative co-creation of knowledge between participant and researcher. Furthermore, these presented the possibility for new information to emerge about experience of music therapy in mental health as it offered participants alternative and creative avenues that have been largely underutilised in music therapy research to date. Therefore, those participating in this study owned a creative licence to relay their experiences about music therapy through arts-based processes that are committed to the study of subjective human experience.

**Self-conscious Criticism**

Critical researchers adopt self-conscious criticality so as to become more aware of the ideological imperatives and epistemological presuppositions that inform their research (Kincheloe & McLaren, 2002b). This is a means of clearly stating their own assumptions so as to avoid confusion with regards to “epistemological or political baggage” (Kincheloe & McLaren, 2002b, p. 306). My own motivations for carrying out this research have been extensively explored through the process. I have reflected upon my past experience as a
practitioner of music therapy in mental health and considered how my efforts to advocate the service user perspective evoked conscious awareness among others towards the experiences of those who attended music therapy. In the early days of practice these most often stemmed from my frustration, and that of other colleagues, that service user voices were lost within a medical paradigm where individual practitioners or the team had the ultimate say about the treatment provided for service users. In such instances, service user voices seemed to be discounted and often regarded as a secondary or irrelevant source of information when making decisions about care planning directions.

I was keen to listen to service user perspectives as a practitioner in mental health, not only as an integral part of music therapy sessions, but also by considering how these could be incorporated into research that would inform the delivery of music therapy in mental health. This led me to carry out multiple surveys and questionnaires with those who attended music therapy. It prepared me listen to both good and bad feedback about service provision in a way that required openness on my behalf. Sharing the service user perspective also took other forms such as recounting personal experiences that had arisen in music therapy with members of the multi-disciplinary team and compiling CDs of people’s life stories through song for the purposes of affirming service users’ personal narratives. I also presented service user song compositions to colleagues when my own language seemed inadequate and redundant in describing the experiences of another. In many ways these actions were rooted in a long personal history of witnessing and listening to the disappointments and celebrations of family members as they engaged with different healthcare systems. This was also coupled with perhaps a then undeveloped and naïve belief that positive change can occur in healthcare when there is a sense of shared human understanding and regard for one another. It is within such a framework that I approached inquiry into service user experience of music therapy, with the intention of gathering meaningful accounts from those who have attended sessions.
and with the hope that the profession of music therapy would embrace such accounts so as to inform future service delivery. It was equally important that conscious criticism be used to focus upon how this research was conducted so that future inquiry and evaluation of an inclusive nature could be further enhanced.

**Summary**

This chapter outlined the phenomenological tradition of this research that is committed to the exploration of mental health service users’ lived experience in music therapy. Having embraced a phenomenological approach into the study design which advocates verbal means of inquiry, this research extended exploration of the life-world in music therapy through use of arts-based methods. This highlighted that ethos of the overall project was situated within a critical paradigm that recognises the need to acknowledge service users as valuable and equal stakeholders in mental health programmes (Kincheloe & McLaren, 2002a). Such a framework aligns with central concepts of recovery in mental health that is critical of the current dominant forces in healthcare. This particularly relates to the scientific paradigm that has served to create power imbalances between service users and professionals where providers of care are considered the primary holders of knowledge and expertise. Instead, this research acknowledges that service users are experts by experience as a result of their engagement with mental health systems. It espouses notions of collaborative working and partnership so that the voices of service users can be further amplified in mental health research.

Two approaches to service user evaluation of music therapy in mental health were presented in this chapter. IPA is a qualitative methodology that offers a way to capture rich description and understanding of human experience. It is the intention that the insights gained from using IPA will provide valuable information so as to enhance the delivery of music
therapy in mental health. In recognition that many service users attend music therapy because of its capacity for non-verbal relating, this research also employs arts-based methods and processes as creative pathways to capture lived experience in sessions. Overall the research is situated within an inclusive approach to mental health research where a founding tenet is that knowledge can be co-created between service users and researcher(s) in a collaborative ethos. Together, it is hoped that IPA and arts-based process will serve to elicit rich description and insight into mental health service users lived experience in music therapy.

This project explores how a conversation with service users about their experiences of music therapy can amplify the experiences of those who attend sessions. In doing so it is hoped that service user voices will be better heard in the music therapy knowledge base. The following ‘Method’ chapter will detail the methods and processes involved in carrying out this research.
Chapter 4

Method

Introduction

Service users’ lived experience of music therapy in mental health was explored through evaluation of music therapy in two mental health services. Ten interviews were conducted with six service users in an inpatient psychiatric unit. These were analysed using IPA (J. A. Smith et al., 2009). In addition, a series of arts-based focus groups were undertaken with service users at a mental health day centre. Using these methods aimed to illuminate service users’ perspectives of music therapy in ways that honoured subjectivity and the acquisition of expertise through experience.

Service User Interviews

This research project aimed to amplify service user perspectives in the emerging evidence-base for music therapy in mental health so as to inform future development of such provision. In particular, the methods and processes of the research were chosen and developed to resonate with the inclusive and empowering philosophy of recovery in mental health. IPA was chosen for its goodness of fit with the intention to investigate human experience (Bramley & Eatough, 2005; Eatough & Smith, 2006; Griffiths et al., 2011; Owens, Crone, Kilgour, & El Ansari, 2010; Pothoulaki et al., 2012). IPA is an approach that has previously been used in research that focussed upon service user evaluation in mental health (Fortune et al., 2010; Furness et al., 2011). Semi-structured, one-to-one interviews are preferred in IPA as they can help foster rapport between the parties concerned while eliciting the participant’s thoughts, stories and feelings with the aim of providing a deep understanding of the phenomenon (J. A. Smith et al., 2009). In IPA the interview has been described as a “dialogue whereby initial questions are modified in the light of participant’s responses, and
the investigator is able to enquire after any other interesting areas which arise” (J. A. Smith et al., 2009, p. 57). This flexible approach to IPA interviewing fitted with the intention of this study to honour the subjective nature of each person’s experience of music therapy in a way that could allow for the idiosyncrasies of accounts to shine through. The interview involves a process of active participation where the participant is regarded as “the experiential expert on the topic in hand” (J. A. Smith et al., 2009, p. 58). This perspective resonated with recovery in mental health that also values the lived experience of the service user as an expert by experience. It was also proposed and intended that the interviews might be able to promote a sense of being heard and valued among those involved (Furness et al., 2011).

The importance of providing feedback to participants at multiple stages of mental health research has been highlighted (Sweeney, Beresford, Faulkner, Nettle, & Rose, 2009). In order to further realise the inclusive ethos of this study participants were invited to participate in two interviews so that feedback on the initial interview findings could be presented by the researcher during the follow-up interview. Although difficulties have been reported around obtaining follow-up data in hospital settings (Silverman, 2011), in preparation for this study it was considered that a second interview would provide participants with an opportunity to clarify, contest, confirm or elaborate upon earlier discussions. This served for the purposes of clarity and transparency (A. Faulkner, 2004), credibility (Finlay, 2006) and trustworthiness (Kowlessar & Corbett, 2009).

Preparation

A statutory mental health provider of music therapy agreed to host the interview stage of this research in an inpatient hospital setting in which two music therapists practiced. In June 2012, the hospital granted ethical approval for the study entitled Music therapy in mental health care: Listening the voices of experts by experience (see uploaded supplementary materials for both application and approval). A meeting was then held with
staff at the hospital to discuss the practicalities of the research including issues relating to the recruitment of participants, dates for data collection, interview locations, safety, duration of interviews, communication, in addition to deciding upon the follow-up procedure with participants after completion of the interviews. In this meeting a staff member agreed to perform the role of research gatekeeper who would be my main point of contact for research related issues in addition to providing introductions and access to potential participants (Green & Thorogood, 2013). A memorandum of understanding was subsequently drawn up between the hospital and the Music & Health Research Group at the University of Limerick as a means of clarifying the terms and conditions of this study (see uploaded supplementary materials).

In preparing for commencement of the research a consultation was held with Paddy McGowan, Expert by Experience and Lecturer at Dublin City University. He provided extensive advice from his perspective as an individual who has lived experience of mental health recovery but also as a career academic who has published on the need for meaningful inclusion of service users in research (McGowan et al., 2009). Paddy suggested that meetings should be arranged with potential participants before carrying out interviews. The resultant rapport from these encounters could potentially enrich people’s descriptions of their experiences. Therefore, an initial visit was carried out at the hospital before commencement of the interviews in order to make contact with potential participants. Paddy also encouraged that where possible during the interviews, it was useful to pursue participant’s descriptions of what their experience of hospital was like before attending music therapy. He advised that these could be used as comparators of participants’ life-world before and after music therapy.

After completing a Garda Vetting (Police Clearance) process and securing indemnity cover (see uploaded supplementary materials) for all research related activities through the
University of Limerick, data collection through interviews commenced in September 2012 and continued to November 2012.

**Semi-structured Interview Design**

Although the direction of the IPA interview is co-determined in situ, an interview schedule was created as a means of keeping the focus of the research in mind for the researcher during the interview. Informed by the wording of phenomenological questions as suggested by Donalek (2005) and Seidman (2006), nine questions were included in this schedule which provided some sense of structure to the interview while also allowing for adequate space in which participants could explore topics that they had introduced. Prefaced with the leading statement of “I am interested to learn about your experience in music therapy”, these questions included;

1. Can you tell me a little bit about how long you’ve been attending music therapy for?
2. Can you say something about what it was like for you before you attended music therapy?
3. How did you decide to attend music therapy?
4. What do you do in music therapy?
5. Why do you attend music therapy?
6. What do you like/not like about music therapy?
7. Is music therapy different or similar to other things you are attending or have attended?
8. Have you learnt anything new or different about yourself since attending music therapy?
9. What would you say to other service users who are considering attending music therapy?
This list of questions was printed on one A4 size page and discretely placed on the floor or chair beside me during the interviews.

**Participants**

IPA is a process in which rich, detailed, accounts of individual human experience are elicited, transcribed and analysed so that a deeper understanding of the phenomena of interest can emerge (J. A. Smith et al., 2009). IPA studies usually advocate for relatively small sample sizes. This study proposed that a minimum of three and maximum of eight participants would be interviewed. As the potential participant pool was small in number, the research aimed to be overly inclusive by not limiting participation to those who were actively attending music therapy.

Participants were invited to engage in two one-to-one 20-50 minute verbal interviews. Inclusion criteria accommodated people who had attended a series of music therapy sessions over an extended period and those who had attended only a few sessions. Inpatients and outpatients were also included so as to allow for a change in patient status between initial information and informed consent stages of the research. The main inclusion criteria for intending participants was that they: 1) were over 18 years of age; 2) were willing and able to speak about their experiences of attending music therapy in a verbal interview in the English language for approximately 20-50 minutes duration; 3) were an inpatient or discharged patient of the psychiatric unit at the hospital; and 4) had attended a minimum of two music therapy sessions within the past six months, thus allowing for the participation of those who were not actively attending sessions but yet wished to reflect upon their experiences therein. The exclusion criterion applied to cases where informed consent could not be given due to diminished cognitive capacity to the extent where a potential participant did not sufficiently understand the nature or purpose of the intervention and its subsequent consequences.
Recruitment

The aim of the recruitment process was to gain participation from people representative of those who are the focus of the research project namely, people who have experienced music therapy while receiving inpatient treatment for mental health problems. The original ethics application stated that the recruitment protocol would involve placing poster advertisements (see Appendix A) on notice boards in the unit. Potential participants would then make expressions of interest to the research gatekeeper who would arrange a meeting between the researcher and those interested. However, it was thought that this strategy alone would result in few participants and that a more personalised approach was warranted. Therefore, mindful of the inclusion criteria, the gatekeeper handed out poster advertisements to a number of potential participants. The gatekeeper in turn arranged that I meet those who had made expressions of interests to be involved in the study.

I met potential participants in various locations within the inpatient unit. These meetings provided an opportunity to discuss the research and circulate written documentation in the form of an information sheet (see Appendix B), that included the nature, purpose, risks, benefits and procedure of the research as described by Groenewald (2004). This was written in accessible language as demonstrated by Claveirole (2004). These meetings served as a means of initial rapport building with potential participants in addition to answering any related questions or concerns about the research. The written information that was provided included my dedicated research mobile number and email address so that potential participants could contact me with any queries that arose beyond the course of this meeting. Due to my limited on-site availability, one participant was not available to meet with me but instead discussed the research with the music therapist and requested that I send on further written information to them. This was followed up with a phone discussion during which the individual’s questions about the research were addressed.
All initial discussions with potential participants were met with a positive response. Some expressed their eagerness to take part in order to give their opinion of music therapy and others spoke about their current and past relationships with music. One individual indicated that he felt “slightly paranoid” about the interview being recorded but added that he still wished to participate. He also queried the meaning of the term *expert by experience* which was featured in the information sheet. He seemed to have difficulty with the idea that he had acquired expertise through his lived experience of attending music therapy sessions.

In accordance to the ethics guidance manual of the hospital, all research participants were given a minimum of 24 hours and a maximum of two weeks between being provided with the written information about the study and signing the consent form to participate. This allowed people time to consult with family, friends and/or staff before making a decision about participation. It also provided an opportunity for people with literacy difficulties to consult with a third party so that they could gain assistance with reading the relevant documents and ensure that they were fully briefed before making a decision about their participation. Recruitment was carried out in accordance to the guideline above that 3-8 participants would provide an adequate sample size to carry out a quality IPA study. Upon reflection with the research gatekeeper, this sample size seemed fitting to the small participant pool that was available at the hospital. Therefore it was agreed that recruitment would continue until expressions of interest around involvement ceased. A total of two men and four women, participated in interviews carried out over six days in a three month period.

**Procedure**

Five participants described their experiences of open group music therapy sessions with one therapist, and one participant reflected on the experience of participating in individual sessions with a different therapist. Participants were asked to choose a pseudonym

The location of the interviews depended upon each participant’s patient status. Five of six participants were interviewed in a private room at the psychiatric unit of the hospital. These included four participants who were inpatients (Pauline, Barbaraella, Carma and Laura), and one participant (Luke) living in the community who agreed to be interviewed at the hospital. Consistent with hospital protocol, I was required to wear a portable alarm at all times while on the inpatient unit. This was clasped to my belt and visible to the participants. A sixth participant, Ollie, was recruited to the research as an inpatient but was discharged from the hospital before interviews commenced. Therefore, Ollie’s interviews took place at a local mental health day centre so as to accommodate his circumstances.

The music therapist facilitating the open group sessions provided a written description of his role at the hospital. He described his role as enabling people to meet, interact and support one and other through here-and-now exchanges rather than providing a therapy. Although known songs presented in the style of a sing song were sometimes featured, these open groups were described by the music therapist as mainly improvisational in nature where varied instruments were made available for people to explore. Attendance of this open group did not require a commitment to stay for the full duration of the session or attendance of future sessions. The music therapist also explained that this group was directed by the social dynamic present on any day and that with his support, service users are facilitated to work out what they require of the session. This might be a calm space apart from the wards, or a sense of diversion from the situation in which they find themselves.

The second music therapist who provided individual music therapy sessions to one participant explained that she employed a psychodynamic approach in working with service
users. She also acknowledged influences from humanistic, community music therapy and mindfulness based approaches in her practice where the over-riding principle is to be person-centred rather than strictly adhering to one particular approach.

In consultation with the gatekeeper, I met each participant at a mutually agreed location before we proceeded to the interview room. After being provided with an opportunity to ask questions and clarify that they agreed to participate, each participant was given an informed consent (see Appendix C) and recording consent (see Appendix D) forms to sign. Once these were completed, participants were reminded that their involvement was voluntary and that they had the right to withdraw from the study without question at any time. A mini-disc recorder was then switched on in order to make an audio-recording of the interview. The interview schedule was left in a discrete location within my visual periphery so that it could be used as a reference point if required.

The interviews opened with the question “I am interested to learn about your experience of attending music therapy, I wonder if you could tell me something about what participating in music therapy is like for you?” Participants then determined the direction of the conversation from this point. I responded with open and non-leading questions in order to provide opportunities for participants to share what they had experienced or had been involved in during music therapy sessions. Techniques used to enrich the interview process involved enhancing reflection, clarification, requesting examples and descriptions in addition to conveying interest throughout the process (Jasper, 1994). As a qualified music therapist, I also drew upon my training in empathic listening techniques and aimed to adopt a stance of “unconditional positive regard” so as to elicit the views and feelings of participants (Rogers, 1967/2004, p. 47).

My main focus during the interviews was upon being open and available to participants in a way that would encourage them to convey their personal experiences (Ezzy,
This involved following their lead on the related topics they wished to discuss so as to allow room for personal accounts and descriptions to emerge as described by Claveirole (2004). At the same time my role also involved gently steering the discussion back to the topic of personal experience in music therapy when participants discussed topics that seemed unrelated to this. The interview schedule was used as a broad framework that was consulted at moments when a natural pause arose in discussion and when it seemed appropriate to introduce a new point of exploration. This resulted in not all listed questions being asked of each participant, particularly in the interviews where the participant wished to discuss a particular aspect about their experiences in music therapy. In these cases I did not interject with questions from the interview schedule but instead encouraged them to continue with the established line of discussion. This allowed for an informal style within a “guided conversation” (Lofland & Lofland, 1995, p. 85). This was carried out with the aim of eliciting descriptions of participant’s experiences of music therapy that could accommodate for new ideas to emerge within a shared journey (Donalek, 2005). In this regard participants were viewed as co-authors of knowledge (Ezzy, 2010) rather than repositories of data (Walters, 1995).

At the end of the interview participants were asked if they wished to receive 2-3 newsletters over the lifetime of the research which would keep stakeholders updated on related progress and developments. The four participants who agreed to this then shared their preferred contact details, all of which were postal addresses. Provisional arrangements were then made for follow-up interviews to which four participants agreed (Luke, Ollie, Pauline and Barbaraella). Carma said that she did not wish to participate in a follow-up interview. It was not possible to carry out a follow-up interview with Laura as her initial interview took place on the final day of data-collection. Some of those who decided to do a follow-up interview chose to liaise with me directly about a suitable interview time while others
preferred that this be arranged by the research gatekeeper. The duration of each of the six initial interviews varied approximately between 18-55 minutes.

Acknowledging that researchers and participants influence each other reciprocally (Stige, 2012), I recorded notes in my reflexive journal about my impressions and immediate thoughts concerning the interviews that had taken place. Through this type of introspective analysis or “memoing” (Groenewald, 2004, p.1), I noted how some parts of interviews were enjoyable and flowed easily while others felt tense and stuck. I also noted how my sense of time quickly passed during the interviews while at other times it seemed to drag. Strong emotional reactions were also documented in my reflexive journal as part of highlighting my preoccupations with potential issues that might impact the research process (Ghetti, 2011).

Before carrying out the follow-up interviews audio-recordings from the initial interviews were listened to make verbatim transcripts. These transcripts enabled me to carefully read and listen to initial descriptions that participants had relayed about their experiences of music therapy. Brief summary points and surprising or poignant moments of the first interview were noted. These highlighted the points of clarification or elaboration to be pursued in the follow-up interview.

All follow-up interviews took place at the same location as the first interviews (see Table 2: Data Collection Venue, p.115). These opened by asking participants about their thoughts about the initial interview which they were encouraged to elaborate upon if they so wished. Thereafter points that required clarification or elaboration from the first interview were discussed and initial impressions about these presented. At the end of the interview participants were given an opportunity for a debriefing about the experience. They were informed that the gatekeeper or I would check-in with them within one week so as to briefly reflect upon their experiences of participating in the interviews. The duration of the follow-up interviews varied between approximately 22-45 minutes in duration. All participants,
including those who were interviewed on one occasion, were either phoned or visited on the
ward by the gatekeeper or me. No issues relating to participation were reported.

Table 2: Data Collection Venue

<table>
<thead>
<tr>
<th>Participant</th>
<th>Initial Interview</th>
<th>Follow-up Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luke</td>
<td>Inpatient unit</td>
<td>Inpatient unit</td>
</tr>
<tr>
<td>Ollie</td>
<td>Day Centre</td>
<td>Day Centre</td>
</tr>
<tr>
<td>Pauline</td>
<td>Inpatient unit</td>
<td>Inpatient unit</td>
</tr>
<tr>
<td>Barbaraella</td>
<td>Inpatient unit</td>
<td>Inpatient unit</td>
</tr>
<tr>
<td>Carma</td>
<td>Inpatient unit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Laura</td>
<td>Inpatient unit</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Analysis

Audio-recordings of all ten interviews were transcribed verbatim. This helped to
maximise familiarity with the data. Any personally identifying information including names
of people, places, and geographical locations were omitted from the interview transcripts so
as to ensure that the participants would not be identifiable to external parties. Only I and my
supervisor had access to the transcripts and audio-recordings. Electronic materials were
stored on an encrypted and password protected computer while the mini-discs and hard-copy
transcripts were kept in a locked cabinet in my office at the University of Limerick. These
materials are required to be stored for seven years after which time they will be destroyed.

As advocated by J. A. Smith et al. (2009), IPA was carried out on a case by case basis
whereby four cases considered two interviews while the remaining two cases involved a
single interview. The following steps of analysis were undertaken:

1. The interview transcript was carefully read a number of times and the audio-recording
   of this was listened to on at least two occasions during which initial impressions of
   these were noted. These notes were considered in relation to the corresponding entries
that were recorded in my reflexive journal at the time of recording the original
interview.

2. The text from the electronic transcript was copied into a table consisting of three
columns allowing space for IPA analysis. Each line of text was double-spaced and
pages were numbered.

3. The transcript was read again for the purposes of familiarity.

4. Exploratory comments were noted in the far-right hand column of the table. These
included; descriptive comments that highlighted the objects which structured the
participant’s thought process; linguistic comments that were concerned with language
use and; conceptual comments that moved towards a more interrogative analysis that
focussed on overarching understandings of what participants said (J. A. Smith et al.,
2009). Each comment category required a separate reading of the transcript.

5. My own thoughts and impressions were noted while reading and analysing the
transcripts. These were written in my reflexive journal and also inserted in comment
boxes in the interview transcript as I occasionally encountered strong personal
reactions. These strategies helped me to differentiate my thoughts from those of the
participant so as to inform subsequent evolving understandings of the data (Finlay &
Molano-Fisher, 2008).

6. Emergent themes were developed from the various forms of exploratory comments.
These were inserted into the left-hand column of the table.

7. All of the emergent theme names were copied and pasted into a separate Microsoft
Word document in a large font size. The corresponding transcript page was noted after
each theme in brackets. This was for the purposes of ensuring ease of reference at
later stages of analysis.
8. The list of emergent themes, varying from 62-178 per interview, was printed and each theme was cut out on a separate piece of paper as suggested by J. A. Smith et al. (2009). These were then placed on the floor so that they could easily be moved around when developing super-ordinate themes. Once cross-checked with the interview transcripts, the super-ordinate themes consisting of multiple emergent themes represented on paper slips were stuck onto a wall. Some emergent themes were made redundant at this point because they did not fit within these super-ordinate themes.

9. Photographs of the super-ordinate themes were taken and transferred onto my computer. These were used to inform the completion of written summaries of each super-ordinate theme. A summary table in relation to each interview was compiled. This featured a description of the super-ordinate themes which were ranked in descending order in accordance to its comprising number of emergent themes which varied in number from 52-2.

10. The process described above was repeated across interviews on a case by case basis until all six cases were analysed. Supporting quotes were then extracted from the transcripts to support each of the super-ordinate themes arising within the interviews.

11. The final stage in analysis of the interviews involved looking for patterns across cases. A master table of all super-ordinate themes from each interview was compiled, printed and laid out on a large table. Written summaries of each super-ordinate theme were carefully considered. Eight shared themes across the interviews were identified in total. Some of these adopted original super-ordinate theme names and others required a new name. These were ordered in accordance to their frequency across cases and began with the themes that were identified by all participants as a way of enhancing the validity of the findings (J. A. Smith et al., 2009). Rich passages of text were then extracted from the transcripts to support each of the eight overall themes.
Concluding Reflections

I had many thoughts about what it would be like for me to return to work within an inpatient environment hospital. From others accounts of this experience (for example, Ledger, 2010b), I was aware that the role of researcher would be quite different to that of therapist. After carrying out the interviews the differences between these roles became more apparent and I arrived at the conclusion that as researcher one has to adopt a more inquisitive stance in order to invite description. This is different to therapy where there is a shared pursuit of finding answers or solutions to personal difficulty.

The role of the gatekeeper in this phase of the research was invaluable on a number of levels. Their regular on-site presence aided the recruitment stage of the project as it ensured contact with a much wider group of potential participants than would have been possible to access over my one day visits every fortnight. Furthermore, the gatekeeper was ideally placed to advise me on day-to-day research operations because of their extensive knowledge of hospital policies, procedures and systems. This enabled a smooth running of the project which ensured minimum disruption to other service users and staff in the inpatient unit.

One challenging aspect of this phase of the research involved writing the participant information sheet (see Appendix B) as guided by template documents provided by the hospital. The obligatory wording featured in the guidance document was rather autocratic towards participants and featured the statement “you understand that your participation in the study may be stopped at any time without your consent”. Although it was a requirement that this wording be included in the final information sheet, it conflicted with the intended collaborative nature of this research.
Arts-based Focus Groups

The interviews had yielded rich, in-depth accounts of participant’s experiences in music therapy. Yet the reliance on verbal methods seemed to challenge some of those involved. Some made related references such as “it’s hard to say”, “maybe I’m not using words in the right way”, “it’s awful hard to put into words” and “I’m probably not expressing myself through words or probably not talking too well with you”. I also noted how words seemed to fail one participant’s descriptions of music therapy during the final interview when our most satisfying mutual communication occurred when we both sang her favourite song together. These observations and comments prompted me to think about other ways of gathering knowledge as demonstrated through other arts-based researchers with which I was working (Ledger & Edwards, 2011). As a member of the Music & Health Research Group I attended a ‘Qualitative Methods in Healthcare Research Summer School’ in 2011. During this summer school Dr Ledger gave an inspiring presentation on arts-based research that broadened my understanding of this field of inquiry. This presentation, coupled with encouragement from my research supervisor, led to the decision to employ arts-based methods in this research in order to engage different ways of knowing (Liamputtong & Rumbold, 2008). Creative methods could be an inclusive means of evaluating music therapy among the service user community.

Preparation

A second statutory mental health provider of music therapy was approached about the possibility of hosting service user research at their day centre facility. Following a meeting about the study with the music therapist and other members of the service’s mental health team, an application for ethical clearance was prepared and submitted to the relevant ethics committee. Approval for the research project entitled Evaluating music therapy through an arts-based focus group was granted in September 2013 (see uploaded supplementary
materials for application and approval). Following confirmation of indemnity cover, risk management approval and Garda Vetting, a memorandum of understanding was drawn up between the relevant mental health service and the *Music & Health Research Group* at the University of Limerick (see uploaded supplementary materials).

**Focus Group Design**

Similar to the theoretical approach taken to the interviews, this phase of the research espoused the perspective that lived experience is a meaningful and valued form of knowledge (Finlay & Evans, 2009). Focus groups were employed because of their capacity to offer participants an opportunity to collectively share their experiences and investigate a range of views (Kendall et al., 2007). A further reason for the focus groups was because of their previous utilisation in service user evaluation in mental health (Fortune et al., 2010; Furness et al., 2011; O'Toole et al., 2004), and usefulness in exploratory research when there is little known about the topic under investigation (Doody, Slevin, & Taggart, 2013a). Focus groups presented a way of collecting data in a peer-supported environment (McDaid, 2009) where group dynamics could be acknowledged (Rabiee, 2004) and flexibility existed so that new ideas and creative concepts could emerge (Doody et al., 2013a). This possibility to uncover new data was further embraced through the employment of arts-based methodology as a less *conventional* means of inquiry within focus groups as demonstrated by Yuen (2004). Arts-based methods presented the possibilities of accessing aspects of music therapy experience more immediately through expressive forms (Liampittong & Rumbold, 2008) without necessary reliance upon verbal means or prerequisite skill (Ledger & Edwards, 2011). This ‘presentational’ or ‘symbolized’ form of knowing (Liampittong & Rumbold, 2008) is one that has been under-utilised in music therapy research in mental health. Therefore, it offered a route of inquiry that was exploratory, innovative and unique.
As an experienced mental health practitioner, I was aware of the complex dynamics that occur when working within a group context. This was reflected in focus group literature that has emphasised the importance of understanding the social dynamics that are at play therein (Doody et al., 2013a; Rabiee, 2004). I was mindful of the importance of working within the here and now and viewed my role as one of facilitator who would aim to create a relaxed and encouraging environment for participants. This would provide participants with opportunity to exchange their feelings, views and ideas about music therapy through arts-based mediums (Rabiee, 2004). Although the materials created within these groups were the primary outcomes from this stage of the research, the research design also made provision for recording other sources of information. This included making audio-recordings of the groups and noting observational data that could potentially deepen my understanding of the processes that had occurred (Doody, Slevin, & Taggart, 2013b). Ultimately, these were viewed as a means of highlighting the context from which the findings emerged (Rolvsjord & Stige, 2013; Stige, 2012).

Guided by Barone and Eisner’s (2011) recommendation that the researcher exhibit mastery in their chosen medium of inquiry, visual art and song writing were selected as the media that would be offered to focus group participants. The choice of visual art was informed not only by my experience of pursing this as a pastime but also because of its capacity to offer a non-verbal means of expression. This decision was further embedded through consultation of the research literature that exemplified the role of visual art in inquiry into human consciousness in a way that cannot be easily put into words (Bagnoli, 2009; González-Rivera & Bauermeister, 2007; Henare et al., 2003; Ogina & Nieuwenhuis, 2010; Woolford et al., 2013; Yuen, 2004). Visual art was also selected because of its capacity to express matters that are personal to the individual (Fleury, 2011). Song writing was also selected as a medium of musical inquiry in the focus groups because of my skills using this
art form as a professional musician and music therapist. Although not as commonly used in
the field of arts-based inquiry, music has been highlighted as a medium that can aid insight
(Aldridge, 2008; Schenstead, 2012). In addition, song writing has been shown to be a
meaningful forum in which to relay service user views in mental health (Grocke et al., 2009).
Overall, the mediums of song writing and visual art were selected as contrasting verbal and
non-verbal avenues that would offer a sense of variety to participants when choosing a means
of expression with the arts-based focus groups.

**Participants**

A series of three arts-based focus groups took place at a mental health day centre that
provided music therapy on a part-time basis. Service users who were 18 years of age or over
and who had attended music therapy in the previous six months before data-collection were
invited to participate. This meant that participation was not limited to those who were
actively attending sessions should such accounts yield reasons for drop out or non-attendance
of music therapy. A further criterion for inclusion in the study was that participants were
willing and able to reflect upon their experiences of attending music therapy in an arts-based
focus group facilitated in the English language for approximately 60-90 minutes duration.

The size of the focus groups was informed from various sources of information. The
practicalities of offering two expressive mediums such as visual art and song writing were
considered alongside the intention of carrying out arts-based methods to produce data of
quality rather than quantity. These issues, coupled with descriptions of focus group sizes
ranging between four and fourteen participants (Doody et al., 2013a) informed the decision to
recruit a minimum of two and maximum of five participants to this study.
Recruitment

The focus of the recruitment process was to gain participation from service users who had experienced music therapy as part of their community mental health care. A poster advertisement (see Appendix E) was placed on numerous notice boards in the day centre. These invited potential participants to make expressions of interest to one of either two nominated members of nursing staff who had agreed to inform me of such interest. In addition, the music therapist also reminded service users about the research and introduced me to potential participants during my pre-data collection visit to the facility. During these introductions from nursing staff and the music therapist, those who expressed interest in the project were provided with an information sheet about the study (see Appendix F). This contained information about participation, confidentiality and my professional background but also information about the nature, purpose, risks and benefits related to the study. It also included details of my research mobile number and university email address should intending participants need to contact me in advance of the focus groups. One intending participant was not on site during a pre-data collection visit so a copy of the information sheet was left with nursing staff to pass onto him. All intending participants were given a minimum of 24 hours and a maximum of two weeks between being provided with the written information about the study and signing the consent form to participate. This allowed people time to consult with family, friends and/or staff before making a decision about participation. It also provided an opportunity to those with literacy difficulties to consult with a third party so that they could gain assistance with reading the relevant documents and ensure that they were fully briefed before making a decision about their participation. Recruitment commenced over a one week period and concluded upon commencement of the first focus group. Three male participants were recruited, two of whom attended music therapy on an individual basis while the third attended music therapy in open group format.
Procedure

The arts-based focus groups took place weekly over a three week period November-December 2013. After discussions with nursing staff it was agreed that 90 minutes duration for each group might be too demanding of participants so duration was reduced to 60 minutes. Three participants agreed to be involved in the study and each chose a pseudonym; ‘Shady’, ‘Jack Sparrow’ and ‘Dreamer’. Two participants attended the first arts-based focus group while all three participants were present at the second and third arts-based focus groups.

The music therapist who worked with the participants provided a brief written description of his role at the facility. This outlined a client-centred approach where the wishes of the individual determine the musical processes engaged in during the session. The music therapist described how relaxation and Guided Imagery and Music (GIM) techniques are sometimes used in sessions in addition to emphasising the value of long-term work in building a strong sense of relationship between client and therapist.

The arts-based focus groups took place in an art room at the day centre. Both participants and researcher sat around a large table in the middle of the room where an array of art materials were placed including coloured crayons, markers, paints, chalks, pencils and sheets of paper in different sizes (see Figure 1: Arts-based Focus Groups - Visual Art Materials, p.125). A dictaphone recorder was also left in the middle of the table for the purposes of making audio-record the focus groups. Musical instruments were left to the side of the table. These included a keyboard, guitar, djembe and a range of hand percussion (see Figure 2: Arts-based Focus Groups- Music Materials, p.125).
Although it was intended to hold the focus group sessions for only 60 minutes some flexibility was needed within this for lateness, and for participants wishing to leave the group early. Participants chose to use the time in the group to actively pursue the creation of arts-based materials. However, accounting for one participant’s delayed commencement to the project, the first and second focus groups shared a similar opening format. This involved general introductions and conversation while the informed consent (see Appendix G) and
recording consent (see Appendix H) forms were signed. Once this documentation was completed the dictaphone recorder was switched on. Participants were reminded of the purpose of the research which was to reflect upon their personal experiences of attending music therapy in mental health through the use of song writing or visual art. They were also informed that the merit of the material created was not of concern, instead the objective was to think about how these arts materials could be used to capture and describe some of their thoughts and feelings about music therapy. These instructions were deliberately left open so that participants might be enabled to structure their approach to working with arts-based methods in different ways (Bagnoli, 2009). After discussing the purpose of the research, opportunity was provided to ask related questions and participants were reminded that their participation was voluntary meaning that they could withdraw from the research at any time without question. Thereafter, the format of each focus group was informed by the group dynamic and the artistic wishes of those present. In some cases groups began with participants initiating new ideas for projects while other focus groups commenced with resuming earlier projects.

Similar to previous arts-based research (Ogina, 2012; Yuen, 2004), my role was one of both researcher and focus group facilitator. The facilitator role involved offering support and assistance to participants as they worked with the arts-based materials, all the while aware that this was a project in which knowledge was co-created. Facilitation also involved accommodating the overall wishes of the group that seemed to prefer actively pursuing creative processes, rather than engaging in lengthily reflective discussion about the art-based materials made. Another facet of facilitation involved supporting creative processes on both an individual and group basis, particularly within the first focus group. However, in the interests of promoting group cohesiveness, collaborative projects were encouraged in subsequent focus groups. Overall, facilitation required a high degree of openness and
flexibility on my behalf so as to enable participants to work in a manner that they felt comfortable with (Bagnoli, 2009).

Supporting involvement in visual art and song writing processes varied across the arts-based focus groups. A visual art process was pursued by one participant on one occasion and required little input on my behalf. This contrasted to a high level of input in supporting song writing processes that involved drawing upon my skills as a qualified music therapist with extensive experience of working in mental health. Such collaborative processes were approached by jotting down participant ideas about the song on a piece of paper and discussing preferences for instrumental accompaniment and genre style. The song was then composed on a line by line basis whereby participants contributed lyrics that I sang back to them with musical accompaniment. These contributions sometimes required gentle prompting as participants appeared to be stuck or short of words. This lyrical and musical process was repeated back and forth until a verse or chorus was completed and sang back to the group. Once the various sections were completed the final composition was sung by all group members with some choosing to play a hand percussion instrument to accompany the song. Recordings of these were played to participants in subsequent focus groups and copies of typed lyrics were shared.

Four arts-based materials were created over three focus groups, each of which lasted for approximately 60 minutes. These materials included one piece of visual art that was pursued on an individual basis while the remaining three arts-based materials were group song compositions entitled Wednesday, When I play Music and Music Therapy Rap. Wednesday is a song parody as it features the original melody of Rhinestone Cowboy (Weiss, 1975) sung by Glen Campbell. When I play Music was based upon poetry written by Dreamer while Music Therapy Rap is an original composition. The degree to which participants were involved in the production of these songs varied due to varying levels of attendance whereby
some participants left the focus groups before the scheduled finish time. Further information on each of the arts-based materials is featured in ‘Table 3: Arts-based Materials’.

<table>
<thead>
<tr>
<th>Arts-based material</th>
<th>Method used</th>
<th>Initiated by</th>
<th>Individual/Group Pursuit</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Wednesday</td>
<td>Song writing</td>
<td>Shady</td>
<td>Group</td>
<td>Song parody to melody of <em>Rhinestone Cowboy</em> (Weiss, 1975)</td>
</tr>
<tr>
<td>3. When I play <em>Music</em></td>
<td>Song writing</td>
<td>Dreamer</td>
<td>Group</td>
<td>Adapted from poetry composed by Dreamer</td>
</tr>
<tr>
<td>4. <em>Music Therapy Rap</em></td>
<td>Song writing</td>
<td>Jack Sparrow</td>
<td>Group</td>
<td>Original composition</td>
</tr>
</tbody>
</table>

The group dynamic varied greatly across each focus group and was influenced by the personalities of those within them. On the whole, the atmosphere was casual and relaxed with many jovial moments among those present. However, there were moments of tension as some participants received more support around engagement in creative processes than others. These observations were recorded in my reflexive journal so that I could return to them at a later point when considering the arts-based materials created.

Upon request of the research participants, the concluding part of the final focus group involved reviewing each of their song compositions. This involved the group singing each song with guitar accompaniment to which some participants played percussion instruments. This enabled an opportunity to debrief with participants about their involvement and inform them of the research follow-up procedure that would occur within the following seven days.
When participants were asked for their preferred contact details for follow-up one individual informed me that he did not have a mobile phone while another told me that he did not use his mobile phone. Instead it was agreed that follow-up would be pursued through a member of nursing staff at the facility who agreed to check-in with each participant about any arising issues from participation in the research. No issues concerning participation were reported by the nurse manager when contacted. Two participants wished to receive a copy of the research newsletter which they requested to be posted to them at the day centre. A CD featuring all of the song compositions along with printed copies of lyrics, was sent to all participants within one week of the study’s conclusion.

**Reflexive Processing of the Arts-based Materials**

The emancipatory ethos of this research that informed employment of arts-based methods as a political act to promote inclusion (Barone & Eisner, 2011) was considered in relation to analysis of the arts-based materials in arriving at definitive findings about lived experience in music therapy. However, with awareness that arts-based materials can be interpreted in many different ways, such a definitive process of analysis was viewed as contradictory to the emancipatory and inclusive ethos of this study. Furthermore, those who had participated in the research did not consent to have their materials analyzed but rather presented to others in a way that would highlight their own personal views of music therapy. Instead it was thought fitting to embark upon a reflexive process concerning the arts-based materials during this final phase of the research. This was inspired by other arts-based projects described in the literature such as that of Gilbertson (2013) who used creative writing and made a cast of his hand to explore the potential meanings of music improvisation in therapy with a teenage boy who had severe traumatic brain injury. Having imaginatively used such processes, it was concluded that “a combination of diverse qualitative methods over an extended period of time can be instrumental in gaining innovative and rich insights into
initially hidden perspectives on health, well-being, and human relating” (Gilbertson, 2013, abstract section). Similarly, I was also aware of earlier research by Trondalen (2007) who used a form of movement called “body listening” as a means of responding to improvisation where, the notion of response was pursued using arts-based methods (2007, p. 203). These examples spurred me to consider the notion of arts-based exploration of processes that surrounded the creation of arts-based materials (Guillemin & Westall, 2008) while at the same time allowing each of these materials to speak for themselves (Leavy, 2009). It also enabled consideration of my role as researcher within the creation of these materials.

The first stage in this reflexive process involved transcribing the focus group recordings verbatim and reading over them in relation to reflexive journal notes in order to gain a deeper understanding of the context that surrounded the creation of each arts-based artefact. Following this the visual image was carefully viewed while the three songs were listened to a number of times. Unsure of what to do with my thoughts, observations and impressions about these, I noted how Fleury (2011) and Yuen (2004) employed the process of triangulation as a way of marrying multiple data sources in order to reach an in-depth understanding of arts-based materials. Triangulation implies that a single point is considered from three different sources (Decrop, 1999). This was originally used for the purposes of validation in quantitative research in order to account for weaknesses of any single strategy toward achieving confirmation of findings (Ramprogus, 2005). However, triangulation has since been used within the qualitative paradigm for the purposes of completion so as to discover a holistic view of the phenomenon under study and to enhance the researcher’s depth and breadth of understanding (Fenech Adami & Kiger, 2005). This resonated with the direction I wished to pursue as it offered a means of combining multiple data sources (Williamson, 2005). However, using triangulation for the purposes of completion would suggest that the arts-based materials were incomplete in some way when both my supervisor
and I were of the view that these could stand alone in evoking discussion and thought among their audience. Therefore, triangulation was used for the purposes of response to the arts-based materials produced in the focus groups.

Having determined that triangulation would be used to bring multiple data sources together in responding to each of the arts-based materials, it was necessary to consider a possible mode for such delivery. This pointed to the employment of an epistemologically congruent arts-based medium as discussed by Ballinger (2004). Having considered a variety of such creative media it was established that song writing would be suitable in this regard, not only as an arts-based method but also as a medium in which I, as qualitative researcher, exhibited mastery and skill.

A song writing response was composed for each of the arts-based materials generated in the focus groups. The songs were informed by different data sources derived from reflexive journal notes and relevant focus group transcripts. These offered contextual and verbal information about the creation of the materials. This information was distilled and organised in a manner that could coherently and directly inform the song writing process as presented in ‘Figure 3: Song Writing Response’ (see p. 132). This took the form of; 1) a written account that outlined the context in which the arts-based material emerged, 2) participant comments about the arts-based material generated and, 3) my own thoughts and questions about the arts-based material, thus leaning into the phenomenological concept of bracketing in which the researcher ‘holds’ or ‘suspends’ their thoughts or perceptions of the phenomenon under investigation (J. A. Smith et al., 2009).
The first step in preparing the data for the song writing process involved writing about the context from which the arts-based materials had emerged. This was informed by information from the transcripts but also observations in my reflexive journal that highlighted the interpersonal nature of focus groups and the varying dynamic that occurred within these. This emerging context traced the conceptualisation of each material and accounted for its developmental process while also acknowledging the contributions and responses of each participant involved in the creation of the material.

The next stage in preparing to write a *song response* to each of the arts-based materials involved extracting relevant participant comments from the focus group transcripts. These not only contextualized how the materials emerged but also how these were reflective of participant’s experiences of music therapy. Extraction involved carefully reading each transcript and highlighting participant comments or statements relating to the visual image and songs (see uploaded supplementary materials). Relevant comments were then inserted into a table in *Microsoft Word*. Being careful to distinguish my thoughts from those of
participants, my ideas about the arts-based materials were inserted into a separate section of the same table which was presented in a way that could directly inform the song writing process. These encapsulated my multiple perspectives as: a group participant and co-creator of the arts-based visual image or songs; a music therapist who wished to understand more about service user experience of therapy; and a researcher who was trying to stand back from the materials to see the bigger picture. All the while I was aware that the presence of ambiguity is a key feature of arts-based research (Barone & Eisner, 2011).

Having reflected upon each arts-based material and its emerging context, the next step of this reflexive process involved writing a song response. Each song featured lyrics that were directly informed by the commentary table. As many of the participant comments were inserted into the song response as possible with minor word insertions or amendments made for the purpose of sense-making. Participant comments were distinguished from those of my own through insertion into separate song sections such as chorus, verse or bridge. The musical style or genre for the song response was inspired by the group dynamic at the time the arts-based material was created. This sought to further narrate the lyric’s semiotic meaning and emotional qualities (F. Baker, 2013). For example, some songs are light-hearted and upbeat with others are slow and sombre. These depended upon the prevailing atmosphere at the time that participant’s arts-based materials were created. The various stages in this reflexive process were repeated until four original songs were composed in response to each of the arts-based materials created in the focus groups. The songs were then recorded and uploaded to an open access website.

**Newsletters**

A newsletter entitled *Voices of Experts by Experience* was circulated on three occasions over the course of this study (see Appendices I, J & K). The idea for this came
from my supervisor who previously supervised doctoral research that had employed
newsletters as an effective way of updating research stakeholders (Ledger, 2010a). All parties
who had supported this project were emailed or posted a copy of the newsletter. This
included subscribed research participants and stakeholders at both data collection sites. One
newsletter was returned to my postal address at the University of Limerick because of having
an incorrect address which, when cross-checked, matched that provided by the participant to
whom it was sent. Unfortunately this participant did not receive this newsletter as I had no
other means of contacting them.

Confidentiality

Each research participant chose a pseudonym that they wished to be identified by in
this study. This not only ensured participant anonymity but also enabled them to follow up
their contribution to the research at a later stage should they so wish. All research data was
stored on a password protected PC and laptop. Written information, visual images, minidisc
files, in addition to the camera and electronic dictaphone used in this study was stored in a
locked cabinet at my office in the University of Limerick.

Summary

This study used two main data sources in the evaluation of music therapy by service
users in mental health. These included participant descriptions of music therapy obtained
through semi-structured interviews and arts-based materials that were generated in a series of
three focus groups. These data streams enabled reflection upon how music therapy is
experienced by those who attend sessions in a mental health context. The findings and
outcomes of these processes will be presented in detail in the next three chapters (Chapters 5-
7).
Chapter 5

Individual Interview Themes

Ten interviews with six participants who described their experiences of individual or group music therapy in mental health were transcribed and then analysed using the processes described in Chapter 4 (p. 114-116). Analysis of the interviews with individual participants revealed a series of super-ordinate themes that are discussed below. Within IPA the super-ordinate theme emerges at the highest level of analysis as a result of putting multiple emergent themes together (J. A. Smith et al., 2009). The following provides a description of each of the super-ordinate themes revealed in interviews with Luke, Ollie, Pauline, Barbaraella, Carma, and Laura, with my commentary and reflection on the issues raised.

Luke

The themes found across two interviews with Luke described his experiences of attending individual music therapy sessions as an outpatient. These included: ‘Being introduced to music therapy’; ‘Polarities of caring’; ‘Person centred nature of individual music therapy’; ‘Therapyness of music therapy’; ‘Music in music therapy’; ‘Uncertainty in music improvisation’; ‘Meaningfully contributing to music therapy research’; and ‘Outcomes of the music therapy process’. Each of these is presented below with reference to Luke’s original interview text – presented in inverted commas or as stand-alone quotes.

Being Introduced to Music Therapy

Luke was first introduced to music therapy at a time when those around him were moving on in life while he struggled to deal with the aftermath of a trauma following physical injury. As a result of his hospitalisation, he was no longer able to play with his band that subsequently moved on to achieve success in the music industry without him. These events left him without musical connection with others and he was left searching for a way of re-
establishing such connection once again, albeit in a different format. “What with being a musician or whatever” he decided to attend his first session without much expectancy of how he might benefit from it:

I didn’t have any major hopes, not that I was looking at it as, as ahm, as an unhelpful thing. I went in with kind of hopes that, especially since ah I wasn’t in the band anymore, like not that I don’t play music to myself, whatever.

Music therapy was initially offered to him on a trial basis. He was confused about what might be involved and stated that “there’s no way of knowing unless you are given the chance”. Therefore, based on an interest in music, he decided to attend music therapy even though he was not sure of what it involved:

I didn’t know how it was going to be applied or whether it was going to fit in with me or whether I would fit in with it or would it aid me or you know would it… I just didn’t know what way to think about it.

Beginning music therapy was a challenging experience as it required him to tolerate the ambiguity of the unknown while at the same trying to be open to the possibility of potential gains:

Luke: The word easy does not apply to…
Tríona: Doesn’t apply?
Luke: No doesn’t apply to music therapy, not at the beginning to say the least. But when you… if you let yourself… it’s kind of like the way I’d express… the way I would say it… if you can let your guards down for at least a moment to let yourself enjoy it comfortably.

Upon reflection of Luke’s description of his experience, it occurred to me that my previous practice in mental health had regularly involved deep and detailed consideration of the processes that occurred within sessions, with almost no thought about how service users initially conceptualise music therapy. Luke’s descriptions highlighted to me that an important process can be initiated in service users in advance of ever attending their first session by the way music therapy is described to them, and the way the invitation is presented.
Polarities of Caring

Past experience of mental health treatment contrasted strongly with Luke’s experience of music therapy. In his view some professionals take a narrowed perception of disability and ability and treatment can subsequently be presented in a regimental fashion. Such approaches to treatment made him feel judged and caused him distress:

When you’re feeling bad I doubt myself, like I said I doubted myself when they were saying like I can’t cause I am you know, not … normal people or disabled or whatever, ah … kind of like maybe I can’t, maybe they’re right and I can’t do these type of things. Maybe I’m not able to anymore, maybe because of my [trauma] I can’t do this sort of stuff. It’s been robbed from me or something along those lines …

Luke doubts his abilities when told often enough that he cannot do certain things. These experiences have left him with the belief that some of his capacities have been physically taken away or “robbed” from him by his experience of a physical injury but also because of the way he was treated by the health care system.

Luke has a preference for dealing with professionals who are “being themselves” and “generally happy within themselves” while also willing to be flexible in their approach. Luke likes to be reminded of his options and encouraged to figure things out for himself:

There always used to be room for things to be approached from a different angle. You don’t always have to be done this certain set way you like. […] I think most people, most people are like that to a certain degree. They like trying to find their own way and it ends up being similarish to the quote on quote “way” but ah, at least it’s found through your own approach to whatever the problem, whatever the issue, whatever the “way” of doing it something is.

Luke’s description brought to mind how perhaps sometimes well intended rigid regimes can be experienced as imposing and unfitting to the individual. It reminded me of my previous experiences of being hospitalised for spinal surgery and detesting how staff in the hospital would insist on unnecessarily opening the curtains in the ward at 6.30am despite my wish and need to continue sleeping. These previous feelings of being imposed and intruded upon perhaps brought me closer to Luke’s descriptions of a rigid system of care, but also of how a flexible approach can make a significant impact upon how care can be experienced.
Person-centred Nature of Individual Music Therapy

Music therapy offers Luke a space in which he feels acknowledged as a unique and individual person. He commenced music therapy following his trauma, at a time when “I wasn’t fully within myself”. He was seeking a personalised approach to aid his recovery. Given his interest in music and “being a musician or whatever”, music therapy seemed like an obvious path to pursue. His sessions were initially offered to him on a trial basis whereby “he’d just do the first few” in order to see if these “would help me out”.

Feeling comfortable in music therapy is something that is important to Luke. His sense of ease in music therapy is due to being within an environment where he has no fear of being judged by others:

When you get to do it you find that you are expressing yourself the way that you feel comfortable that you want and you are not judging yourself or if you’d just like to decide “I’ll create this, this is what I like to do, I love to do in my own way.

Music therapy is a place of openness for Luke, a space in which he can relay personal issues as he so wishes. He can set his own agenda for discussion and at the same time feel that his issues are being acknowledged: “like therapeutically wise, you can say whatever, as long as you’re comfortable, you can say whatever you’d like to say about the issues or whatever it would be that you’re dealing with of your own accord”.

Luke alluded to music therapy’s flexibility. Such flexibility fosters Luke’s sense of self-direction given the multiple choices that can arise in sessions; these require him to make decisions about what he wishes to pursue. The music therapy process involves negotiation between Luke and his therapist, a person who offers him “a helping hand” in order to support Luke as he assumes a leading role in sessions. Feeling a sense of control and ownership reinforces Luke’s willingness to trust and belief in himself. This has been “pretty amazing”, particularly when his own suggestions led to personal benefits.
For Luke music therapy is a place of possibility rather than certainty. One possibility presented to him in sessions related to the development of his musical skills. For Luke this is a way of “bette", youself on an instrument” and enabling personal growth. This notion of connecting with or enhancing oneself is something that is very important in Luke’s life:

Triona: And you’ve mentioned already that music therapy helps you … helps you to be you.
Luke: Yeah, I mean if there’s anything in anybody’s life that they do or it would be that helps them to be really themselves, that’s a very good thing for anybody or if they can be more themselves I think that’s a very positive thing that they should keep that in their lives as best as possible.

Reflection upon this description made me realise that some of the processes that occur in music therapy can be part of a much grander narrative in one’s life that extends beyond participation in sessions for the purposes of addressing an illness or need.

**Therapy
ess of Music Therapy**

For Luke, music therapy offers a form of therapy, after all “the word therapy is in there”. This therapy environment is attributed to the actions of his therapist who is someone who can listen and is “comfortable with listening” while also having a willingness to offer “constructive advice”. Luke is of the view that such advice “has been really helpful”. At the same time both he and his therapist are “our own individual selves”; differing perspectives are involved in music therapy. Luke is a person who can get “a sense of people” adding “if they’re comfortable within themselves then I’m comfortable being around them”. He is comfortable with his therapist and knows he can confide in them all the while assured of confidentiality. At the same time Luke acknowledges that familiarisation with the therapeutic processes of music therapy can take time, hinting that the initial stage of therapy has to be endured before one feels at ease with this process:
I think for anyone, it would take them a while enough like, they’d get a taste from the first meeting and they could form some sort of an opinion of what it is but it could take people three or four meetings before they feel fully comfortable to actually maximumly benefit from it, we’d say like, we’re all individuals and we all have our own opinions and this that and the other.

Having carried out many assessments with service users during my practice in mental health, it occurred to me how I too often required three to four meetings before arriving at a conclusion about music therapy provision. This reminded me that assessment is not only a concept applicable to the therapist but also to the service user attending therapy.

**Music in Music Therapy**

Luke views music as a natural means of expression in sessions. Music is something that is not set apart from discussion but instead an extension of it and vice versa, whereby easy transitions are made between these two mediums of expression. For Luke, improvisation involves making choices and opening up multiple possibilities during play where both structure and duration of the music are variable. Luke is “drawn to an instrument” in accordance to his emotional state or in relation to how he wishes to deal with an issue or situation at a particular time. This sometimes involves his music therapist checking with him to see if he is satisfied with his choice of instrument. This has encouraged him to be more decisive and take ownership of his decisions in sessions.

According to Luke music is an “unverbal way of kind of expressing yourself” where there is a strong focus upon his emotions. This means of expression gives him an opportunity to address difficult feelings and “deal with an issue” while at the same time recognising that his therapist has a role within this process. He recalled how sometimes he and his therapist “would jam around” in a casual manner whereas on other occasions a highly interpersonal process has been at play:

whatever instrument you decide to play and then the music therapist plays another instrument with you by you playing that and then you can feed off it and they would be giving you a certain way of doing it or playing their instrument to try and benefit you in some way.
“Feeding off” the therapist’s play contributes to Luke’s feeling of being nurtured in improvisation, a space in which he shows an awareness of how such interactions are aimed to his benefit. These shared exchanges in music are experienced by Luke as a form of communication:

Whenever I’m playing I don’t have to like contradict or stop the way I’m playing through it and often what she will be playing with me, I can tell music wise, like she wouldn’t physically say it you know or wouldn’t act physically a certain way it’s the way that she’s been musically playing with me.

In Luke’s opinion, improvisation can accommodate his variable emotional and cognitive states even when he is “absent minded”.

Luke has had varied experiences of adjusting into shared play with his therapist. Assistive factors in this process are attributed to his therapist “being themselves” and having “an open ear”. When engaged in such play Luke sometimes feels “quite soulful in a happy way” in addition to being “comfortable” and “ecstatic”:

I wouldn’t throw this word around too often … very ecstatic, you feel mildly ecstatic at times depending on how soulfully you would feel. You feel very happy sometimes to the ecstatic wise you know, sometimes musically especially I’d say… when I’m feeling very ecstatic I can let myself go and forget about almost everything apart from music and the feeling and the sense of it and just in that whatever it would be musically wise.

These emotional experiences of playing music are moments for Luke when the music takes over and his sense of time is lost: “it just happens, you can’t stop it”.

**Uncertainty in Music Improvisation**

There are many challenges and unknowns within improvisation for Luke. This way of playing music can be “hard to get into” and recent experiences in improvisation have been found to be challenging: “I didn’t feel confident and happy with what it was I was playing, you know. I was kind of just, I ended up just playing the same sort of thing”. For Luke, this lack of direction in play can sometimes invoke his feeling of boredom.
Luke attributes over-thinking as a hindrance to improvisation which he referred to as a way of “analysing”. This can result in him “not being as comfortable and confident” in his playing. Instead he proposes that emotive improvisations offer a better and more positive experience. These can be accessed when Luke uses familiar percussion instruments as he is “mainly a drummer slash percussionist”.

**Meaningfully Contributing to Music Therapy Research**

Luke was humoured that his second interview took place in the same room in which his music therapy sessions are held. He relayed a wish that his contributions to the research process will make a positive difference for other people who will attend music therapy in the future, adding that “if the right people are doing it with the right people are receiving it then it’s a very positive thing … to be honest”. For him the process of sharing his experiences of music therapy was meaningful and worthwhile. In addition he shared his view that the first interview went “swimmingly well”. At the conclusion of his final interview he said:

I’d like to say within doing this, these interviews ahm … about music therapy, I’ve been, I’ve tried to be, I hope I have been nothing but honest ah … truthful and hopefully enough to a certain degree, helpful, with benefitting and making, not necessarily, just use the word, better but making it, trying to improve music therapy for [ ] the people who are receiving it.

The account above illustrated how Luke participated in this research with the hope that his views could be used to inform the enhancement of music therapy provision in mental health. It also highlighted his efforts to offer and open and honest description of what it is like to participate in individual music therapy.

**Outcomes of the Music Therapy Process**

Music therapy offers Luke a means of reconnecting with music following his trauma. He is thankful for “just that little bit of help” and explained how the benefits of attending sessions have been met to his surprise:

It’s, surprisingly, like, when ya do think about it deeply, unsurprisingly enough but surprisingly cause I didn’t know what it was, what I’d be doing …very, very helpful.
It’s helped me through some serious type things, you know. Like if I didn’t have it or, I wouldn’t have gotten through them as easier, or as easily as I have thankfully.

“Positive” is a word Luke uses a lot when talking about music therapy perhaps because “I don’t believe there’s a negative side to it”. He experiences “fun” and “enjoyment” in sessions while also gaining a sense of achievement from learning musical skill, something that he said he wishes to continue to develop in the future:

Bettering yourself on an instrument that, and then you’d feel like, I’ve accomplished this, that I can now play this instrument to the best of the ability that I want to and now I go on further with it type of a way.

Luke’s weekly music therapy session usually takes place at the beginning of the week and that this sets him in good stead for the rest of his week. This gives him something to look forward to:

it starts my week off, week off well I find, kind of getting more comfortable and I’d get up early-ish, I don’t know, around nine, or sometime like that, not ridiculously early but early enough like, morning time I’d be up at, ready to go, get out there.

However, coupled with the gains outlined above are Luke’s feelings of disappointment and frustration that his programme will soon be terminated beyond his control or that of his music therapist. He acknowledges the opportunities that will be unrealised as a result. Although aware that sessions were not infinite, he is of the view that he still has issues that could be addressed in additional music therapy sessions:

Tríona: Are you disappointed about that?
Luke: Honestly yes, to be honest. There’s probably a lot, I mean, I can’t be going to music therapy for the rest of my life type of a thing but just to be dealing with, I mean, everybody has their own issues, difficulties that they have to deal with the best that they can.

It occurred to me how within the context of this research, informed from a social justice perspective, Luke too took the potentially political opportunity to share dissatisfaction about the discontinuation of his music therapy process.
Ollie

Themes found across two interviews with Ollie described his experiences of attending group music therapy sessions in an inpatient setting. These included: ‘Deciding to attend music therapy’; ‘Denying the pleasure of music’; ‘Finding a voice in play’; ‘The gentleness of Music Therapy’; ‘Creative contribution in music improvisation’; ‘Music therapy reignites a spark for music’; ‘Music therapy offers a satisfactory level of depth’; ‘Social dualities: Before and during music therapy’ and, ‘Motivations for participating in interviews’.

Deciding to Attend Music Therapy

At the time of deciding to attend music therapy Ollie was experiencing “a lot of stress” and felt “really down at the time”. He found that there was not much to do on the ward besides smoking or watching television. This made the passing of time seem long as he reassessed his life and contemplated something to do:

when you get ill or anything bad happens you sort of prioritise things and ... we’re sort of all rushing around doing things, while I, you know, in the world and if you get sick you have to go into hospital and reassess things. The world sort of goes by a bit and ... this time I didn’t, the last time, only the last few weeks, I’ve had to ah... you know you have to reassess things when you get ill or ... and I ... I have to ... I’m starting to look at trying to do something I like doing instead of doing something

During this stage of contemplation Ollie was aware that music therapy was offered as part of the occupational therapy programme on the unit. Rather than contemplating further about what to do next, Ollie recalled how his doctor advised him that it might be “better to just go to it” instead of waiting for things “to get better”. He wasn’t “forced to go” to music therapy but instead attended because of his interest in music. This was despite “not feeling good about myself” and initially being “sceptical or nervous about going to it”. Ollie’s attendance of his first music therapy session was a way of “testing it out” and seeing “what it was like”. This indicated that he viewed his attendance of sessions as an active step towards his recovery and one that was premised upon his interest in music.
Denying the Pleasure of Music

Initially for Ollie, the notion of playing music was particularly challenging to him because of not being “in a good enough place”. He recalled how he deals with his feelings of low mood by denying himself certain things and activities. Sometimes “great experiences with music” make him “feel guilty” because he is of the view that he does not “deserve to feel good”. Denying himself of music is a way that Ollie deprives himself of enjoyment due to “a complex set of reasons” that he are connected to having a hard time in life:

It’s something in me or something that I’ve always felt if, anyway I think I’ve said that already about feeling guilty or something, or if you are enjoying something, sounds really bizarre, even as I’m saying it but … ahm … ahm… I suppose it’s quite, it’s quite natural as you’ve had quite a hard time in life and ahm, and you’ve had little pockets of enjoyment in between of happiness or whatever.

I recall feeling particularly sad at this moment in the interview. It occurred to me that pleasurable experiences in music therapy have the potential to evoke guilt and inner conflict because of one’s previous harsh existence. As a music therapist I thought about the many happy moments I had experienced with service users and wondered if these were reciprocal in the way I had perceived at the time. Further reflection led me to the conclusion that positive experiences in music therapy can be received quite differently between service user and therapist.

Finding a Voice in Play

Ollie’s early memories of music therapy are of a place where an array of different instruments are available to choose while beginning to embark upon shared play with other people. He recalled being encouraged to try out a number of instruments stating that this type of encounter of playing music with others was:

surprisingly great, you know. Ahm, surprisingly great, I was… I don’t know if it’s about the acoustics in the room, [ ] the sound is great, you know it’s sort of ah. You sort of experience good sounds and it was just, it was just really refreshing or something surprising.
Within improvisation Ollie tries to “pick up on whatever I’m feeling myself or [pause] try to express myself”. This type of playing is “a sort of voice” that aids him to express himself and makes him “feel better”. Over time Ollie has come to the opinion that:

You can be yourself through an instrument or you can express yourself and it’s really a very simple way of expressing, it’s a very simple way of… I don’t mean that in a wrong way or I tend to say something simple but it is really simple and it’s a great way, it’s a great way of saying how you’re feeling or … music is a great way of expressing yourself and, ah, probably more than actual words actually you know.

When playing music in sessions, Ollie is of the view that “there was a communication there”. This type of musical interaction is one where he can find a voice but also share his voice with other people. Playing music with others offers Ollie a way of breaking down social barriers related to culture, language, and ability:

you could put people in the room like that room when we were doing the music therapy, it could be different countries, different continents, speak different … not speak the same language … you would be able to communicate with that, I thought that was really powerful like so …

Ollie can find a means of communicating with others using music. This caused me to reflect upon how verbal language, as the predominant means of communication, can sometimes place demands upon people. I wondered if such linguistic complexity can sometimes be a burden to service users as they navigate mental health services including deciding to attend music therapy.

The Gentleness of Music Therapy

Ollie appreciated the gentle approach offered in music therapy. With a tendency to “put myself under pressure doing things” he values experiencing “no pressure, absolutely no pressure” in music therapy where “we were like, totally encouraged” to play in a manner that felt comfortable to him and “it was all very gentle”. He experiences a sense of ease in “just tapping a drum or whatever” and recalled how when starting music therapy “there was no pressure really cause other people were also starting, you were experimenting with whatever
instrument that you wanted”. Other contributing factors to such a gentle approach are that there is no right or wrong way to play an instrument and that group members have freedom “to stay or leave” the session as they so wish.

Upon returning to my journal notes, I recalled how there were many contrasting moments in Ollie’s interviews when he seemed to feel pressurised and other times seemed to be at ease. Particularly interesting was that the moments of ease were ones in which he described his engagement in musical processes in sessions, ones when he “went back to the music”. These embodied moments seemed to easily flow in our discussion and appeared to mirror the gentleness that he described experiencing in music therapy.

**Creative Contribution in Music Improvisation**

Ollie experiences a sense of contribution in music therapy through playing music with other people. At a poignant moment in the interview he recounted how in improvisation he can hear his own sound apart from that of others. This reminded him that everyone has a valuable contribution to make in life:

> you could hear your own sound, you could hear what you were doing yourself from everyone else and … I suppose as in life I think you know, everyone, everyone sounds very … everyone has a unique contribution and that’s a really good … that’s a really good example of it… when you’re sitting there with a few people … and that’s really emotional, so … yeah … its’ great, thanks … I got that out of me… yeah.

That’s something I haven’t thought about in a long time.

The idea of making a contribution in life was something that Ollie had forgotten. Music therapy gave him an opportunity to make a contribution in a creative manner. Even when this contribution is small, it is meaningful to Ollie nonetheless. This makes him feel good and he is surprised about his own abilities: “you’re sort of like, ‘well I didn’t know I could do that, you know’”.

Ollie’s awareness of his musical contributions is encouraged by the music therapist who he referred to as a “facilitator”. This role involves facilitating discussion after improvisation where group members are encouraged to think about “what were the sounds
people were making and what sort of … what was coming sort of, was there anything coming out?” Ollie views such discussion as a way of acknowledging and valuing each group members’ musical contribution in improvisation.

**Music Therapy Reignites a Spark for Music**

Ollie recalled how “there was a lot to take in” when he attended his first session. Due to the array of instruments that were on offer to him at that time, this environment was unlike anything that he had previously experienced. “Having sort of stepped back” from playing guitar in the years previous he recalled immediately seeing this instrument as he entered into the music therapy room, stating that “the last thing I wanted to do was pick up a guitar and play it”. There was “a good sound” in his first experience of improvisation which sort of “hooked” him into playing. By the end of the session he found himself improvising music on guitar despite his earlier wish not to play guitar at all. For Ollie, “something sparked” in that session, adding that “it takes something really special to get me moved or towards, cause I get really down”. He found that he had a wish to play music beyond the allotted time of the first occasion in music therapy and recalled how he “couldn’t wait for the next music therapy session the next week”.

With this spark to play music once again reignited, Ollie has plans to get back playing outside music therapy: “the spark, the thing has got me back, I checked about maybe going doing a bit of music, going back playing ahm… love to play with other people, I’d love to get back playing myself”. Such rekindling of music in his life is “strange” and a “totally unexpected thing”, particularly considering that this spark has occurred at a time when is quite unwell. For Ollie, music therapy:

helped me get back doing… it’s a great help to me to go from not wanting to do anything, play guitar, play music or … and then by then end of maybe two sessions, two, three sessions I was back playing guitar and wanted to make music or whatever.
Reigniting his interest in music “was the best thing really, I have to say, it’s probably the best compliment I can give”.

**Music Therapy offers a Satisfactory Level of Depth**

Ollie has awareness of the concept of depth in terms of the level of analysis that is involved in music therapy. The passage below accounts for his thoughts about depth before he commenced music therapy:

Ollie: [I] was thinking as well ah … when I ahm, when I see therapy like I think of something you know … emotional you know and … like going through therapy or going through things … talking feelings out, ahm … that was one thing, I was wondering as regards music therapy, what that entailed like so ahm …

Tríona: And did that side of things come into play?
Ollie: Not really no, I thought it might have been very deep or something or … I thought therapy, I dunno, I mightn’t … mightn’t have been the best word now [.]. Maybe I felt that the music therapy was going to be very deep but it wasn’t.

The level of depth in music therapy appears to be of his satisfaction. He does not want to go “too deep” while offering his descriptions as “it’s not great to over analyse things”. Upon reflection, I wondered if these comments mirrored Ollie’s engagement in music therapy and wish to refrain from entering into a deep level of analysis.

**Social Dualities: Before and during Music Therapy**

Two contrasting experiences are presented of Ollie’s social world. These relate to his social world both before and within music therapy. Before attending music therapy he had no desire to play music, a time when he was feeling very low:

I didn’t really want to do anything. I didn’t want to do any occupational therapy. I just was very low, I’d just sort of stay… stay in my room or whatever or stay on the… stay on the ward. I didn’t really want to talk to anyone or do anything.

This evoked strong imagery on my behalf of a man sitting alone in his room in a psychiatric unit. It is in sharp contrast to the way in which Ollie described his social world within group music therapy where “everyone was sort of in the same boat” playing music and people were
encouraged to talk about the sounds that each other made. Multiple interactions take place in
the group where there is an “intimate feeling” and a sense of connection with others:

you sort of link up, [ ] I suppose it’s important that there is a sort of a link with other
people … ahm … when you’ve other people having instruments ahm … and you have
your own, you’re going at your own pace and but there is sort of a natural sort of link
between everyone.

This sense of social connection in music therapy is “fantastic” and “a great experience” that
is “very unique to me now”. Ollie added this is a space in which he “ can learn things from
other people”.

Motivations for Participating in Interviews

Ollie was aware that the purpose of the interviews was to find out about how he
experiences music therapy. His willingness to partake in the research was partly motivated by
his wish to discuss the benefits of music therapy: “I suppose it’s as I took a lot out of it you
know or it gave me a lot … and that’s part of the reason why I wanted to at least sit down and
talk with yourself”.

Ollie also shared another reason for wishing to participate in the interviews; he
attended music therapy in hospital some years previous and recalled his feelings of
disappointment when he found out that there was no “follow-up” music therapy service in the
community at that time. Keen to still continue music therapy he recalled how he asked his
nurse:

would there be any chance in going back, I didn’t mean back into hospital but to, as
there wasn’t anything in the day hospital there as regards to music, I said was there
any chance in going back to hospital for that, that ahm, time in the day [ ] for the
music therapy and go back on the unit and not to go back into hospital or whatever …

However, his wish to continue music therapy was not possible at that time. Having recently
gone through a similar discharge process, Ollie once again finds himself in the same
predicament where music therapy is not available in the community despite the gains he has
made within sessions: “now, I don’t know why that’s not, maybe that’s not possible whatever
ahm … I just think it’s something that’s helped me, could help me further”. This to him is a “a pity you know, ahm, I suppose a pity that there was nothing, nothing further”. Ollie used the interview as a means of relaying this disappointment and at the same time realised that circumstances have not changed with regards to music therapy provision, despite the passing of time since he was first discharged from hospital. This caused me to feel frustrated that having identified music therapy as a service that is beneficial to him, Ollie can no longer participate in sessions as an outlet to support him in community living. I also felt frustrated that this was the second time that this had happened to Ollie and that little had seemed to change in relation to service provision in the interim.

**Pauline**

The themes found across two interviews with Pauline were developed from her descriptions of her experiences of attending group music therapy sessions in an inpatient setting. These included: ‘Music therapy is about one’s life in music’; ‘Musical knowledge offers direction’; ‘Frustration and tolerance are part of group music therapy’; ‘Shared improvisation is interpersonal’; ‘Music is a pulsing reference-point’; ‘Feeling normal and worthwhile in music therapy’; and ‘Hope against hopelessness’.

**Music Therapy is about One’s Life in Music**

Music plays an important role in Pauline’s life. It is laden with memories, meaning and connections with others. She attributes her interest in music to her mother who encouraged both Pauline and her siblings “to do everything” when growing up. Pauline has also taken on a similar encouraging role whereby she purchased a keyboard for her relative’s son one Christmas in the hope that this would nurture this young boy’s love of music.

Pauline’s relationship with music and music therapy is something that is bound in her musical relationships with many immediate and extended family members and friends. She
grew up in a house where many family members played music or sang. She has strong musical memories of her late father and also of her late brother “whom music meant a lot to”. Her deceased brother loved playing the guitar and growing up they both spent time listening to artists such as Neil Diamond, Tom Jones, Neil Sedaka, the Beatles, Rolling Stones, Queen, Sting and Cat Stevens. These musical experiences “meant a lot, and we’d listen to it nonstop” to the point that she “would be up listening to the music all night instead of studying”. Although these are memories that Pauline fondly describes, they are also painful for her to recall as she stated of her brother: “he’s dead poor [name], yeah, my one and only brother”. Pauline prefers to keep her past and present separate which is perhaps for the purposes of guarding against painful memories:

Pauline: Ahm, remind me of the past, the music?  
Triona: Mmm  
Pauline: Ah, that would happen me in ah …  
Triona: Mmm  
Pauline: I don’t think it does  
Triona: Ok  
Pauline: It doesn’t really. No.  
Triona: Is it very much about the present?  
Pauline: Well I’d say it’s about the present but the past would come into it if I wanted to think about it but it wouldn’t happen, it wouldn’t happen. Everything becomes separate.

Pauline wishes to keep the past and present separate, nonetheless her memories of music therapy are blended into the other musical memories in her life. As the interviewer and later when undertaking the analysis of the transcript, I found it difficult to distinguish which of these memories were related to music experiences in her life, and which related to music therapy. This brought me to the conclusion that these were inextricably bound for Pauline as she said:

I can think of lots of them, they blend in with everything, [name] and [name] here especially and everywhere I go I can blend in with music and therapy. And back to choirs, singing in choirs in the chapel, hymns and anything and everything.
Pauline connects music therapy participation with other music experiences in her life. Her reason for attending music therapy is simply because she “took an interest in music”. This interest was the starting point for participating in sessions, unlike frequent accounts in the literature that describe how people begin music therapy because of having a specific need that they wish to address.

**Musical Knowledge offers Direction**

Pauline values the acquisition of musical knowledge. In the past she has attended piano lessons with encouragement from her family and achieved skill to a level that she was satisfied with: “once I played the piano and got qualified and got a cert, grade A, I said I’d only play it for pleasure. I wouldn’t play it as a teacher or go onto grade six or anything like that”. Pauline gained a sense of reward from these lessons which gave her the skill to read music and she likes to demonstrate this knowledge when a suitable opportunity arises.

Well I’ll tell you what’s rewarding about it for me. I never could read music, I always wanted to … use my brain and be taught how to read it and I always thought I never could manage it so I went to Mrs [name] who is a good teacher and qualified and she helped me and I learnt how to read.

Other musical knowledge acquired by Pauline includes skills that she learnt in a percussion class in which “the teacher came in to teach some of them here about a month ago about evaluating all the drums she brought in”. She explained that “you see with a drum you hit it at the c… the side, it’s mild. Hit it towards the middle there’s a loudness to it, a louder side to it, you know”. As Pauline relayed this information it struck me that she seemed to do so with a sense of pride.

Pauline is known for her singing ability over the years as a result of her participation in choirs and music therapy. Her music therapist “let me sing one day here and they all said I sounded nice so I must be good at that”. A priest who heard her singing at mass one day said to her “keep your singing up”. This surprised Pauline as “I didn’t know he was there listening
to me, you know”. Pauline’s revels in the sense of achievement her musical accomplishments provide. She prides herself upon others’ recognition of her singing skills.

**Frustration and Tolerance are part of Group Music Therapy**

Pauline sometimes experiences a feeling of frustration in music therapy because of the lack of musical instruction during sessions. Pauline prefers her previous music classes as “it’s good that you know what each instrument is for starters, you won’t be sitting there thinking well what will I do with this and what will I do with that”. She thinks that “you have to be shown and you have to be taught”. Fellow group members playing instruments in music therapy frustrated her sometimes and this is because if they were “showed how to use it, there wouldn’t be any problem”. Sometimes there can be a “problem” in music therapy for Pauline as her wish to attain further instrumental skill is not being fulfilled.

Pauline sometimes thinks there is a lower standard of professionalism in music therapy compared to experiences of music instruction in her life. The music teacher has been important to her development of music skills in the past as “they had music there, we did it with a music teacher”. Pauline prefers music education because it is “more professional”. Music therapy has a lower standard of professionalism because it offers a small range of instruments and there is no piano. She thinks that music therapy is presented in an inadequate way because “they hadn’t enough xylophones, they hadn’t the right bongo drums, they haven’t the right equipment”.

Pauline does not always appreciate fellow group member’s musical contributions because of the standard musical quality displayed. One lady recently sang a song in a music therapy session in such a way that required Pauline to demonstrate a certain degree of tolerance:
Pauline: She was alright, you know… I wouldn’t criticise her, she’s an old lady
Tríona: Yeah… So is it important to be tolerant of other people in music therapy?
Pauline: Of course it is, yeah, of course.
Tríona: Can that be hard sometimes?
Pauline: Ah no, not really. Unless they start really getting into you, you have to say
well … I’ll … just leave it be or … turn the other cheek, whatever you do…

At first I interpreted such experiences of frustration and tolerance to be reflective of an
overall dissatisfaction in music therapy but this was not evident in her statements overall. On
reflection and through journaling I came to the view that many of these comments were
related to her participation in a collaborative group environment where her preferences and
interests may not always be possible to pursue.

**Shared Improvisation is Interpersonal**

Improvisation can involve the playing of multiple instruments such as xylophones,
“the gondolas, the shakers, rattly things” and “many instruments that you shake and rattle …
cow bell and all”. A recent improvisation in music therapy began by a process of one group
member playing a leading note on an instrument which others followed in play. This
sequence was facilitated by the music therapist who “is very good and gives us all time to get
organised”. Pauline explained how the ensuing music is then developed by the group:

Well you have to just ahm, hit a note on a drum or whatever you want…[therapist’s
name] had the guitar, I had the drums. [Name] had the xylophone, somebody else had
something else so it all worked out nice what the instruments were playing into many
instruments.

This ‘working out’ process involved in improvisation comes with Pauline’s awareness that it
is “everyone’s music” rather than one’s “own music”. Such shared play with fellow group
members is to Pauline a culmination of multiple musical contributions that blend together
within a dynamic process that involves “playing and listening”:

I blend in with them and then when I know they’re… even though I’m playing and I
know they’re playing and I’m playing along with them and when they play along with
me then I play with them and then they ease off, I ease off too then… ease off with
them.
Pauline explained how one person usually assumes the role of leader within this shared process of blending music. She sometimes takes on this role within the group: “well today we did of, sort of a little, our own little … I was the one who started the music off and they followed, you know, their own little syndromes and follow the leader. I was the boss”. Pauline easily assumes this role; “there’s no problem with it”. This made me think about the flexibility and adaptability of this group environment where Pauline could easily move in and out of a leadership role as she wished. She recalled the leading role of others in the music therapy group, describing how “notes can be hit off” the therapist who she views as someone who provides a musical centre or anchor point in play. The music therapist may ‘hold’ the group during musical processes.

**Music is a Pulsing Reference-point**

Rhythm is a central point of reference in Pauline’s experiences of music in music therapy. She has a preference for percussive instruments and she can hear the beat when these are played:

Pauline: The drums are my favourite.
Tríona: What, what’s …
Pauline: I like the sound of the beat cause if you can get the beat, you can feel the beat.
Tríona: Feeling the beat?
Pauline: Feel the beat, the ticking of it. The rhythm of it.

Feeling the beat while playing percussive instruments is important to Pauline. This pulse provides her with a point of reference that not only stimulates her but also makes her feel calm when playing music:

Tríona: Do you like the sound of the beat?
Pauline: I like that, the beater and drums, the ‘tap, tap, tap’ on the drums, I love that.
Tríona: What do you think, what’s it like?
Pauline: It’s like Indians tapping on the drums you know, its like ‘do do do do’, you get the beat on the drums quicker than you would on a guitar.
Tríona: How does it feel when you’re listening to the beat?
Pauline: Very interesting and very calming.
Tríona: Calming.
Pauline: Very calming.

Pauline “always liked music, you know. It’s quite simple and I can pick it up and I can get with it and listen to the beat, listen to it intensively but then think clearly”. Listening to the beat of music aids Pauline’s clarity of thought. These stable rhythmic qualities serve as an important anchor point for her during play which not only impacts upon her mood but also upon her mental processes.

Feeling Normal and Worthwhile in Music Therapy

Pauline felt “glorious” after attending music therapy for the first time because:

I played the piano, and the stigma had come off me, you know. I’ve a chemical imbalance but I’m not mental, far from mental but I loved it. I don’t care whose here, if they were on crutches or if they were in a pick of health. I still would be the same person I always was. I go in the same way as I come out. I go in normal but I come out elated and happy knowing that I spent an hour with music, to sing a song, to play a tune if I could manage it, tinkle with a piano.

Feeling glorious is concomitant with feeling “normal”, something that music therapy provides for Pauline. She experiences a sense of feeling worthwhile in sessions which she relates to being in the presence of other people:

Triona: When you come to music therapy. And I wondered about … what is it like to feel worthwhile?
Pauline: It feels that you are wanted, you feel worthwhile in yourself and you feel that people sort of … they all come together and that you have a meaning to what they’re worth and that we all come together and feel at all together … and we get going on the music and we’re all happy to be in one piece and sort of play along with the tunes.

Feeling worthwhile in music therapy comes from the opportunity to make a contribution. In partaking in group music therapy. Pauline can contribute herself to something which fosters a sense of belonging:

Triona: And tell me a little bit more about feeling worthwhile, what’s that like?
Pauline: A little bit … well I feel like I contribute myself to something, you know… cause I’m in a group and sort of … you know, I’m happy to with them, glad to see they’re all getting on and they’re all happy and they have their own little… whatever they’re doing… it’s good to see them and I’m happy to be in their group.
Triona: So being part of something?
Pauline: Being part of something, exactly
Triona: And giving something?
Pauline: Maybe giving a little, hopefully, if that’s what I do you know.

Although Pauline had some frustrations and tensions of being part of a group process, but the description above highlighted for me the important role that collective processes can play in mental health and how these can be valued by those who participate in them.

**Hope against Hopelessness**

Pauline was “happy” in experiences both inside and outside of music therapy.

I must say I was very happy speaking to you in the first interview and the second one too as well, it’s coming to a nice end and I’m happy to do with that and I’m glad that you’re happy. I don’t know if you are or not but I’m happy anyway.

Another important concept to Pauline is that of hope. She hopes that good things will happen such as in improvisation, a space in which she hopes that “something will come out of it” such as “a lovely piece of music”. Pauline’s hope that good things will happen to her extend beyond her engagement in music therapy. She hopes that she will move into her own house and host a house warming party for all her friends, family and those who have helped her while she has been unwell:

Have my instruments in and I’ll have the house decorated and painted for them and I’ll have a house warming party and invite up Dr [name], invite [name], the nurse, invite [name], the nurse, invite [name], the nurse, [name], the nurse. Invite loads of them up for a house warming party and my family. That’s my aim, the whole lot. And [name] here and [name], the occupational therapist, my friend [name], my friend [name] [ ] That’s all I have to say. On that happy note, pray for me that it comes true and I’d be so happy.

My impression during this interview was that holding onto hope was of utmost importance for Pauline. Upon reflection, this seemed to serve as a way of helping her through the challenges of mental illness by maintaining a hope that she would once again live an independent and fulfilling life. After stating such hopes for her future Pauline said “I hope the tape recorder there is listening to everything and it’s played”. Putting such hopes ‘on the record’ was perhaps a means of officially documenting how she wishes her life to progress.
While holding onto a sense of hope and positivity Pauline also experiences despair, sadness and irritation in her present circumstances. She has “come to such a sad way” adding, “I don’t want to be growing old in a hospital you know, I want to live the remainder of my youth outside it”. These statements were quite profound for me as they seemed to encapsulate Pauline’s fear of not being able return to living in the community but also of how mental illness can have a devastating impact upon one’s life. Another moment of sadness occurred after she enthusiastically described the importance of music in her family and then frankly stated about her brother: “he’s dead, I’ve told you that so he’s dead unfortunately”. Pauline’s medication is a source of irritation for her as it makes her feel drowsy: “they’re too, it’s too groggy for me you know [ ] they’re strong tablets, a good tablet but a bit strong for me, I’m not physically able for it”. Another annoyance for her is the hospital food which is “horrible”. She views the hospital as a place where it is important to be seen to try so that staff can witness her efforts to do something about her situation. Attending music therapy has been a way of making such an effort: “I made the effort rather than saying oh god, she’s doing nothing about it, you know. I made the effort to go and not be gossiping about me, God forgive me for saying it”. Each of these descriptions suggest Pauline’s experience of a life-world where hope and positivity co-exist with despair, sadness and irritation.

Barbaraella

Themes found across two interviews with Barbaraella described her experiences of attending group music therapy sessions in an inpatient setting. These included: ‘Ability replaces disability in music therapy’; ‘Music is a reminder of youthful wellness’; ‘Valuing the music therapy group’; ‘Group leadership in music therapy’; ‘The significance of rhythm in music’; ‘Music is a driver of mood’ and, ‘Understanding acceptance and rejection of music therapy’.
Ability replaces Disability in Music Therapy

Barbaraella portrays herself as someone who is “disabled”, particularly when recounting how her efforts to learn ballroom dancing were unsuccessful. This disabling self-image is set against contrasting descriptions of past abilities and achievements in her life such as writing for a magazine, public speaking and accomplishments in music. In relation to her present circumstances, she is of the view that “there’s a comfort to be able to do anything really”.

In contrast to her portrayal of herself as someone who is “disabled”, Barbaraella’s involvement in music therapy as something that is based upon her ability. As a person who would “like to throw my hand in on everything”, Barbaraella can “pick up a new instrument” in music therapy to learn a new skill. These experiences in sessions have fostered “a sense of fulfilment and achievement”, particularly when she succeeds in playing an instrument, stating that: “I think it’s a pleasure, as I’ve told you, for people who’ve never played an instrument to go in there and achieve something”. For Barbaraella, hearing the sound of her instrument during shared play is a way of instilling “confidence to get up and do it”. In speaking about the various instruments Barbaraella she likes “to try them all” and only recently tried “a completely different instrument”. These encounters with unfamiliar instruments not only enable new experiences for Barbaraella but also overcome barriers by offering those with no formal music skills opportunity to engage with music:

Well music is a drug. It can make you feel great, it can make you high, it can make you feel good, that’s why the world is full of musicians. People like music. Often we do without it. You know, it’d be a boring world if we didn’t have it. It’s a chance for people to, who never studied music to get out there and try and do their thing every week and it gives him a sense of fulfilment and achievement if they succeed … that’s what I think anyway. So it gave me a chance to get out there and do my thing.

At first I was unclear of whether Barbaraella was referring to music or music therapy in the lines above. However, upon reflection I concluded that she was describing both, and appeared
to place these on one continuum. Barbaraella’s use of the word “drug” was interesting and seemed to portray music as something that is beneficial medicine to the individual.

**Music is a Reminder of Youthful Wellness**

Barbaraella is aware that she is getting older saying “I joined an old person’s group, I’m sixty-four now”. However, it is important for her to connect with younger people in order to stay young at heart. She recalled previous experiences of watching young people dancing:

Barbaraella: I used to go to dances where young people danced and sit on the steps and watch them do all their dancing and movements.

Tríona: So it keeps you young?
Barbaraella: That’s the way I look at it.
Tríona: And how important is that for you as a person?
Barbaraella: Well, that’s the kind of person I am. I’m young at heart when I’m well

Barbaraella’s interaction with and observations of young people serves as a reminder of what it is like to be well. Since becoming unwell she makes many associations between things. As group music therapy sessions are often attended by people of varying age range at the hospital, these give Barbaraella an opportunity to mix and associate with young people. This association with youth is reflected in her choice of music as she prefers to listen to popular music for purpose of keeping young:

it has an effect on you like, when I grew up I always loved pop music, I was trained in classical music. I loved pop music and I said why should I stop loving it if I get older and I still love it. It keeps me young.

For Barbaraella, music plays a significant role in reminding her of the wellness part of her identity. In sharing her determination to return to wellness she explains how she associates wellness with past experiences of dancing and engagement with various genres of music:

Tríona: Is that fair to say Barbaraella about music being important about identity?
Barbaraella: Maybe not for everybody, maybe not to everybody.
Tríona: Ok
Barbaraella: To me certainly yeah.
Tríona: Yeah.
Barbaraella: That’s the way I would say now.
Tríona: Mmm. So what’s the important parts of your identity in music at the moment?
Barbaraella: I have to remember I’m young at heart. I want to go back to the scene I have before I got sick. I want to go back to my dancing and my lovely Irish traditional music, country and western music and everything else. That’s my goal. Is to get out of here and go back.

Music provides Barbaraella with a means of helping her to connect with her youth, a period in her life in which she was well. Reflection upon this description brought me to the conclusion that this is an important connection for Barbaraella as it not only reminds her of what it is like to feel well but also that wellness is possible.

Valuing the Music Therapy Group

Barbaraella places significant value on the group setting in which music therapy is offered. As a person who sometimes gets lonely she stated: “I like groups. I like talking to people. I’m very articulate”. Being part of a group brings Barbaraella a sense of satisfaction “to join something … and express myself through the medium of music”. Not only is she aware of her own progress in group music therapy but also that of fellow group members. She shared her hope that one man who is very unwell will soon be able to return to sessions in future.

For Barbaraella, group music therapy offers her a place where many people’s different ‘musics’ meet to achieve “a unique blend, combination of people’s talents”. This is a place where “there’s great unity”. This combination of music “depends on who turns up”. The classes are always set apart from each other as “the music’s totally different, a different blend of music which is never quite the same”.

Barbaraella hears her own music during play in improvisation and also that of others in the group; “you can hear other people as well. Yeah. You could switch off and just hear yourself but you’re not allowed to … you’re meant to take in everybody else’s instrument as
well”. It is important to her that her musical play is heard by others, and that she can be aware of how this contribution can “add something to the group”. She shared a loyalty towards the group continuity as the “main thing is to get people to come back, otherwise the group will fall apart”.

**Group Leadership in Music Therapy**

Barbaraella is interested in the role of leadership within group music therapy; “I’m always the leader, I start off, or I finish first or something like that”. Barbaraella’s leadership of the group is for the purpose of benefitting others.

Barbaraella: It’s only a new thing, a lot of responsibility.
Tríona: What’s it like to have that responsibility?
Barbaraella: I don’t mind, I don’t mind
Tríona: How did you fall into that role?
Barbaraella: Ah, it just happened
Tríona: Yeah. And what do you think … what do you think it’s like for the other people to have a leader in the group?
Barbaraella: They like it. Two new ladies came and they’ve the confidence to pick up a new instrument and they walked into the room they didn’t think they could do it… so I think they’ll be back again.

Part of Barbaraella’s role as leader involves “drawing” other group members “out” during improvisation:

Tríona: How do you draw out people in music therapy?
Barbaraella: It depends on what you’re playing, how you play it and when you play it.
Tríona: Mmm
Barbaraella: You kind of combine with one instrument. I will combine with the drum beat.

Thus *drawing out* people during improvisation seems to be a way where Barbaraella plays close to the music of another and tries to “bring out something else in somebody else” or “bring the best out in them”. This is a task that can also be taken on-board by the music therapist who Barbaraella views as an individual who has an ability to relate with others in the group:
He can relate to people, he’s very firm, and he’s very controlled and he’s a brilliant guitarist and he knows exactly when to stop the music and talk to people and to draw them out and ask them what they thought of their music. He draws people out as well.

Although Barbaraella said that she is “always the leader” in improvisation, it would appear that leadership is also assumed by the music therapist who is someone who:

Barbaraella: … is very good, a very good teacher. He allows everybody to give their opinions, he never puts across his opinion. He allows us to make up our own mind about the music.
Triona: Is that important?
Barbaraella: Yes
Triona: Why is it important?
Barbaraella: You rely on [therapist’s name]. You could ask him any questions, do you know what I mean? He’s a guitarist.

Therefore, leadership is transient in Babaraella’s life-world in music therapy. Leadership can be shared among group members and the therapist. Barbaraella intends to “give that to somebody else now, let them do it” so that somebody else is “in with a chance”.

The Significance of Rhythm in Music

As a former dancer, Barbaraella explained how the elements of rhythm and pulse are important to her in music. She said “it’s the beat that’s very important” and she enjoys playing the drum in music therapy sessions. To her the drum is a “powerful instrument”, adding:

I like the rhythm of the drum. It’s a good part to my day. I like the rhythm of the drum, the beat of the drum. In music you need a beat. There has to be something to do with a lead sort of beat.

With reference to playing the beat on a drum Barbaraella explained, “well, it goes out of, the fusion goes through your hands … and you can use your hands to do it or … there’s drumsticks”. This indicates that Barbaraella not only hears rhythm in music but also feels it when she plays the drum in sessions. These experiences not only offer her something that she
describes as important in music but also enable her be self-sufficient as she can provide this rhythm herself in play.

**Music is a Driver of Mood**

For Barbaraella, music is “a driver, it can change your mood, which is important in a mental home, people suffer from mood disorders, it affects you a lot”. With music one has to “be careful” as how it is received depends on how one is feeling. Music “can have a different effect on different people”. Music therapy is only useful in certain states of mind, “if it’s not working for me, if I’m in a bad mood then I’ll walk out. You have to be in a good mood to enjoy it”. Music can also change her mood in music therapy because “if I’m frustrated I can bang on the drums”. Therefore, there seems to be a complex emotional element at play that influences how music therapy is received and this does not necessarily directly correlate to whether she is in a “good” or “bad” mood.

Improvisation can “be very stimulating, sometimes it can be very soothing, sometimes it can be very powerful”. Barbaraella often desires “soothing music” that makes her “feel good” in music therapy. One instrument provides her with this desired experience. An instrument that had “the sound of the sea”, one that was “lovely” and “beautiful”. Barbaraella intends to play this instrument in future in the hope that more soothing music will be produced in sessions.

**Understanding Acceptance and Rejection of Music Therapy**

Barbaraella has an understanding of why some people reject music therapy which is “an unusual musical group” which she “didn’t know existed until they told me when I came here”. Her first encounters with improvisation in music therapy required acceptance of a new music as she stated that “when I first heard it I thought, that’s not music at all [ ].You have to accept it as you find it. And once you accept it, you like it”. However, because of this “unusual music” in music therapy, Barbaraella can see that “some people mightn’t like it”.  

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She recalled how one man in his eighties attended the group and despite her efforts to convince him of the contrary, he could not accept that the sounds created in improvisation were music:

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Tríona: And how would you explain it to him?
Barbaraella: I’d just tell him nobody studied it, I said it to him. He was thinking of studying music, he was a great ballroom dancer and all these sort of things. You wouldn’t understand the type of music here
Tríona: So do you think is it a hard concept to grasp, improvisation?
Barbaraella: It is in a way…
Tríona: Did you find it hard to grasp improvisation?
Barbaraella: In the beginning …
Tríona: What was hardest about it?
Barbaraella: It was so different to what I had studied when I was young, do you know what I mean? Hard to articulate music, it’s not the kind of music you’d record and listen to, that’s the thing, do you know what I mean? It’s not soothing type of music.
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Barbaraella’s experience of improvisation illustrates how the music created therein can somehow disrupt participant’s traditional understanding of music while also arousing unsettled feelings. The older man who attended music therapy and rejected the music in improvisation did so because he “was used to singing songs, all jokes and songs”. These encounters with music are different to those offered in improvisation. Barbaraella sees how age might have a factor in how people receive improvisation as older people are “set in their ways and they’re used to certain values and music they grew up with”. Younger people are more “open-minded” about such music experiences and there are “plenty of young guys and girls” in the group who like improvisation. At the same time one young man found his experience of improvisation to be frightening, arriving at the conclusion that acceptance of this type of music “depends on how you feel, how you are in therapy and your treatment”. She recommends that those who come to music therapy should do so with an open mind:
Triona: And what would you say to people who were attending music therapy?
Barbaraella: Tell them to give it a try. Go in with an open mind. There are several instruments there and they make a combination of sounds between them, they might like it they might not like it. Give it a try and find out.
Triona: Is it important to have an open mind?
Barbaraella: Yeah, with that type of music it is.

I was particularly struck by Barbaraella’s recommendation to be open-minded towards music therapy. As a music therapy educator, I too have often encouraged students to be open-minded about music therapy, in addition to having a tolerance for ambiguity as they venture into unknown territory. Barbaraella’s comments reminded me these qualities can be universal for both those who provide and use music therapy services.

**Carma**

Carma described her experiences of attending group music therapy sessions in an inpatient setting. Themes emerging from her interview included: ‘Accessibility of music therapy; ‘Experiencing sound in music therapy’; ‘Incredible stimulation in improvisation’; ‘Mindfulness of others in music therapy’; ‘Recommending music therapy for children’ and, ‘Implicit catharsis in music therapy’.

**Accessibility of Music Therapy**

Carma experiences music therapy as accessible on multiple levels. Unlike other programmes or interactions music therapy does not necessarily require her to use words in that “you don’t have to speak if you don’t want to, it’s optional you know”. The music in sessions is a language of its own.

I mean they have music rather than words … to bring you into that group is nicer particularly as a therapy because you don’t have to speak, you can just tinker around with the instruments and you are part of a group, and the same goes for the other people, they’re part of the group when they tinker around with an instrument of their choice.

This non-verbal way of relating is a means of overcoming social barriers as people can come together without knowing each other. Words are sometimes an unnecessary distraction:
Carma: You’re not distracted by words.
Triona: Can words be hard sometimes?
Carma: Well it’s like listening to the radio, it’s easier to listen to Lyric FM than it is to listen to words you know.

Carma enjoys there being no requirement for musical skill among those who attend sessions. Many people who attend music therapy have never experienced the instruments that are offered therein: “people don’t have those in their home … you know so you’re picking up and instrument you’ve never held in your life you know so that’s excitin’”. For Carma, music therapy is great.

It’s great for makin sounds without being a qualified musician and … extraordinarily enough, it brings out a sound like they were qualified musicians … you know that kind of a way … you didn’t require a skill to learn it. Nobody were learned, the musicians sitting there, the only one that was learnt was the tutor, you know …. so that was good.

Even though those who attend music therapy may not have musical skill, Carma values the opportunity to make music with other people in a manner that is “de-stressin’. Improvisation does not appear to place demands on people as those who are involved in it can play in a way that is manageable and personable to them. In Carma’s opinion this is why improvisation “works”:

It works because people go into their own zone, they get into their own place and none of them are musicians sitting there so they’re all just tinkerin, tinkling with the instruments so none of them know what they are playing but because they have a nice sound, they’re bringing off their identity

A final facet of music therapy’s accessibility relates to the sense of equality in sessions. As there is no distinct leader in improvisation everyone becomes “the leader in the music so to speak”. Because all those in attendance are “novices” in music, everyone is “just doing their own thing” and “nobody’s better than each other”.

**Experiencing Sound in Music Therapy**

Carma’s first memory of music therapy related to the sound of the drums. This made the first “class” “a bit daunting”. This “noise” prompted feelings of apprehension about
returning to the second class which she was able to overcome. Over time she has learnt how to disregard certain sounds during musical play:

Carma: You can just disregard it from the sound
Triona: And is that a good thing to be able to disregard it?
Carma: I think it’s good because you’re in tune with what you are listening to
Triona: Right
Carma: You know. You’re bringing it together, what suits and what doesn’t.

This disregarding of sound enables Carma to experience music in a way that “suits” her. In improvisation she listens to the sound of her instrument and that of others. Sometimes certain instruments “wouldn’t necessarily fit” with musical play “but it doesn’t matter that it doesn’t work”. Sometimes tolerance is required of sound in music therapy, particularly when she is feeling unwell: “well I suppose if you are distressed you’re sensitive to noise”. Pleasant experiences of hearing sound can also be experienced as the bongo drums are “nice and sweet and enticing so to speak”. As I reflected upon this theme, it occurred to me how much of my previous practice in mental health had considered the overall _music_ that was created within sessions. Yet music comprises of many sound components. Carma’s perspective brought to mind that not all sounds are experienced as music by service users and that elements of sound can be quite selectively experienced in music.

**Incredible Stimulation in Improvisation**

Carma appreciates that improvisation is a forum in which multiple senses can be stimulated. She is enthusiastic about the “international” set of instruments that can stimulate her imagination in a way that “can focus on the different places” such as Asia, Africa, America, Australia, China, Greece, Europe and Norway. Different instruments “could really tap into” these different locations and sometimes “strong” images can be experienced when playing:

Carma: You know, there would be like maybe the Swiss Alps with the bells, you know the tinklin’ little bells, maybe the antelope going across, you could, you know, just tinkling them little bells.
Triona: Yeah.
Carma: That was interestin’, or goats or something, or maybe it could be in Greece or something but that’s what the bells gave ya, you know, that’s all. You know the way the bells, you see the goats with the bells on their necks and their clippin up and down the mountain, that’s what it was like. Then you got, there was another instrument there and it was also bells and it was more like Norwegian, you know like ahm, reindeer bells.

Carma prefers to use her imagination and be taken to “a different place” during improvisation. Some of the sounds in music remind her of films that she has watched in the past, as she is someone who has been “reared up on watching films on the television”. Carma has strong sensory experiences in music therapy. She can “feel the huge big waves coming in” and “feel the sun so to speak”. Being part of an improvisation is “incredible”; “it was incredible, just sitting around the table”.

Improvisation can mentally transport the individual. While in my early days of practice I might have interpreted such transportation in music as a form of escapism, it occurred to me in this instance that perhaps Carma can provide what she needs for herself at a particular time and sometimes this may include momentary escape from her present circumstances of being an inpatient in a psychiatric unit.

**Mindfulness of Others in Music Therapy**

Carma considers that music therapy is “great for bringing people together”. In music therapy the group is “we” or “us”. Group participants are “bringing off their identity”, or revealing who they are, during play in improvisation where “everybody came together”. Even though people play music at their own individual pace, “they’re all part of a group”. In sessions, discussion often follows improvisation and this involves reflection upon people’s feelings and observations in the music which “lets you know whether people are on the same wavelength as yourself”. Carma can empathise with other people in the group because they both share similar experiences; “I did always have a fairly good foresight into what people
were experiencing but because of what I’m physically experiencing myself I can empathise with them you know”.

**Recommending Music Therapy for Children**

Carma recommends music therapy for children. Having recalled her first childlike experience of improvisation, she explains how it “can get quite noisy, like a group of children in a kitchen, do you know, with pots and pans”. Certain instruments have the potential to be “incredible” and “fantastic” for children because of the enjoyment that they can conjure in the player. She recommends music therapy particularly for children because “they can grow up with a love for music” and added “it should be in the curriculum” in schools.

**Implicit Catharsis in Music Therapy**

For Carma, music therapy “does exactly what it’s supposed to do” it is something that is “good”, “very therapeutic”, “very interestin’” and, “de-stressin’”. She likes that “it does take you out of the moment” and that “it does work”. Music therapy is “there to assist you, and it does it without you even knowing it does it. Well you’re slightly aware but you’re, you don’t realise how effective it is”. This indicates that Carma experiences music therapy as something that implicitly helps her in a manner that is subtle and yet effective.

**Laura**

Themes found in Laura’s interview describe her experiences of attending group music therapy sessions in an inpatient setting. These included: ‘Context of the music therapy setting’; ‘Music and personal associations’; ‘Instruments visually stimulate’; ‘Music therapy is adaptable to a personal process’; and ‘Hints of dissatisfaction with music in music therapy’.
**Context of the Music Therapy Setting**

This theme outlines the context in which music therapy is offered. Laura views the hospital where music therapy is provided as “home” and like herself, the other service users in this facility are “all wound up”. She recalled other settings in which she has been placed in the past, exclaiming that these were “the good old days” thus suggesting that she has had satisfactory experiences of institutionalised care.

When first attending music therapy Laura thought “the whole lot” of the other group participants “were mad”. Different people attend the session every week “but once they join they come back again”. Patience is required in music therapy because “there’s always someone coming in, coming out like … the fellas come out to go the toilet, they don’t come to the toilet, the divil knows what … but I’m the same meself sometimes”. Therefore, Laura’s experiences of music are set within a restless environment.

**Music and Personal Associations**

Talking about music therapy brings up references to Laura’s family and past encounters with musical instruments. Laura’s father used “to boast” about his “bit” of musical knowledge, as he reminded people that the first violinist is leader of the orchestra. A number of musical instruments in music therapy remind her of other people such as her brother who “sold off a mandolin” and “sold a guitar”. Her experiences of playing instruments in music therapy remind Laura of her mother who bought her a xylophone in a “big shop” when she was about “ten or so”. When she plays the drums in sessions it brings “it all back to me”. Her auntie gave her a present of drums one Christmas and she “banged it all over Christmas”. The “rattler” instruments in music therapy remind her of “rattlers on a baby’s pram” reminding her of the birth of her nephew.
Instruments Visually Stimulate

Some instruments in music therapy visually stimulate Laura as they resemble various sorts of objects. The “yellow rattlers” in sessions look like the “jangled things” on a baby’s “pram” and the xylophone reminds her of “typing” on a typewriter. One instrument, that’s name is unknown to her, resembles the stairs in a block of flats; “like little sets of stairs on the side of it”. These descriptions suggest that some instruments featured in music therapy are a source of visual stimulation for Laura.

Music Therapy is Adaptable to a Personal Process

Music therapy is a process that “relieves a lot of the tension, distress as they say”. For Laura, music therapy can be adapted to her own worries and relaxation is an important part of her experience in sessions:

Tríona: Do you get anything out of attending music therapy Laura?
Laura: I do yeah, relax yeah. Even if I think of something else like
Tríona: So you relax and what else…
Laura: You sit down, you relax, you join in and … he doesn’t mind if you have a little nod off … once you’re sitting on a good chair [laugh].
Tríona: Yeah.

Laura can use music therapy in a way that suits her needs in any moment, whether this be sitting down and relaxing, playing, or falling asleep if she feels tired. Therefore, Laura puts forward the idea that there is flexibility within music therapy so that the individual can engage with it in a way that they feel is manageable.

Hints of Dissatisfaction with Music in Music Therapy

Although not explicitly stated by Laura, there seem to be aspects of music therapy that are dissatisfying to her. Even though the content of music therapy is “agreeable”, it would be better to learn an instrument in sessions. For Laura, one such instrument would be the mandolin. She also makes an effort “to try to get them to play things that I can’t play” and wishes to be given “a bit of music” when asked about what she would like to accomplish in
future sessions. She is “dying to get the words” of a particular song for a forthcoming family event but does not seem to perceive that it would be appropriate to follow this request up with her music therapist. This indicates that Laura’s dissatisfaction seems to be related to the music that she experiences in sessions. This seems to be different to the type of experiences in music that she desires.

**Summary**

This chapter has provided description of each of the super-ordinate themes that arose from analysis of interviews with Luke, Ollie, Pauline, Barbaraella, Carma and Laura. These themes present a rich description of each of these individual’s life-world in music therapy. The next chapter presents super-ordinate themes that are shared across each of these accounts, and the discussion chapter which follows presents an extended critique of these findings.
Chapter 6

Overall Interview Themes

Super-ordinate themes were found across ten interviews with six participants who described their experiences of individual or group music therapy in mental health. These included; ‘The music therapy context makes a difference’; ‘Music therapy brings challenge’; ‘Music therapy makes a positive impact’; ‘Group music therapy fosters contribution’; ‘Music therapy is person-centred’; ‘Music therapy creates a sensory world’; ‘Music is bound in meaning’; and ‘Frustrations and tensions can occur in music therapy’.

The Music Therapy Context makes a Difference

The context in which music therapy is provided was described by all participants. Music therapy is provided in a health service environment which for Laura is “home”. Many participants are encouraged to attend music therapy by mental health practitioners and many indicated that they would not have attended without this encouragement.

Both Carma and Ollie viewed the hospital environment as monotonous where there is little to keep them occupied. Despite having initial doubts about music therapy after attending her first session, Carma decided that she would return to a second session because there was nothing else for her to do in hospital:

Tríona: What made you change your mind?
Carma: I don’t know. I suppose it’s because there’s nothing else to do [laugh]. I mean, that’s a reason isn’t it.
Tríona: Sure, it absolutely is a reason. So having something to do is important
Carma: Of course.

Ollie had the option of staying in his room or attending music therapy as part of the overall occupational therapy service. His sense of time can drag for him while on the ward where the days are experienced as long:
Triona: Yeah and you said that the time on the ward can be very long …, can you say a bit more about that? What can it be like on a ward?
Ollie: What can the time be like?
Triona: Yeah
Ollie: You know, you’re up from a very, you’re up from about 8 or 9 and breakfast it about 9 am … unless you’re in occupant … unless you try the occupational therapy there’s just really smoking and ah, or there’s a TV, ahm or unless you’re seeing a doctor or something which ya, you generally don’t see anyone in the morning or whatever so [ ] I didn’t want to do any occupational therapy. I just was very low, I’d just sort of stay… stay in my room or whatever or stay on the … stay on the ward. I didn’t really want to talk to anyone or do anything so I saw my doctor and he told me, he didn’t tell me go down just encouraged me to go down to occupational therapy, I didn’t feel like it.

Despite not wanting to do anything, Ollie found ways to occupy himself as a result of receiving encouragement from his doctor. The words above describe the starting premise from which service users may begin music therapy whether this be because of a wish to be occupied or to be involved in something different on an otherwise dull or dreary day in a low stimulation context. Ollie felt very low at this time which perhaps serves as a reminder of the magnitude of a step that those in similar circumstances take as they embark upon therapies and activities in an inpatient setting for the first time.

**Music Therapy brings Challenge**

Music therapy can offer a range of challenges for service users. These challenges have three facets in music therapy including; the unknowns about the role and process of music therapy; the impact of the past upon one’s musical engagement; and the interpersonal challenges that can arise in a group. Ollie explained how he was initially sceptical about music therapy before he commenced attending sessions:

Triona: And you said there that you felt a bit sceptical initially. Can you say a little bit more about that?
Ollie: Ahm, I suppose when you see music or music therapy, maybe it’s ahm, maybe I’m only speaking for myself, do you feel you need to make music or make a piece of music or do you feel you have to be skilled in music and that was just myself ahm… I never thought of doing music therapy or anything like that before so I suppose it’s like … it’s like you see cookery or something, do you need to know who to cook or
something or art, do you need to be good at art and I suppose for some reason I felt you see music and it says music therapy you wonder what music therapy is first of all.

Ollie’s early reaction to music therapy was one of scepticism as this evoked numerous questions around terms of involvement. This caused him to compare music therapy to his understandings of other activities offered in the inpatient unit and wonder if musical skill was a prerequisite. The word music appears to merit its categorisation within that of activity, yet the term music therapy was challenging for Ollie as it presented so many unknowns.

Challenge is also encountered in music therapy due to service users’ past experiences that can impact upon their musical engagement. Luke’s background as a musician resulted in feelings of doubt when improvising on the guitar in music therapy. He associated improvisation with music performance and reflected on how he is critical of what he plays. However, to him music therapy is a space that is non-judgemental and open:

Luke: Ahm … it makes my slightly, not overly the toply, but slightly doubt myself that, doubt myself to the degree of like, ahm, I’m not always, but only slightly, I’m not a guitarist or I shouldn’t be playing the guitar, I’m not good at the guitar, something like that when, [ ] I’d almost kind of say I shouldn’t play the guitar to a certain degree and that’s probably the over-thinking side coming in, I mean possibly Tríona: Right, do you think that that’s a feeling that you pick up on from music therapy or is it a feeling that you pick up from being a musician with a very musical past?

Luke: More the musician side I’d say. The music therapy wouldn’t be … wouldn’t push that on me at all like, no [therapist’s name] wouldn’t be or isn’t, not just, wouldn’t be and isn’t, in my opinion judgemental to that degree at all. I mean, I could play an instrument that would be brand new to me and I could bring it in and play it. [Therapist’s name] said to me, it’s just an instrument you’re learning therefore, or you’d like to learn. You can bring it in and if I know some, any information or if I can tell you anything about it or … or you’d like to learn to certain degree about it I can find you information about it of my own accord or not.

Service users also encounter interpersonal challenges in group music therapy. Pauline recalled how earlier that morning she had listened to one group participant, with “a hopeless voice”, sing a song by a popular Irish artist. Although she did not appear to have appreciated this contribution, she refrained from saying so within the group because she did not want to criticise a fellow group member:
Pauline: … we don’t normally bring our own music in we go for the … for everyone’s music to sing differently or song differently, whatever they want to do you know
Triona: Ok. I wonder … in your opinion, why, why is that?
Pauline: Well the lady today wanted to sing a song so [therapist’s name] let her, I didn’t, she wanted to sing a Joe Dolan song but [therapist’s name] let her anyway 
Triona: And do you like Joe Dolan?
Pauline: Mmm?
Triona: Do you like Joe Dolan?
Pauline: Oh I do indeed like Joe Dolan, he’s dead, he died of a brain tumour, he was ‘make me an island’ but she couldn’t sing that, she said she had a hopeless voice so I said nothing [laugh] … She’s right!
Triona: And … was there ever a time when somebody wanted to sing a song or sang a song when you thought ‘I don’t really like this’
Pauline: Well … that’s what I was saying about today … she was ok, you know I don’t want to criticise her, who am I?

**Music Therapy makes a Positive Impact**

Music therapy makes a positive impact upon service users. These effects are across a range of domains that relate to: music therapy as an overall process; playing music in music therapy; and particular aspects of the music created in music therapy. As an overall process, music therapy is viewed as positive, helpful, de-stressing and tension relieving, as well as being something that can be adapted to processing of one’s own worries. It helped Ollie through “some serious type things” and sparked his motivation to return to playing music once again. Luke is of the view that “I don’t believe there’s a negative side to it from my point of view anyway”.

Carma differentiates music in music therapy from music in the “outside world”. She attributes the latter with enjoyment and listening while in therapy music has an assistive or perhaps cathartic function that can mainly go unnoticed by those who participate in sessions:

Well I didn’t do music therapy before I done it with regards to the term outside world, music in the normal everyday life it’s purely for pleasure and you’re not thinking about it being of any help to ya, you’re just enjoying it and listening to it and paying to listen to it probably you know where as in therapy, it’s there to assist you, and it does it without you even knowing it does it. Well you’re slightly aware but you’re, you don’t realise how effective it is.
Music therapy’s effectiveness does not seem to equate to one type or characteristic of music over another as Carma’s first encounters of music in music therapy were “daunting” while Barbaraella recently experienced music as “not soothing”. Both Pauline and Barbaraella experience the beat and rhythm in music which Pauline finds “very interesting and very calming”. This indicates that steady rhythm has a positive impact upon her.

Playing music in improvisation is an emotional experience that is mainly described in emotional terms such as “fun”, “heavenly”, “enjoyable”, “fantastic”, “great”, “soulful”. Service users may also search for something during play and hope that something good would come as a result. The following highlights Barbaraella’s feeling of being stimulated in music, so much so that on one occasion she improvised for twenty minutes:

Barbaraella: Playing is stimulating we had a very good musical session, it lasted twenty minutes, we’ve never had one before that lasted so long. I just didn’t want to stop playing, for some reason… I felt stimulated… to continue. And the group continued, we had a beautiful… produced some lovely music.

Tríona: Right. And what do you think, what do you think lead to the group lasting for so long or your improvisation for twenty minutes?

Barbaraella: Well, I didn’t give up and stop, I used to stop and I … everybody else would stop if I stopped so I continued and I think it continued that way…

Tríona: And everybody else continued on also obviously?

Barbaraella: They did yeah, all the different instruments.

Tríona: So what’s it like then to stop or to … to, to continue on?

Barbaraella: It was very stimulating, I found it.

Overall experiences of music therapy are positive and the majority of these are described in emotional terms which seem to be of particular relevance to service users. Although experiences of the music produced in sessions can evoke mixed feelings among participants, the overall process of music therapy is portrayed in a positive manner.

**Group Music Therapy fosters Contribution**

Group music therapy is a place in which people can contribute and in many examples this contribution is appreciated because it is for the benefit of others. This can present in various ways through participant’s taking on-board of supportive roles towards the therapist,
group and individual group members. The notion of contribution also arises in relation to providing leadership in play, “sharing identities”, “listening out for” and “drawing out” the best in others, which places each participant in an active stance. When reflecting upon creating music in improvisation, Ollie explains that even the smallest contribution has meaning and that this makes him, and hopefully others, feel good about themselves:

Ollie: You’ve created something and … your sort of like ‘well I didn’t know I could do that, you know’ and that’s … maybe that’s the feeling I got in the music therapy. Now, I dunno whether that’s, maybe it’s just talking … no, I think that could be the thing, yeah.

Tríona: Do you almost surprise yourself?
Ollie: No, I’m just … I’m trying not to be too deep or sound ahm… yeah, it’s great to be able to create something, it is and I felt that that was really great in the music therapy, I have to say that even the tiniest contribution I did, it made me feel great and I hope it made other people feel great as well… and I hope it’s not just me banging on about it.

Pauline is a part of the music therapy group and this gives her a feeling of being worthwhile. Her capacity to contribute to the group makes her feel happy. There seems to be a reciprocal relationship between the notion of contribution and that of reward whereby service users get something out of giving to others. Although Pauline at one point doubted if she gives at all, she equated her contribution in music therapy to playing music with others in a group environment:

Pauline: I’d feel very worthwhile, very worthwhile and elated?
Tríona: Worthwhile… ok.
Pauline: And happy, to be able to do that and play the drum.
Tríona: And tell me a little bit more about feeling worthwhile, what’s that like?
Pauline: A little bit … well I feel like I contribute myself to something, you know… cause I’m in a group and sort of … you know, I’m happy to with them, glad to see they’re all getting on and they’re all happy and they have their own little… whatever they’re doing… it’s good to see them and I’m happy to be in their group.
Tríona: So being part of something?
Pauline: Being part of something, exactly.
Tríona: And giving something?
Pauline: Maybe giving a little, hopefully, if that’s what I do you know.
Tríona: And the ways… Tell me about the different ways then that you contribute in music therapy?
Pauline: Well, I’m not sure if I contribute anything but I do my best. I just sort of play… we all sort of take our turns to do our little thing.
**Music Therapy is Person-centred**

The degree to which music therapy places the individual at the centre of its process is best described by Luke who compared his contrasting experiences of treatment following the trauma that led to his engagement with mental health services. This trauma robbed him of ability and negative experiences arose from his subsequent treatment. This highly contrasts to the way in which Luke experiences music therapy where choice-making and joint-decision making play a central role. These contribute to his experience of receiving a treatment that is supportive and helpful:

Luke: Maybe I’m not able to anymore, maybe because of my [trauma] I can’t do this sort of stuff. It’s been robbed from me or something along those lines …

Triona: Robbed from you …

Luke: Well [ ] I didn’t go out and try or put myself into the situation [ ] on purpose obviously enough but ahm …

Triona: So is there something that can be taken away sometimes in treatment?

Luke: Sometimes, depending on how its approached. I mean with certain people, everybody’s their own individual. Everybody’s affected by it in a different way but if its, if you’re approaching things in a different way, [ ] if they make themselves aware of whoever they are that they’re dealing with that it’s negative towards a said person or people, ah, they should maybe try a different route [ ] cause they’re not receiving any positive, as much positivity from the treatment that they would, that would do them better. That they should be getting in a way.

Triona: Cause one of the things that struck me from our last interview was how you described ahm, being the person who decides on what direction you want to go in in music therapy and I was quite struck by that … and you mentioned about the therapist almost offering you a helping hand and … but then you’re the driver which sounds quite different to maybe some of the past experiences that you might have had where you felt that things were taken away?

Luke: Yeah. Ridiculously different. I mean if someone’s kind of going here, would you like to receive this type of treatment I mean, we’re all offering it just to see. I’m thinking you might enjoy this, you might benefit from this like, there you go, if you would like it, I’m offering, as you say, the helping hand and then it’s up to me to kind of say, yes I would like it and I’d like it, I want it to be done this way and be like, [ ] whoever’s receiving say music therapy can be like, ok, I would like to have it done this way, I benefit, I am benefitting and will futurely benefit from … from receiving the therapy this way and that did happen and I’m receiving a lot of positively and helpfulness from this type of therapy.

Triona: So does it help when you’re in the, when you’re in the driver’s seat rather than maybe being in the passenger’s seat?

Luke: Mmm. To a certain degree. I mean if you can, if you know to a certain degree you can, the way that you feel and along with the help of the therapist that you will benefit the best from, from ah, whatever way the therapy is being applied towards
Luke experienced a sense of being in control, all the while being supported by his therapist as he embarked upon his journey to wellness. He indicates that music therapy is a beneficial and positive process as he can exercise his ability and willingness to take an active part in his own treatment. The reciprocity between Luke and his therapist engage both individuals to focus on shared goals.

The person-centred approach of the therapist is also admirably recognised by Barbaraella who described how the “teacher” or music therapist encourages opinion from group members without enforcing that of his own on others. He is reliable and is someone who can be depended upon:

Triona: And do you feel, do you feel quite responsible for keeping the group together?
Barbaraella: Not really. Not responsible for it but I’ll be there anyway cause I’m here. I like it, I attend it now, every week. [Therapist’s name], our spokesman, our leader is very good, a very good teacher. He allows everybody to give their opinions, he never puts across his opinion. He allows us to make up our own mind about the music.
Triona: Is that important?
Barbaraella: Yes
Triona: Why is it important?
Barbaraella: You rely on [therapist’s name]. You could ask him any questions, do you know what I mean? He’s a guitarist. [pause] I find it very therapeutic …. to be part of a group, … to join something, … and to express myself through the medium of music.

Barbaraella values her leadership role within the group which is meaningful to her and something that she does not feel burdened by. This highlights that music therapy has the flexibility to offer service users what they may need at a particular time, whether this be to assume a leading or less active role. Such an approach is quite different to the rigid style of treatment that Luke previously experienced after his trauma. The adaptability of music therapy is also recognised by Carma and Laura who can adjust sessions to suit their
individual needs. Carma commends music therapy because of its use of the language of music because “everybody can come together” without using words.

**Music Therapy creates a Sensory World**

Four participants focussed upon the sensory world of music therapy where senses of sight, sound and touch are often stimulated. The instruments featured in sessions appear to be a source of visual stimulation for Laura who considers these in terms of size, colour, shape and sound. She usually plays one of two xylophones during improvisation:

I love the xylophone so I ah pick up the little one and afterward pick up the big one. The blue one is the little one and the red … is the big one so then there’s all these things like ah …

Carma also receives sensory experiences from playing music where the music therapist’s contribution to improvisation instigates a feeling of warmth within her. Seasons and countries can also be evoked in Carma’s mind during play that is a process in which she can embark upon a multitude of experiences that are in stark contrast to the reality of an inpatient mental health setting. Therefore, improvising in music therapy can provide a sense of escapism away from one’s immediate circumstances:

Carma: … and then the guy that’s the teacher, he plays guitar but he has a, he has the skill to throw in a little bit of Spanish playing, even on a traditional Irish tune
Tríona: Ah, what’s that like when he throws in a bit of Spanish playing or Irish playing?
Carma: Well it’s nice cause you can feel the sun, d’ya know that kind of a way. You can feel, you can feel the sun, so to speak. You know you’re gone through a different place and you’re goin, you’re gone into the seasons as well, you know you go into the seasons if you were to take say the Norwegian, China, bells like of the reindeer and all that. You’d get the atmosphere of winter, summer or Autumn you know or you can get the seasons.

The way the sound of music is processed, imagined and, in the text above, *seen* is unique and idiosyncratic. Like Carma who can sometimes feel the warmth of the sun on her body during play, Luke also has an embodied sensation of “getting something out” or releasing something in a constructive manner while improvising with his therapist:
It’s like both sides hearing each other’s opinions or each other’s issues with whatever the problem may be but then this physical way to do it, I don’t mean along the lines of violence or anything like that, but in a constructive, positively constructive way.

The sea is a central element in both Barbaraella’s and Carma’s experiences of calming improvisations. It is not only experienced through the sounds of the instruments contributing to this improvisation but also through the visual imagery that is evoked therein. Carma spoke about “how the sea was dancing so to speak so I was in control as to whether the waves were bouncing off the top off the cliffs or whether it was just the calm rolling of the sea”.

Encounters in music therapy can provide sensory experiences that are highly stimulating and yet unique to the individual. Furthermore, this is not only through the mechanism of sound but also through the senses of sight and touch.

Music is bound in Meaning

For Pauline, Barbaraella and Laura, music is bound in personal meaning. This can relate to past experiences but most notably, to personal ties and relationships with other people. Reminders of these connections can be comforting but they may also be painful as they can trigger experiences of upset or loss as indicated by Pauline:

Triona: Ahm …. and, ahm, also recalling memories of music with your family
Pauline: That’s correct. Most important. My father and my brother and myself.
Triona: Yes, and your brother …
Pauline: He’s dead poor [name], yeah, my one and only brother.
Triona: I’m sorry to hear that.
Pauline: He’s dead, I’ve told you that so he’s dead unfortunately.
Triona: Yeah… [pause] What it reminded me of was that when you spoke about your long history with music, ahm … about maybe … all the possible connections that you have with different people through music.
Pauline: Yeah, and my cousins … my cousin [name], he is my mother’s brother’s son. He plays the guitar too as well and my brother played the guitar and he has my brother’s guitar even though, brother [name] is dead he has his guitar and plays on it. He loves the aul guitar … Ahm, as I said before, my sister’s husband [name], he plays the bagpipe as I’ve told you, that’s basically it and you know … take it from there.
Triona: I was thinking about what you said about the xylophone reminding you of the piano.
Pauline: That’s right, it does, it has the notes on it, you know the notes on it. Or the Yamaha, the Yamaha piano, I got that when my … [ ], my nieces son. He has all the
keys he know that he can play on, I bought that for him for Christmas about two years ago. He was delighted with it.

Pauline makes many connections between music and members of her past and current social network, referring to her mother, father, brother, sister, music teacher, parish priest, cousins, nieces, nephews in her interviews. Even though the memories of her father and only brother, who have both passed away, appear to live on in descriptions of her relationship with music, her sense of loss is also apparent. This highlights that reflections on one’s music, as something that can be steeped in personal meaning, should be approached with sensitivity and awareness that this can have the capacity to evoke many different emotions.

The suggestion that caution be exercised when considering people’s personal connections with music does not necessarily mean that this practice should be limited. For Barbaraella it is important to make such associations, particularly since she became unwell. This perhaps relates to maintaining her sense of personhood despite her change in circumstances. Music offers her a connection to the wellness part of her identity that may become under threat or forgotten about during a time of illness:

Barbaraella: One girl played the chimes and it reminded her of home, she came from [name of country] where they used it, the chimes, to get rid of the devils so when she plays it it reminds her of home …
Tríona: So the music can bring a connection with things?
Barbaraella: Mmm, mmm
Tríona: A little bit like …
Barbaraella: Association with things
Tríona: Association with things. You mention with the drum and being a dancer and rhythm. Is it important to make associations with things?
Barbaraella: For me it is.
Tríona: Why?
Barbaraella: It’s just the way I am. Associate things.
Tríona: Does it give it a meaning?
Barbaraella: Since I became ill I associate things a lot [pause].

**Frustrations and Tensions can occur in Music Therapy**

Although never explicitly voiced by participants, it became apparent in analysis of three cases that sometimes frustrations and tensions are experienced by those who attend
music therapy. When asked about her dislikes of music therapy, Laura referred to her wish to learn music despite finding the current format of sessions agreeable:

Tríona: And Laura, is there anything you don’t like about music therapy?
Laura: [pause] Well I suppose we could be learning something really … trying to learn something although I know what he’s doing, it’s very agreeable … but ah …. I would really like to … learn the ah …

This frustration seems to be shared by Pauline as she compared her past attendance of a music tuition group with her experiences of using unfamiliar instruments when improvising in music therapy. She has a desire to learn about the instruments and receive instruction on how to play them but this perhaps goes against the inclusive ethos of improvisation in music therapy where there is no right or wrong way to play an instrument:

Pauline: Well it’s good that you know what each instruments is for starters, you won’t be sitting there thinking well what will I do with this and what will I do with that?
Tríona: Mmm, mmm
Pauline: You have to be shown and you have to taught, you know.

These feelings of frustration hint that participants sometimes attend music therapy because they have a wish to learn a new musical skill. The primary use of improvisation in group music therapy seems to create tension and even disappointment among participants such as Pauline who find this form of musical engagement difficult because of its lack of instruction and structure. In reference to one instrument offered in music therapy she is of the view that “if they were shown it and showed how to use it, there wouldn’t be any problem”.

The transition from music in a traditional sense to music featured in improvisation was also highlighted by Barbaraella who views the music therapy group as being “unusual”. For her, this group “creates unusual music” and she realises that “some people mightn’t like it”. This unfamiliarity amidst the familiar concept of music can evoke frustration and unease in those who wish to pursue more conventional musical experiences.
Summary

Analysis of the ten interviews from six service users revealed eight common themes about participation in individual and individual music therapy. These were: ‘The music therapy context makes a difference’; ‘Music therapy brings challenge’; ‘Music therapy makes a positive impact’; ‘Group music therapy fosters contribution’; ‘Music therapy is person-centred’; ‘Music therapy creates a sensory world’; ‘Music is bound in meaning’; and ‘Frustrations and tensions can occur in music therapy’. Each of these themes will be given further critical consideration in the discussion chapter of this thesis (Chapter 8).
Chapter 7

Arts-based Process and Outcomes

Three arts-based focus groups were attended by participants Jack Sparrow, Shady and Dreamer who used creative processes, including visual art and song writing, to describe and represent their experiences of music therapy in mental health. These materials included one visual image and three song compositions, one of which was a song parody. Each of these materials was reflected upon and individually responded to with a song response I made; where song writing was used as part of a reflexive process seeking to gain a deeper understanding of the arts-based materials produced, and by association the experience of service users within music therapy.

An initial response to the arts-based materials created in the focus groups involved writing an emerging context. This involved gathering information from the focus group transcripts and from reflexive journal notes in order to create a written account of the context in which the arts-based material was produced. The next step in this reflexive process was the development of a commentary table that relates participant comments to the relevant arts-based material. This table also includes my own thoughts and impressions of the arts-based material in relation to my multiple roles as group facilitator, music therapist and researcher who wished to gain a participant informed perspective on what it is like for people to attend music therapy in mental health. Building on the information gained through the process of description informed by the emerging context and devising the commentary table, a song response was then composed that encapsulated these multiple sources of information with the purpose of deepening my insight about each of the participant’s arts-based processes. After completing the song response, a high-quality recording was made of each composition which features my vocals and guitar playing. For the purposes of increasing the accessibility of this
research to mental health community, this recording was uploaded onto SoundCloud (https://soundcloud.com/#stream) which is an online audio distribution platform for originally-created compositions.

The following section of this chapter provides an emerging context, commentary table and song response for each of the arts-based materials created by focus group participants. These are in relation to one unnamed visual image, a song parody entitled Wednesday and two original song compositions entitled When I play Music and Music Therapy Rap.

Visual Image

The following visual image (see Figure 4: Visual Image) was created by Jack Sparrow in the first of the arts-based focus groups.

Figure 4: Visual Image
Emerging Context

Before the first focus group commenced, I arranged a variety of art materials in the centre of a large square table that had chairs positioned on three of its four sides. The art materials included coloured pencils, paints, chalks, felt tip pens, crayons, paint brushes, a water jar and paper in different sizes and colors. The musical instruments were left to the side of the table and included a keyboard with a sustain pedal, a guitar, a djembe and a variety of hand percussion (see Figure 5: The Arts-based Space).

At the start of the focus group participants Jack Sparrow and Shady completed informed consent and recording forms. We then made introductions and had a brief discussion about the purpose of the project. I asked both participants to think about what it is like to go to music therapy, adding that this could be reflected on using visual art or song. Jack Sparrow said that he would like to draw something. I was surprised when he asked for an ordinary pencil to be able to draw given the array of coloured materials I had placed on the table in front of him. After fetching a lead pencil I turned his attention to the different sizes of paper on the table and he replied by asking for “an ordinary sheet” and “something
to lean on” while he drew. I handed him an old newspaper to place under his sheet and he began to draw.

Jack Sparrow initially pursued the creation of his visual image quietly but as the group progressed he joined in discussion about a song writing process that Shady had chosen to work on. After a few minutes when I enquired with Jack Sparrow as to how he was getting on, he told me that he had completed his drawing and that he was happy with it. He told me that he drew himself, later adding that he was smoking a cigarette in the picture and that he loved music. He told me that he had been attending music therapy for three years, adding that it cheers him up and puts him in good form. He also shared that he sometimes played drums and guitar in music therapy sessions. I took a photograph of Jack Sparrow’s visual image at the end of this focus group and he took this original drawing home with him.

After the focus group concluded I reviewed the visual image created and it struck me that the person in the image had a beard and glasses yet Jack Sparrow had none. I also noticed that the word ‘music’ appeared to be misspelt. I hadn’t noticed any literacy problems on Jack Sparrow’s behalf when he was reviewing and signing the research consent forms yet I worried that this might have perhaps been a source of discomfort to him. I was also curious about his choice to use pencil in his drawing given the art materials that were available. I had many thoughts and questions about this image and yet I wasn’t sure of what ‘to do’ with these.
### Commentary Table

**Table 4: Commentary Table of Visual Image**

<table>
<thead>
<tr>
<th>Source</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Jack Sparrow (Focus group 1)    | I might draw so, I might draw so  
You haven’t an ordinary pencil have you?  
An ordinary sheet  
Do you have something to lean on?  
I’ve done it, yeah  
Colour?  
I’m happy with that  
I drew myself  
Oh, it’s myself and ah… smokin’ a cigarette. I love music, put down that.  
Three years  
It’s music therapy, listen to music  
It cheers me up you know  
Puts me in good form  
The music  |
| Jack Sparrow (Focus group 3)    | I drew myself with a fag [giggles]  |
| My thoughts and impressions     | You requested an ordinary pencil  
No colour was desired  
Looking for something to lean on, do you lean on Johnny?  
A picture of you, smoking a fag  
You are happy with that  
Yet I see you now, no glasses no beard  
Where did these come from?  
Lots of space between your sketch  
Lots of room to interpret  
You drew yourself, are you happy here?  
Three years- a long time- is there lots to say?  
It cheers you up, improves your mood, puts you in good form  
You love music, perhaps hard to spell?  
This starts with you and what you love  
The music  
Is this art? Is this of merit?  
To say such things do I discredit?  
I’m not judging but I have questions to ask  
What does this say about music therapy?  
How to show to others?  
So much room to read between the lines  
Yet so beautifully simple  
Personal to you  
This starts with you and your love of music |
**Song Response**

Having reflected upon the emerging context of this visual image and having considered the comments featured in ‘Table 4: Commentary Table of Visual Image’, the song writing process commenced in order to produce a song response. The commentary table was used to directly inform the lyrics of this song. Jack Sparrow’s comments were incorporated into a chorus of *service user lyrics* with only minor word insertions made for the purposes of sense making (in red font). It was decided that it was important to highlight such minor insertions, not only for the purposes of coherency but also to illustrate efforts to maintain the integrity of the participant perspective. A similar process ensued for completion of lyrics pertaining to my own views yet because these comments were my own, these were subject to more of an artistic license.

After completion of the lyrics, the musical style and melody of the song were chosen as the final stages of this reflexive process. The musical style was informed by the prevailing mood of the focus group at the time the visual image was created. A reggae style was chosen so as to reflect the casual manner in which Jack Sparrow approached his drawing whereby he shrugged his shoulders and said “I might draw so”. I kept an image of Jack Sparrow’s demeanor in mind whilst crafting the song melody so that this might increase the understanding of the song’s narrative, the lyric’s semiotic meaning and the feelings embedded in the lyrics as suggested by F. Baker (2013). The final song featured five distinctive sections including: 1) service user chorus; 2) researcher verse (italicized); 3) service user chorus; 4) researcher bridge (italicized in blue font); and 5) service user chorus. A final recording of this song response can be listened to at:

[https://soundcloud.com/#user687354335/arts-based-response-1](https://soundcloud.com/#user687354335/arts-based-response-1)
Lyrics

I might draw so, I might draw
I might draw so, I might draw
Have you an ordinary sheet, an ordinary pencil, something to lean on, no colour
I drew myself, smokin’ a cigarette
I’m happy with that, I’ve done it
It cheers me up, the music
It’s music therapy, three years listening to music
It puts me in good form, it’s the music.
I love music, put down that.

An ordinary pencil, no colour was desired
Something to lean on, do you lean on your music therapist?
I see your picture, you’re smokin’ a fag
Yet he has a beard and glasses
I see you now you have none.
You drew yourself, you’re happy with that, do you look happy?
Lots of space between the lines, lots of room to interpret.
Three years, a long time, I bet there’s lots to say
It cheers you up, improves your mood, music is your love

I might draw so, I might draw
I might draw so, I might draw
Have you an ordinary sheet, an ordinary pencil, something to lean on, no colour
I drew myself, smokin’ a cigarette
I’m happy with that, I’ve done it
It cheers me up, the music
It’s music therapy, three years listening to music
It puts me in good form, it’s the music.
I love music, put down that.

A misspelt word, can words be hard?
Is this art? Who decides its merit?
I have so many questions, what does this say about therapy?
How to show to others? How to share your ‘voice’?
So beautifully simple and personal to you
These ‘impressions’ start with you
Your love, your music.
**Wednesday**

*Wednesday* is a song parody written by participants during the first and second focus groups. It used the melody of *Rhinestone Cowboy* (Weiss, 1975). The pseudonym ‘Johnny’ has been used with reference to the music therapist who is featured in this and other compositions. A recording of this song as performed by participants and I can be listened to online at: [https://soundcloud.com/#user687354335/wednesday](https://soundcloud.com/#user687354335/wednesday)

**Lyrics**

Every Wednesday morning at eleven I go to music therapy  
It cheers me up, improves my mood on a Wednesday  
Johnny hits me with a stick, after I hit him with a stick  
He threw me out of his class  
He told me not to come back no more  
You’re suspended for two weeks now  
I came back for another two weeks  
He said you’re gone for two more  

Chorus  
Johnny get rid of the stick now  
He threw it out of the window, ridding it eventually  
On a Wednesday, Christmas is comin’  
And Johnny don’t like Christmas at all  
But he really likes the New Year  

Johnny shook my hand after breaking the stick  
He said he’s very sorry  
He got mad, I got mad on a Wednesday  
We’re friends again after all of that  
On a Wednesday in music therapy  
I’m glad we’ve made up  
We’re back making music again  
Myself and Johnny are best friends  
We’re singing songs, playing the drums, making music on a Wednesday  

**Chords**

- D  
- D- A  
- G  
- A  
- G-D  
- G-Em  
- A7  
- D  
- D-A  
- D  
- D-G  
- A-G-D  
- D  
- D  
- D-A  
- G  
- G  
- D  
- A  
- G-D  
- G-Em-A7
Chorus
Johnny get rid of the stick now       D
He threw it out of the window, ridding it eventually    D-A
On a Wednesday, Christmas is comin’      D
And Johnny don’t like Christmas at all      D-G
But he really likes the New Year          A-D-G

Emerging Context

In the first of the focus groups, Shady said that he would like to like to write a song to
describe his experiences of music therapy. He commented that he “was no good at school”
and asked that I help him with this creative process. I in turn agreed to jot down ideas that
arose in conversation that might be suitable to include in his song. He shared his preference
for country and western music and said that he liked the artist Glen Campbell, making
particular reference to the song ‘Rhinestone Cowboy’ (Weiss, 1975). As I hummed the air of
this song, Jack Sparrow, who was already engaged in his own drawing project, said “sing
up” so I continued to hum the song. Shady then identified this as his chosen melody for his
song composition. At this stage, another focus group participant, Jack Sparrow, said that he
had completed his drawing. I asked him if he would be willing to tell Shady and I a little bit
about this drawing in a minute or two to which he agreed. He then sat at the table quietly
staring at me all the while.

I noticed that I asked quite a few questions of Shady as we tried to generate some
ideas for his song. He responded with brief answers and I think that we both found it difficult
to start writing a song so early in the first focus group. I thought about my feeling of
apprehension concerning whether or not participants would wish to engage in this arts-based
process and this anxiety was further added to as Jack Sparrow looked at his watch several
times and made an enquiry into the remaining duration of the group.

As we discussed musical preferences, Shady offered other names of songs that he
liked such as ‘Noreen Bawn’ (McBride, 1910) and ‘Blanket on the Ground’ (Dowling, 1975)
and I began to think that the song parody we had agreed to pursue might be lacking in direction. Noticing that Jack Sparrow was looking at me, I made an effort to include him in the song writing process and asked him to let us know if he had lyrics suggestions that he would like to contribute. I put the capo on the guitar in order to change the key of ‘Rhinestone Cowboy’ (Weiss, 1975) and I made a joke about “cheating”. This was an attempt on my behalf to add some light-heartedness to the group. I asked some further questions about attendance of music therapy and recalled some lyrics that I had jotted down from my earlier song discussion with Shady which resulted in agreement among the group about the first two lines of the song parody. Shady commented that we were doing well when Jack Sparrow added in a line about their music therapist Johnny, laughingly saying “hits with a cup on the top of the head now”. Slightly taken aback yet amused, I asked Jack Sparrow to repeat what he had said but he offered different lyrics which were “Johnny hits me with a stick after hitting him with my stick”. Jack Sparrow laughed again and Shady laughed heartily at the lyrics that had just been shared. From this point on, Jack Sparrow began to offer the song lyrics and Shady took more of back seat in the song writing process, laughing loudly after each of Jack Sparrow’s lyric contributions. At one point Shady said “good man Johnny”, in acknowledgment of their music therapist who was the focus of this song composition. There seemed to be a mischievous air to the focus group at this point.

My role during this process was to craft Jack Sparrow’s song lyrics into the air of ‘Rhinestone Cowboy’ (Weiss, 1975). Sometimes he sang phrases to the group and on other occasions these were spoken. I confirmed each of these lyric contributions by singing each phrase with guitar accompaniment, making suggestions as to how to alter the lyrics if the syllabic content didn’t match the air of ‘Rhinestone Cowboy’ (Weiss, 1975). Shady continued to laugh heartily after most of Jack Sparrow’s contributions. They both appeared to be
‘having the craic’ 1. As the song progressed Jack Sparrow made comments that the music therapist would “kill him” and “kill the three of us” when he heard the final composition.

Shady appeared to like the idea of the song being recorded so that it could be played back in the next focus group. Keen to maintain his involvement in the song writing process that he had initiated, I regularly asked both he and Jack Sparrow if they were satisfied with the lyrics. Just as the first verse was near completion, Shady made a grimacing face and pointed to his hip. I recalled how earlier on he had told me that his hip regularly troubles him and that he might have to leave the group early. With this in mind I asked him if he would like to take a break from the focus group and suggested that he come back later. Shady agreed to this but did not return to the room.

After Shady’s departure Jack Sparrow chose to continue on with the song that was being composed. When asked what this song was about he said “music and Johnny like, and Johnny in bad form with me” and laughed. I probed a little further and asked if Johnny is often in “bad form” to which he replied “I’m only joking”. I asked him how the story of the song should finish. Jack Sparrow commented “we’re good friends after all that” and added that he wanted “to get my stick back” and he laughed once again. This indicated to me that Jack Sparrow wished there to be a sense of resolve between he and his therapist at the end of the song.

The remainder of this song parody was written in a similar fashion to that of the first verse with Jack Sparrow singing or speaking lyrics that I in turn tried to weave into the air of ‘Rhinestone Cowboy’ (Weiss, 1975). I also used verbal prompts to aid the song writing process at this time by asking Jack Sparrow questions such as “what happened next?” or “what did you do?” . As the verse neared completion I realised that Jack Sparrow had made

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1 A term used in Ireland to describe having fun
no reference to “making up” with the music therapist. I recalled his earlier comment about his friendship with Johnny and asked Jack Sparrow if it was his intention to address this in the final part of the song. In reply, Jack Sparrow sang “we’re friends again after all of that” which then became a concluding idea of this song. After completion of the lyrics, both Jack Sparrow and I sang the final song after which he commented “that was good” and “I liked that”. In the following focus group Jack Sparrow told me that he was telling the lads in the bar about the song and explained that this was great “craic” or fun.
### Commentary Table

#### Table 5: Commentary Table of Wednesday

<table>
<thead>
<tr>
<th>Source</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Multiple participants (Focus group 1) | I’d love to… to write about ah…ah… about music  
That’s a lovely guitar  
The music of it  
Country music  
I like country and western  
Glen… Campbell  
Glen Campbell Rhinestone Cowboy  
That’s… that’s the air of it  
I like music now  
I was very bad at school  
I’m no good at writing  
I’m no good at drawing either  
They’re mellow [sounds]  
No, I’ve no ideas…  
Noreen Bawn  
Blanket on the Ground  
Only a few [meeting other people]  
I do [like meeting other people]  
Doing well  
Good man Johnny! [laughs loudly]  
Wait til we show him that Johnny comes in now!  
Did you know Johnny before you came here?  
He’ll kill me now when he hears that song [laugh]  
Oh lovely  
He’ll kill the three of us now!  
We’ll tell you  
Sounds alright  
No, it’s grand  
Music and Johnny like, and Johnny in bad form with me [laughs]  
No, no, I’m only joking  
We’re good friends after all that  
Ok  
That was good  
I liked that |
| Multiple participants (Focus group 2) | Like the song Wednesday  
Will we sing the song again, I think it’s a great song?  
It’s a good song Jack Sparrow  
Yeah, I would like a blast of it  
That was good  
Yeah, it’s quite good like you know  
Well… from what you… a song  
Yeah, it is. I kind of thought that. I’m trying to think of the song [laughs]  
It’s about Johnny, you know having the craic with Johnny like, a bit of a laugh with him like  
Oh yeah, he’s great craic, he goes like that  
He goes like that, puts his hand up if there’re something wrong  
Yeah  
Yeah  
I think it’s very excitin’  
I kind a, I’ve a great interest in music and Johnny has, he’s great with music  
Dreamer is very good with music  
He’s very good at music, he’d play anything for you  
Do a couple more lines of this song |
<table>
<thead>
<tr>
<th>Source</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>I liked the song</td>
<td></td>
</tr>
<tr>
<td>I’ll show it to the lads in the pub</td>
<td></td>
</tr>
<tr>
<td>Can I take this away with me? I’ll show it to the lads in the pub [laughs]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Multiple participants (Focus group 3)</th>
<th>Will we sing the song again?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you play the song <em>Wednesday</em> again?</td>
<td></td>
</tr>
<tr>
<td>I like that</td>
<td></td>
</tr>
<tr>
<td>Put on the music there</td>
<td></td>
</tr>
<tr>
<td>Put on the music there</td>
<td></td>
</tr>
<tr>
<td>I like that</td>
<td></td>
</tr>
<tr>
<td>I like that</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My thoughts and impressions</th>
<th>Starting out feeling nervous</th>
</tr>
</thead>
<tbody>
<tr>
<td>New direction, dimension with Jack Sparrow’s input</td>
<td></td>
</tr>
<tr>
<td>Fun and laughter</td>
<td></td>
</tr>
<tr>
<td>Are you trying to shock me?</td>
<td></td>
</tr>
<tr>
<td>You know I know Johnny</td>
<td></td>
</tr>
<tr>
<td>I thought it was funny, fantastical</td>
<td></td>
</tr>
<tr>
<td>Should I have taken it more seriously?</td>
<td></td>
</tr>
<tr>
<td>So much laughter</td>
<td></td>
</tr>
<tr>
<td>I’m worried that I would lose your interest,</td>
<td></td>
</tr>
<tr>
<td>Lot of movement in the group,</td>
<td></td>
</tr>
<tr>
<td>Participant’s looking at their watch</td>
<td></td>
</tr>
<tr>
<td>Are you trying to shock me, did this really happen?</td>
<td></td>
</tr>
<tr>
<td>Enthusiasm for the song, singing it in the pub- craic, excitement, comradely</td>
<td></td>
</tr>
<tr>
<td>Jovial, giddy atmosphere</td>
<td></td>
</tr>
<tr>
<td>Did you have a row with Johnny?</td>
<td></td>
</tr>
<tr>
<td>Is this about give and take, getting over something?</td>
<td></td>
</tr>
<tr>
<td>Who doesn’t like Christmas?</td>
<td></td>
</tr>
<tr>
<td>What is the stick, is it a metaphor?</td>
<td></td>
</tr>
<tr>
<td>A song about equals</td>
<td></td>
</tr>
<tr>
<td>Does this make your relationships stronger?</td>
<td></td>
</tr>
<tr>
<td>You make up</td>
<td></td>
</tr>
<tr>
<td>Is it a really a friendship?</td>
<td></td>
</tr>
<tr>
<td>What does putting your hand up mean?</td>
<td></td>
</tr>
</tbody>
</table>

### Song Response

The melody for this song response was taken from a song sung by Christy Moore called *Casey* (Egan, 2006). *Casey* could be described as a playful song that is written about Bishop Eamon Casey who was at the centre of a scandal in Ireland in the 1990s when it was revealed that he had fathered a son. In the song *Casey* (Egan, 2006), the Bishop is referred to as a *divil* which is a term of endearment used in Ireland for someone who has been mischievous. The jovial mood of *Casey* seemed to capture that of the focus group in which *Wednesday* was written so therefore I decided to use its main melody in my song response. This light-hearted melody features in the song response chorus that relays the comments of
focus group participants in relation to the song *Wednesday*. Each chorus is written in black font below and minor word insertions are included in red font. The sections in italicised font feature my thoughts and impressions about *Wednesday* and comprise of a contrasting minor tonality in order to portray the serious manner in which I reflected upon the song’s account of interactions between therapist and service user. A final recording of this song response can be listened to at: https://soundcloud.com/#user687354335/song-response-2

<table>
<thead>
<tr>
<th>Lyrics</th>
<th>Chords</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good man Johnny</td>
<td>C</td>
</tr>
<tr>
<td>Wait til we show him</td>
<td>C-F-C</td>
</tr>
<tr>
<td>He’ll kill <strong>all of us</strong> when he hears this song</td>
<td>C-G</td>
</tr>
<tr>
<td>Johnny in bad form with me</td>
<td>C-F-C-G</td>
</tr>
<tr>
<td>No, I’m only jokin’</td>
<td>F</td>
</tr>
<tr>
<td>We’re good friends after all</td>
<td>G-C</td>
</tr>
<tr>
<td>It’s about Johnny, <strong>tis</strong> very excitin’,</td>
<td>C-F-C</td>
</tr>
<tr>
<td>A bit of a laugh, will we sing it again</td>
<td>C-G</td>
</tr>
<tr>
<td>He’s great craic, he goes like that</td>
<td>C-F-C-G</td>
</tr>
<tr>
<td>Puts his hand up if there’s something wrong</td>
<td>F-G-C</td>
</tr>
</tbody>
</table>

*Are you tryin’ to shock me?*  
*For you know that I know Johnny*  
*Did this really happen?*  
*But there’s so much fun and laughter*  
*Is this just a fantasy?*  
*Or is this stick a metaphor?*

| Good man Johnny                                 | C               |
| Wait til we show him                            | C-F-C           |
| He’ll kill **all of us** when he hears this song | C-G             |
| Johnny in bad form with me                      | C-F-C-G         |
| No, I’m only jokin’                              | F               |
| We’re good friends after all                    | G-C             |
| It’s about Johnny, **tis** very excitin’,        | C-F-C           |
| A bit of a laugh, will we sing it again          | C-G             |
| He’s great craic, he goes like that             | C-F-C-G         |
| Puts his hand up if there’s something wrong      | F-G-C           |

*Should I take these words quite literally?*  
*In such a giddy atmosphere?*  
*You’ve been talkin’ bout this in the pub*  
*Havin’ the craic with those at the bar*  
*Is this about the give and take?*  
*In an equal, healthy relationship?*
Good man Johnny	C
Wait til we show him	F-C
He’ll kill all of us when he hears this song	C-G
Johnny in bad form with me	C-F-C-G
No, I’m only jokin’	F
We’re good friends after all	G-C
It’s about Johnny, tis very excitin’,	C-F-C
A bit of a laugh, will we sing it again	C-G
He’s great craic, he goes like that	C-F-C-G
Puts his hand up if there’s something wrong	F-G-C

This stick has beat me on the head	Am
Workin’ through your songs and words	G
Tryin’ not to be bias	Am
Open to possibility	G
Be guided by just what you’ve said	Am
Hit this stick upon its head	G-Am

Good man Johnny	C
Wait til we show him	F-C
He’ll kill all of us when he hears this song	C-G
Johnny in bad form with me	C-F-C-G
No, I’m only jokin’	F
We’re good friends after all	G-C
It’s about Johnny, tis very excitin’,	C-F-C
A bit of a laugh, will we sing it again	C-G
He’s great craic, he goes like that	C-F-C-G
Puts his hand up if there’s something wrong	F-G-C
Can I take this away, show it to the lads?	F-G-C
**When I play Music**

The idea for *When I play Music* first emerged in discussion between Dreamer, Jack Sparrow, Shady and I. This was written across the second and final focus group sessions. A recording of this song as performed by Dreamer and I can be listened to online at:

https://soundcloud.com/#user687354335/when-i-play-music

<table>
<thead>
<tr>
<th>Lyrics</th>
<th>Chords</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I play music it makes it makes me feel so good</td>
<td>C-F-G</td>
</tr>
<tr>
<td>It lifts me up to where I want to be</td>
<td>C-F-G</td>
</tr>
<tr>
<td>In the clouds like a dream is how I see the world so clear</td>
<td>G-Am-C</td>
</tr>
<tr>
<td>The music that I hear is all so dear to me</td>
<td>C-F-G</td>
</tr>
<tr>
<td>It reminds me of the world that I know best</td>
<td>C-F-G</td>
</tr>
<tr>
<td>My imagination, being all the rest, it makes me feel so good</td>
<td>G-Am-F-C</td>
</tr>
</tbody>
</table>

**Emerging Context**

In the second focus group, Shady, Jack Sparrow and Dreamer said that they wished to continue working with music so they chose to write another song about their experiences in music therapy. Jack Sparrow said that he hadn’t a clue what they should include in this song and Shady wondered if their previous song choice for ‘Wednesday’ had been correct, adding that he didn’t feel that the group were adequately prepared to write a song last week. I asked Shady about what the right song might be and he replied ‘Raglan Road’, an Irish ballad sung by Luke Kelly, which was adopted from a poem by Patrick Kavanagh (1972). Shady identified that he liked this style of ballad which was quite different to that of the ‘Wednesday’ song. I then sang the first verse of ‘On Raglan Road’ (Kavanagh, 1972) with guitar accompaniment to the group and afterwards Shady pondered about whether the song would be effective if we were to put some new words to it. After asking the group about ideas for lyrics, Dreamer replied “dreamers or something like that”. At this point Jack Sparrow said that he had to go outside for a while and Shady announced that it was also time for him to finish up meaning that Dreamer and I were left to work on the new song.
Dreamer told me that he had “kind of” already written a song as he took some sheets out of a plastic bag that lay on the floor beside him. He explained that he regularly wrote poetry, adding that songs were a recent development. He handed me the sheets of paper that featured a number of poems including one called ‘Dreamer’s Heart’ which he seemed to be proud of. As these poems weren’t specifically about music therapy, I suggested that we write a new song together about his experiences in sessions which he appeared happy to pursue.

Dreamer spoke about the importance of rhyme and explained that he wanted a “soft song”. He seemed proud of his achievements in poetry and told me that he had written a bunch of poems that were put into books. He talked about his experience of music therapy and informed me that he had been attending sessions for over two and half years, adding that he loves classical music and likes to play songs in sessions. He spoke about his efforts to learn the organ and piano in recent times and shared his wish to acquire more musical knowledge. He told me that he was due to attend a piano lesson immediately after the focus group so we agreed that we would finish ten minutes early so that he could get to his lesson on time. As Dreamer spoke about his enjoyment of being able to play songs on piano, it struck me that he was someone who was keen to nourish his musicality.

After some discussion between Dreamer and I about this song writing project, I began to re-echo some of his comments about his musical experiences back to him and suggested that we could use these as a basis for the song lyrics. Dreamer emphasised the importance of writing one line at a time, just like he would approach his poetry writing. He started to offer lyrics which I jotted down on paper and after completing two lines of lyrics I asked him if he had any ideas of how he wished the song to sound. He said that he had no ideas and seemed slightly anxious as he continued to focus on writing the lyrics. I began to gently finger pick an A minor chord progression on the guitar which seemed to fill a space in an otherwise anxious atmosphere. As we continued to ponder over the lyrics, I wondered about what it must be like
for Dreamer to write a song with someone like me who was unfamiliar to him. My impressions of him were that he was a deep thinker and an individual who required space and time to reflect upon what he was doing. As we progressed, I noticed how the gentle guitar music seemed to lighten the atmosphere.

After completing some more lines of lyrics, Dreamer and I entered into a discussion about musical accompaniment and he explained that he wasn’t too sure of the chords he wished to use. He spoke about music going up and down the stave and made reference to similarities between music and poetry while also sharing his wish for the song to be sang somewhere around the ‘middle C’ note.

The middle C note served a starting point from which the musical style of the song was worked out. Dreamer said that he wished the song to have a mellow mood, cheerful “he supposed” and suggested that I write out the chords so that he could later play them on the piano. After playing a number of different accompaniment styles on guitar, Dreamer said that he preferred one which was slow in tempo. With this decided, we returned our focus to the lyrics working through these on a line by line basis as Dreamer made suggestions about whether the melody should go “up” or “down” the stave in addition to sharing his ideas about the notes he wished to include in the chordal accompaniment. I sang or played each of these musical suggestions back to him so that he could listen to the song as he was creating it and decide whether there were certain facets of this that he wished to change or review. By the end of the second focus group, Dreamer and I had completed the first verse of this song of which I jotted down its lyrics and chords so that I could give them to Dreamer the following week. He seemed pleased with this composition and sang this with me before he left to attend his piano lesson.

Dreamer, Shady and Jack Sparrow were all present at the start of the final focus group. Shortly after commencement Jack Sparrow announced that he had to briefly leave the
room but said that he would return. In the interim I spoke to Dreamer and Shady about the song verse that was written in the previous group. When asked about what they would like to pursue in this final focus group, Shady suggested that we review materials completed so far to which Dreamer agreed, adding that he’d like finish out the song that was started last week and to “listen to some music or something”. As Jack Sparrow returned to the room he enquired about singing the ‘Wednesday’ song and we agreed that this would be sung later on in the focus group. He then sat next to Dreamer and lifted Dreamer’s plastic bag up off the floor while joking that this belonged to him. Dreamer sat quietly during this without speaking and looked closely at Jack Sparrow who then enquired about writing a rap about music therapy.

Given the varied requests in relation to the content of the final focus group we decided to work out a satisfactory plan about what we would pursue for the next hour. It was agreed that this would involve completing the unfinished song, writing a rap and singing ‘Wednesday’. I handed out lyrics of the first verse of the song that Dreamer and I wrote in the previous session. We then listened to a recording of this that was extracted from the overall recording of last week’s overall focus group. After listening to this I asked if anyone would like to add more words to this composition to which Dreamer informed me that he had “kind of wrote another verse”. As he reached to get a copy of these words out of his plastic bag, Jack Sparrow started joking with him once again, insisting that the plastic bag did not belong to Dreamer. This seemed to distract Dreamer momentarily but nonetheless he continued to take a sheet of paper out of his bag and present this to me. Jack Sparrow once again enquired if we could play the ‘Wednesday’ song and Shady said that his hip was “paining” him, thus indicating to me that he needed to leave the room. I assured Jack Sparrow that we would sing ‘Wednesday’ a little later on in the focus group and then thanked Shady for his input over the past few weeks before I wished him farewell as he left the room.
We then returned to focus on Dreamer’s lyrics and I noticed that he had independently written a further three lines of lyrics since the last focus group. Dreamer said that he wished to use the same melody on these lines as that which featured in the first verse. Once again we began to work through the musical accompaniment for each line making slight re-adjustments to the words so that these would fit Dreamer’s chosen melody. During this Jack Sparrow began to vocalise a rap beat and I assured him we would pursue the rap once we had completed the current task at hand. I noticed how Jack Sparrow assumed a passive role in this song writing process despite my efforts to encourage his participation. The ownership of this song seemed to lie with Dreamer who made decisions about its musical content and style. At this time I was acutely aware that I was working with two very different people. I also noticed that Jack Sparrow was looking at me intensely as Dreamer and I conversed about the content of the song.

As the second and final verse of the song was near completion, it was agreed that we needed a few more words to finish off the lyrics. In response to this, Jack Sparrow sang “makes me feel so good”. I acknowledged his lyric contribution and noted how these fitted perfectly with the song’s melody which thus completed this song writing process. Jack Sparrow said that he was happy with the final song and Dreamer initially said nothing but moments after made some utterances that were inaudible on the focus group audio-recording. He seemed hesitant to share his opinion about the final song and I wondered if the last line of this song had just been stolen from him. Noting his reaction, I once again checked with Dreamer to see if there was anything he wished to change about the song but he did not reply. With awareness that there were other tasks to pursue within limited remaining time, I asked both Dreamer and Jack Sparrow to choose a name for their song. Jack Sparrow said that he was unsure about this but after a long pause Dreamer replied, ‘When I play Music’ to
which it was agreed that this would be the song’s title. Upon Dreamer’s suggestion, we all
finished this arts-based process by singing the completed song together.
**Commentary Table**

### Table 6: Commentary Table of *When I play Music*

<table>
<thead>
<tr>
<th>Source</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Multiple participants (Focus group 2) | I haven’t a clue about another song. Have you ‘Shady’?  
I kind of, I wrote a song [takes sheets of paper out of bag]  
[pause] Well it’s very good like you know, it’s great like you know for ahm, it’s great therapy but the music is great expression as well. Ahm… and it kind of builds you, it builds you back up as well you know, so And ahm… you kind of ahm… it’s a great achievement to be able to …. play music like  
Ahm [pause]. Well… I always say, it’s very good if you can find the skills that you’re good at  
[pause] well you kind of have to think of poetry like, kind of writing lines. Well I think most music it kinda goes up and down the stave  
I suppose a mellow  
A kind of mellow one  
Cheerful I suppose.  
[pause] Well you could, you could maybe write the chords then I might be able to play them on the piano. That sounds good yeah.  
Yeah, sounds good yeah.  
Is how I see the …. |

| Multiple participants (Focus group 3) | I kind of wrote another verse  
I kind of write poems in five minutes you know  
I think them up like you know  
‘Imagination’  
‘When I play Music’  
‘When I play Music’  
Will we sing along? |

| My thoughts and impressions | A solo affair  
One line from another  
More about the process  
Achievement  
Bringing in your poem  
Working on it at home  
Does music take you away to somewhere better?  
Dreamer who dreams, thinks, reflects  
Sharing your poetry  
Discussing your musical likes  
Your enjoyment of learning  
Your lesson was next  
Is this music in general or music therapy?  
Is there a distinction  
Softness, gentleness  
A type of escapism, does it take you away from something?  
What do you leave behind?  
A process at home and in the group  
Where do you want to be?  
Above the world, a different view?  
Was the last line stolen? |
Song Response

The song response to *When I play Music* is an original composition that was inspired by the A minor chord progression that is referred to in the emerging context above. This song was written to assume a pensive yet positive tone in order to reflect Dreamer’s sentiments about his experiences of music therapy. Italicized sections of this song response represented my thoughts and impressions of *When I play Music* while other sections feature participant commentary about this song where red font highlights any minor word insertions or omissions made on my behalf. A final recording of this song response can be listened to at:

https://soundcloud.com/#user687354335/song-response-3

<table>
<thead>
<tr>
<th>Lyrics</th>
<th>Chords</th>
</tr>
</thead>
<tbody>
<tr>
<td>I haven’t a clue about another song</td>
<td>Am</td>
</tr>
<tr>
<td>I kind of wrote a song</td>
<td>C#m</td>
</tr>
<tr>
<td>Write poems in …minutes you know</td>
<td>E7</td>
</tr>
<tr>
<td>I kind of wrote a verse</td>
<td>Am</td>
</tr>
<tr>
<td>I kind of …wrote a song</td>
<td>C#m</td>
</tr>
<tr>
<td>I think them up …you know</td>
<td>E7</td>
</tr>
<tr>
<td>Will we sing along</td>
<td></td>
</tr>
<tr>
<td>It’s very good like you know</td>
<td>C- G</td>
</tr>
<tr>
<td>It’s great therapy and great expression as well</td>
<td>Am-G</td>
</tr>
<tr>
<td>It kind of builds you back up… you know</td>
<td>Am-G</td>
</tr>
<tr>
<td>A great achievement to be able to play</td>
<td>D</td>
</tr>
<tr>
<td><em>This was a solo affair</em></td>
<td>C-G</td>
</tr>
<tr>
<td><em>When you brought in your poem</em></td>
<td>Am-Em</td>
</tr>
<tr>
<td><em>You worked from line to line</em></td>
<td>C-G</td>
</tr>
<tr>
<td><em>Even took it back home</em></td>
<td>Am-Em</td>
</tr>
<tr>
<td><em>But I wonder if its music or music therapy?</em></td>
<td>Dm- slide</td>
</tr>
<tr>
<td><em>Is there really a distinction for you?</em></td>
<td>Dm- E7/m</td>
</tr>
<tr>
<td><em>Something</em> mellow, a kind of mellow song</td>
<td>Am</td>
</tr>
<tr>
<td>Cheerful I suppose</td>
<td></td>
</tr>
<tr>
<td><em>Music that</em> moves up and down the stave</td>
<td>C#m</td>
</tr>
<tr>
<td>Maybe write the chords,… I might … play them too</td>
<td>Em7</td>
</tr>
<tr>
<td>It’s … good if you can find</td>
<td>Am</td>
</tr>
<tr>
<td>The skills that you’re good at</td>
<td>C#m</td>
</tr>
<tr>
<td>Will we sing along</td>
<td>Em7</td>
</tr>
<tr>
<td>When I play music?</td>
<td></td>
</tr>
</tbody>
</table>
It’s very good like you know
It’s great therapy and great expression as well
It kind of builds you back up… you know
A great achievement to be able to play

Does music take you somewhere, far away from here?
What do you leave behind?
What do you find when you’re there?
Your skills and your achievements mean so much to you
Think this was most about the process of writing songs for you
But the last line was stolen, is it others you escape?
Does music bring you to a place where you’re in control?

**Music Therapy Rap**

_Music Therapy Rap_ was written in the final focus group by Dreamer and Jack Sparrow. A recording of this song as performed by participants and I can be listened to online at: [https://soundcloud.com/#user687354335/music-therapy-rap-1](https://soundcloud.com/#user687354335/music-therapy-rap-1)

**Lyrics**

I met Johnny on a Wednesday for music therapy
I met Dreamer for a fag, I met Tríona after tea
I listened to the Eagles and I played the guitar
It really made my day up, it really made my day up

I listened to the hotel Cal-iforn-i-ay
I sang along with it and I played the drum
It have me a buzz, it cheered me up
I sang along with it to all of the words
It’s the best kind of therapy singing along
I say to other people go and come along

**Emerging Context**

Before leaving the second focus group, Jack Sparrow referred to the rap artist ‘Eminem’ and shared his wish to write a rap song about music therapy. He once again referred to this wish at the start of the third and final focus group in which it was agreed that a rap would be written. As there was a variety of items on the agenda for that day, it was decided that the rap would be pursued later on in the focus group. However, Jack Sparrow seemed keen to start writing this rap as he began to vocalise a rhythmic beat and rapped
some words that referred to “Wednesday” and “meetin’ Dreamer for a fag” while another song was being written. Jack Sparrow then asked Dreamer and I if his brief rap had been “alright”, and afterwards laughed at what he had just done. I assured him that we would write a rap as soon as the other song was finished and encouraged him to focus on the task at hand in the interim.

As we turned our focus to writing the rap, Jack Sparrow asked for a biro which I handed to him unsure of whether or not he wished to use this to jot down the rap lyrics. Dreamer said that he could only write standard poetry and that he wouldn’t be good at composing rap songs. I tried to assure him by saying that I had never written a rap before either and added that there is always a first time for everything.

I enquired with Jack Sparrow and Dreamer about the content of the rap. Jack Sparrow told me that it would be about music and Johnny, Dreamer and I. Once again he vocalised a rhythmic beat to which I responded to playing a djembe drum with a matching rhythm and tempo. Given my background as a music therapist, this felt like a very natural type of interaction to me as I was aware of the ease and fluency with which I could support Jack Sparrow’s musical contributions. I continuously played this rhythmic beat on the djembe throughout the rap writing process so as to provide a grounding rhythm that could serve as a backdrop to Jack Sparrow’s and Dreamer’s lyric contributions.

Jack Sparrow became quite animated during this process and rapped about “meeting Johnny on a Wednesday”. I responded to these lyric contributions by repeating back words to him in order to confirm what he had rapped. This marked a ‘call and response’ type of exchange between myself and Jack Sparrow who momentarily paused to check what my name was, before resuming to rap an additional lyric contribution that concerned “going for a fag” (a cigarette) with Dreamer and I. In an effort to encourage both participants focus upon their experiences of music therapy, I asked them about the things they do in music therapy.
Jack Sparrow responded by rapping that he listened to ‘The Eagles’ and he played the guitar, adding that this “really puts my day down”. I encouraged Dreamer to join in by asking him if there was anything he would like to include into this rap to which he seemed amused after which Jack Sparrow rapped “Johnny roarin’ and shoutin’ at me”. At this point, I recalled all of the lyrics that had so far been composed but later noticed from the audio-recording of the focus group that I hadn’t included Jack Sparrow’s line about “Johnny roarin’ and shoutin’”. This made me wonder if these lyrics had been a cause of anxiety to me as they concerned Johnny as the music therapist who works at this centre where these focus groups were held. Jack Sparrow did not comment on my omission and instead began to rap about having a game of pool with another individual at the centre. I enquired with him about what putting ones “day down” meant and he told me that this meant that this was him having a good day. In response to this, I queried if “day down” should be “day up” to which Jack Sparrow agreed. Dreamer reminded me of the start of the rap as I once again recalled the completed lyrics. I suggested that we change one of Jack Sparrow’s lines in the rap for factual reasons because this referred to me smoking when I am not a smoker. After this amendment was made, I wondered about all of Jack Sparrow’s lyric contributions to date and whether these were inspired by fact or imagination.

Jack Sparrow rapped about a particular staff member called Julie (pseudonym) who gave out to him. Committed to the topic of focus remaining on music therapy, I asked him if this event was related to his experiences in music therapy sessions to which he said that it wasn’t so we agreed to omit these lyrics. As Jack Sparrow said that he didn’t have any more ideas for lyrics and Dreamer appeared tired, I decided to use some prompting techniques in order to help them complete the rap. I asked about their favourite songs in music therapy to which Jack Sparrow replied ‘Hotel California’ by ‘The Eagles’ (Felder, Henley & Frey, 1976). After rapping a line back about Jack Sparrow’s song choice I decided to write down
all the rap lyrics as by now they had become too difficult to recall. Dreamer commented
twice that ‘Hotel California’ (Felder et al., 1976) was a really good song and Jack Sparrow
said that he sometimes sang this Eagle’s number in music therapy sessions. Jack Sparrow
also said that this song gave him “a buzz” and Dreamer said that it “cheers” him up. All the
while I noted these ideas so that the lyrics could be further developed. Jack Sparrow yawned
loudly as the time in the focus group drew to a close at which point Dreamer assumed a
leading role in completion of the rap lyrics. I asked them both if there was an overall
message that they would like to include in the final rap. Dreamer said that he would like to
encourage people to give music therapy a chance and added how it was great for the likes of
himself, given his interest in music and song writing. He then complimented Jack Sparrow for
his rap-writing abilities to which Jack Sparrow seemed pleased. The final focus group
concluded with each of us rapping the ‘Music Therapy Rap’ to which I played the djembe and
Dreamer played the tambourine.
### Table 7: Commentary Table of Music Therapy Rap

<table>
<thead>
<tr>
<th>Source</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack Sparrow (Focus group 2)</td>
<td>Will we do a rap song next week, a rap song That’s a good idea I’d say now, I’d love that. Eminem, do you like Eminem?</td>
</tr>
<tr>
<td>Multiple participants (Focus group 3)</td>
<td>Could we do a rap song today, no? Ah… I go to… What’s your name? Is that alright? [laughs] About music and Johnny Yeah. About yourself and you [sounds a rap beat] What’s your name? [giggles] I haven’t got a clue what to write about Really good It really put my day down, really put my day down, it really put my day My day down Johnny roarin’ and shoutin’ at me Then I got a game of pool with [name] A good day like Yeah, we smoke cigarettes, yeah Julie gave out to me this mornin’ Yeah [inaudible on recording] I can’t think of anything else It’s a good song Smokin’ a fag [laughs] It gives me an aul buzz you know Just with a song like you know Give it a go, it’s good like you know You know, it’s great for, for the likes of myself it’s great like you know I’m really interested in the music you know Yeah, and writing a song Jack Sparrow is good at writing rap songs I’ll take that [takes tambourine] The rhythm… you know Yeah it’s the first rap song I wrote now I’m not too sure of how the rhythm goes of the words or</td>
</tr>
<tr>
<td>My thoughts and impressions</td>
<td>Is this more about the process of creation rather than what the creation is about? An idea that was sparked a week earlier Some played some didn’t in the end Noticing other people’s abilities Being ‘cool’ Including others in the song- what’s your name? Including other topics, a fellow service user, a nurse We can do it Sense of achievement Are you ‘given out’ to a lot? What is a buzz? Importance of being able to participate What is the likes of yourself? Our first time to write a rap</td>
</tr>
</tbody>
</table>
**Song Response**

The song response to *Music Therapy Rap* was written in a theatrical style and was inspired by an artist by the name of ‘Duke Special’. This song composition assumes a style that was chosen to reflect the cool and playful manner in which the original rap was written. Similar to each of the other song responses, italicized font represents my ideas about *Music Therapy Rap* while the other sections include participant comments where minor word insertions or omissions are highlighted in red font. A final recording of this original song composition can be listened to at: [https://soundcloud.com/#user687354335/song-response-4](https://soundcloud.com/#user687354335/song-response-4)

<table>
<thead>
<tr>
<th>Lyrics</th>
<th>Chords</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will we do a rap song, <strong>yes</strong> a rap song</td>
<td>Am</td>
</tr>
<tr>
<td>That’s a good idea, I’d say now</td>
<td>E7</td>
</tr>
<tr>
<td>Do you like Eminem?</td>
<td>C#min</td>
</tr>
<tr>
<td><strong>Let’s</strong> do a rap song today?</td>
<td>E7-Am</td>
</tr>
<tr>
<td><strong>It’s</strong> about music, <strong>it’s about</strong> Johnny</td>
<td>Am</td>
</tr>
<tr>
<td><strong>It’s</strong> about yourself and you <strong>too</strong></td>
<td>E7</td>
</tr>
<tr>
<td>Will we do a rap song</td>
<td>C#min</td>
</tr>
<tr>
<td><strong>But</strong> I haven’t got a clue what to write</td>
<td>E7-Am</td>
</tr>
<tr>
<td><strong>What’s this about</strong> Johnny roarin’ and shoutin’ at you?</td>
<td>E7</td>
</tr>
<tr>
<td>You say Julie gave out this mornin’ too</td>
<td>Am</td>
</tr>
<tr>
<td>Do people be upon your case, disruptin’ your groove?</td>
<td>D7</td>
</tr>
<tr>
<td><strong>Is this song more ‘bout</strong> attitude and playing it cool?</td>
<td>G-G7</td>
</tr>
<tr>
<td>It really put my day down, put my day down</td>
<td>Am</td>
</tr>
<tr>
<td>It’s a good day like, <strong>we’re</strong> smokin’ a fag</td>
<td>E7</td>
</tr>
<tr>
<td>It’s a good song</td>
<td>C#min</td>
</tr>
<tr>
<td><strong>Music</strong> gives me an aul buzz you know</td>
<td>E7-Am</td>
</tr>
<tr>
<td>You know it’s great for, for the likes of myself</td>
<td>Am</td>
</tr>
<tr>
<td>It’s great like you know, yeah and writing a song</td>
<td>E7</td>
</tr>
<tr>
<td>Interested in music</td>
<td>C#min</td>
</tr>
<tr>
<td><strong>This is</strong> the first rap song I wrote</td>
<td>E7-Am</td>
</tr>
<tr>
<td><strong>Can you elaborate, who is the likes of yourself?</strong></td>
<td>E7</td>
</tr>
<tr>
<td><strong>What is it that music does compared to anything else?</strong></td>
<td>Am</td>
</tr>
<tr>
<td><strong>Is it the taking part, the playing, singing the songs?</strong></td>
<td>D7</td>
</tr>
<tr>
<td><strong>How do I pass these findings on?</strong></td>
<td>G-G7</td>
</tr>
</tbody>
</table>
Will we do a rap song, yes a rap song  
That’s a good idea, I’d say now  
Do you like Eminem?  
Let’s do a rap song today?  

Do you like Eminem?  
Let’s do a rap song today?  

Summary

A visual image and three songs were created in a series of three arts-based focus groups in which participants described their experiences of participating in music therapy in a mental health service. The process of creating these works, and the resultant materials were reflected upon through a reflexive process that involved describing and reflecting on the context in which the material emerged, the participant commentary that surrounded the production of these materials and my own thoughts and observations about this creative process. The content of each of the song responses will be given further critical consideration in the discussion (Chapter 8).
Chapter 8

Discussion

The experiences of nine people who have attended music therapy sessions in health services as part of their participation in mental health treatment were examined through interviews, arts-based focus groups, and arts-based reflections of the researcher. Service users were given the opportunity to provide reflection and evaluation about their views and thoughts regarding participation in music therapy. The analysis and results are intended to inform practice and practitioners in the local, national, and international music therapy and mental health communities about how service users experience programmes in which they participate. Individual interviews and arts-based focus groups were used to provide accessible means for service users to evaluate music therapy.

Six participants attended one or more interviews, and three service users participated in three arts-based focus groups. Acknowledging that recovery in mental health considers that each individual undertakes a unique and personal journey towards recovery, a review is presented of the individual interview findings in which each participant’s unique descriptions of music therapy are presented. The general themes emerging from participants’ experiences are then presented with reference to existing accounts of music therapy in the literature. A review of the findings from the arts-based phase of this research is provided which features interpretation of participants’ arts-based materials via further arts creations, in addition to observations about the process. The chapter concludes with consideration of the contributions and limitations of the methods used to gain further understanding of service user experience of music therapy.
Interview Contributions

Luke, Ollie, Pauline and Barbaraella participated in two interviews while Carma and Laura participated in one interview. Two separate music therapists’ practices were described. Luke focussed on his experience of attending individual sessions with one therapist other than the therapist who provided music therapy via an open group to the other five service users involved in this part of the study. Reflection on these individual descriptions of music therapy highlighted not only their similarities but also the idiosyncratic nature of each account in relation to the other. Honouring the individual and personal nature of lived experience provided a way to acknowledge that those who had attended music therapy sessions were not simply “minds or brains” that attach meaning to a neutral world of process (Todres et al., 2007, p. 55). Rather, they are experts by experience who can offer a deeper and more nuanced understanding of their participation. This can further the relationship between personal experience and the life-world in music therapy practice. Furthermore, representing the individual voices in this research resonates with the ethos of recovery in mental health, recognising that each person follows their own unique recovery journey. The journey towards wellness is always personal and individual. This does not dismiss the possibility that horizons may be shared along the journey of music therapy but instead recognises that the qualitative moments shared and evaluated by service users in this research are locally and contextually bound (Stige, 1999; Todres et al., 2007). The following section presents a series of interview summaries that outline the distinctive features of the six service user contributions made in the context of this research. Where appropriate, these features have been considered in relation to other descriptions of music therapy found within the literature.

Luke

Luke identified as a performing musician. At the time of commencing music therapy he had lost connection with this part of his personhood, explaining how prolonged treatment
after physical trauma had “robbed” him of important things in his life such as his role as a band member but also his right to make decisions and choices for himself. He attended music therapy because he wished to reconnect with music once again despite the many unknowns and uncertainties that the word therapy elicited within him.

The rigid and depersonalised culture of previous healthcare services viewed Luke through a disabled lens which caused him to doubt his own abilities. By contrast in the music therapy environment choice, direction and leadership were encouraged by his therapist, similar to that recounted by other services users (Stige, 2012). Luke appreciated health professionals who were “being themselves”. He valued genuineness in others. This resonates with approaches in psychotherapy where the authenticity of the therapist is esteemed (Rogers, 1967/2004), and with references in the music therapy literature to the authenticity and presence of the music therapist (Rolvsjord, 2010), where the therapist is “a warm and empathic partner, trying to understand and meet the client as an equal” (Stige, 1999, p. 61). This genuineness of the practitioner is also a central tenet of cultural-relational theory (Baker Miller et al., 2004). The authenticity of the music therapist positively influenced Luke’s ability to be at ease and feel comfortable in sessions.

Luke was someone who noticed “being drawn” to an instrument before playing it. His instrument choice was variable from session to session, with decisions based upon his emotional state or the way in which he decided to deal with a particular issue. The complexity involved in service user choices of instruments in music therapy has received scant attention in training and practice literature to date. Luke’s experiences highlight the importance of catering to such complexity by offering a broad rather than narrow selection of musical instruments within sessions for some service users.
Luke could “feed off” the music therapist’s playing during improvisation. The dynamic and reciprocal nature of playing music with his music therapist and the nurturing role of the music therapist were important to him. The psychodynamic music therapy literature has likened such interactions to a way that people behave in music which can be closely linked to their parent infant experiences. However, in the context of adult mental health the risk of patronising and potentially infantalising overtones need to be navigated. Nonetheless the powerful image of Luke feeding from the therapist is striking.

Luke was sometimes “absent minded” while playing music which resonates with Edwin’s descriptions of participating in music therapy in the mental health services in UK. He said “when I’m playing music, the brain just goes completely blank” (Ansdell & Meehan, 2010, p. 36). Music participation in these descriptions is revealed as having the potential to promote interpersonal communication and to switch off one’s negative or preoccupying thoughts and be completely immersed in an interpersonal sound world. Luke’s descriptions validate improvisation as a type of “human communication in sound” (Pavlicevic, 2000, p. 275).

The overall positive experience offered in music therapy sessions sets Luke in good stead for the rest of his week. Music therapy may therefore have far reaching impact than those factors occurring within sessions. A study of these aspects of potential benefits in music therapy has been recommended for future research (McCaffrey et al., 2011). Despite the positive descriptions of his personal experiences of music therapy, Luke experienced disappointment because of the forthcoming termination of his music therapy programme due to circumstances beyond his control or that of his therapist. He participated in this research in the hope of benefitting other service users of music therapy, and to advocate for the avoidance of such terminations in future. Luke’s participation in this research serves as a reminder of how such involvement may be grounded within a willingness to benefit others.
Ollie

Ollie was unprepared for music making when commencing music therapy. He was not “in a good enough place” for music due to his low mood and mental state. He associated enjoyment of or participation in music with wellness, a state of being that he felt far removed from when first attending music therapy. This sense of unpreparedness caused Ollie to feel guilty about engaging in music because to him it was a source of pleasure of which he felt undeserving. Ramona also wondered if she was deserving of her place in music therapy (Stige, 2012). Ollie attributed his guilt to having a hard time in life. Music therapy in some way disrupted Ollie’s music narrative as it presented music to him at an unexpected time in his life when he was trying to overcome mental illness.

Ollie was surprised upon hearing “good sounds” as he played music with others in his first session. This highlighted the newness and wonder that can be involved in playing music with others. Group improvisation offered Ollie a new way of experiencing himself among others where musical expression offered him “sort of a voice” that could be heard and witnessed by others in a social setting. Aigen (1991) has previously described music as a natural voice of the human spirit.

Ollie’s appreciation for the gentle approach engendered in music therapy was evident through his demeanour as he recounted such amiable experiences within the interviews. Ollie, as a person who has high expectations of himself, appreciated the supportive and encouraging environment within music therapy where there are no demands were placed upon him. In this welcomed absence of expectancy, Ollie enjoyed improvisation where musical skill was not a prerequisite, but also appreciated his freedom to stay or leave the session as he so wished. I noticed Ollie’s increased verbal fluency whenever he recounted the non-pressurized environment of music therapy. A separate yet perhaps related aspect in creating such an environment was due to the manageable level of analysis that Ollie experienced in sessions.
Initially he thought that music therapy would be “very deep” in terms of talking about his feelings but this was not what he encountered. Ollie was reluctant to engage in a form of therapy where verbal analysis featured. Music therapy’s suitability as a mental health intervention for those who have low motivation for other therapies such as psychotherapy has been proposed (Gold et al., 2005). Results from an RCT have shown that individual music therapy is an effective addition for mental health service users with such low motivation (Gold, Mössler, et al., 2013). Perhaps this is because in terms of expression “music makes it less scary” (Rolvsjord, 2010, p. 158) as possibly reflected in high attendance rates of participants in previous music therapy studies (Grocke et al., 2009).

Ollie was reminded that through improvising with others he could make a contribution in life. Suddenly realising how playing and hearing the sound of his instrument among that of others made him feel valued and connected within the world was a moving recollection for him, and touching for me to hear. This is similar to other service user accounts of music therapy in which Emma used song to acknowledge that she had something to contribute to others (Rolvsjord, 2010).

Music therapy helped Ollie reconnect with his previous relationship with music. Having “stepped back” from music during his illness, he was amused at how the “spark” to play guitar once again was reignited in his first session. This rekindling of a relationship with music in such a short space of time was to Ollie, “the best compliment” he could give music therapy. Ansdell and Meehan (2010, p.32) defined the “music-health-illness narrative” as one in which music is mobilised as a health-promoting resource for people in times of illness or difficulty. It relays how Ollie’s past relationship to music as a health resource was lost due to illness but then recovered through music therapy so that music could once again play a helpful role in his life. For Ollie this meant making plans to resume guitar lessons in future. This exemplifies a central process of recovery in mental health that relates to having hope.
and optimism about the future (Leamy et al., 2011). Ollie’s wish to pursue guitar lessons not only indicates that he is thinking about his future but also that he is looking forward to continuing his relationship with music in a way that will extend beyond the parameters of the music therapy room.

Ollie’s music therapy sessions had reached a conclusion as he was no longer an inpatient at the hospital in which sessions were provided. This was the second time Ollie found out that there was no follow up music therapy available to him once discharged from hospital. To him this was “a pity”, particularly when many other services provided in the hospital are also available in the community. This created a political incentive to make his voice heard in this research. His dissatisfaction with discontinuity of music therapy provision in the community raises an important issue related to the service development of music therapy in mental health especially when so many service users will spend more time in the community than in hospital based care, yet funding models favour intensive therapies during inpatient stays.

**Pauline**

Music and music therapy were inseparable for Pauline. Her experiences of sessions blended into other music related events and interactions of her life. When Pauline talked about music therapy this could trigger personal and sometimes painful musical memories relating to family and friends. Pauline related genres of music and instruments in music therapy to various people and this prompted considerable reminiscence about her life. All of these experiences of music, both within and outside of sessions, blended together, thus suggestive of the idea that music therapy may represent an extension of past relationships and events involving music experience rather than being set aside as a therapy that is distinctively different to other experiences with music. Pauline’s perspective also highlights the polysemic nature of music; as an entity that contains many possible layers of meaning (Stige, 1999).
Pauline was proud of her and others’ musical knowledge and skill. This indicated the value and importance of music in her life while also highlighting the importance she placed upon receiving musical instruction in order to develop her music skills. However, within the music therapy environment Pauline also experienced a sense of frustration because she received little musical direction. This impacted how she perceived others’ musical contributions that were less aesthetically pleasing to her. This highlights how the aesthetic expectations of service users of music therapy may influence one’s satisfaction during sessions when experimental improvisation methods are used, or when songs are sung by individuals or by the group.

The beginning stages of improvisation in group music therapy were distinctive for Pauline. This may commence with one person playing a note from which other’s followed. Yet, in her view there is something of a working out process during this time where group members explore a way to play with each other until they arrive at perhaps an unknown destination in music where some sense of consensus is achieved. In relation to improvisation, Pauline has a strong perception of rhythm and has a preference to play percussive instruments in order to “feel the beat” which can cause her to feel calm and “think clearly”. It is possible that rhythm’s “discernible temporal distribution and organization of events” (Thaut, 2005, p. 5) offered her a form of auditory scaffolding around which thoughts are organised in space and time (LaGasse & Thaut, 2012).

Pauline’s first music therapy session was “glorious”. This was because it was possible for her to leave her identity as someone who is mentally unwell outside of the music therapy room. When playing the piano within this first session the “stigma came off her” and this musical participation offered her a space in which her illness did not feature. If normal is “connected to how well one fits within a particular setting”, then Pauline’s feeling of being normal when going to music therapy indicates that she can relate to this environment and
perhaps feel accepted within it (DeNora, 2013, p. 45). Feeling normal has also been attributed to the notion of feeling valued in the world (Glyde, 2014). This freedom from illness in music therapy is a theme that has been reported by service users in other studies that have considered consumer perspectives in mental health (Ansdell & Meehan, 2010; Clemencic-Jones, 1999; Solli, 2014; Solli & Rolvsjord, 2014). These highlight how music therapy can offer service users experiences that extend beyond those that are bound within the notion of illness. Such meaningful activity plays a central role in encouraging one’s journey towards recovery (Davidson, 2003).

Hope played an important role in Pauline’s life. This was apparent when playing music in sessions but also in her wish to return to independent living within the community. For Pauline, playing music with others in music therapy offered her a buffer against the hopelessness that she sometimes perceived of her life situation. In improvisation she hoped that “something good might come out of it” such as “a lovely piece of music”. This concept of musical hope has also been described by other mental health service users through the experience of play in music therapy (Ansdell, 2014). Deegan (1988) has described hope as a cornerstone of recovery as it promises that there can be something more other than the darkness that one perceives of their situation.

Barbaraella

Barbaraella’s ability in music therapy was distinctive and positive. It contrasted to a disabling self-image outside of sessions. She experienced achievement and success when playing instruments because musical skill was not required. The freedom and accomplishment gained within this process seemed to “redefine and reframe” the limiting lens from which she viewed herself in circumstances beyond music therapy (DeNora, 2013, p. 45). A more nuanced interpretation of this process of play has been termed as musicking, defined as a place where common artistic and human values are shared (Small, 1998).
process of play or, musicking, was a type of drug for Barbaraella that gave her a chance to “get out there and do my thing” every week, similar to other service users who have described music as a medicine or “legal dope” (Stige, 1999, p.77).

Barbaraella is experiencing herself getting older and has become a member of an older person’s group. When she is feeling well she is someone who is “young at heart”.

Various musical processes, genres and experiences connect Barbaraella with her youthfulness and perhaps remind her of younger days in her life when well-being prevailed. Barbaraella used music to experience herself differently in a way that reoriented her to wellness. Ansdell (2014) suggested that the altering of identity in music is made possible because within music making the boundaries of the physical and psychological self are less defined. Therefore music allows for a type of transcendence that is without risk, where “the extraordinary is prepared and controlled through the ordinary” (Ansdell, 2014, p. 271).

Like Pauline’s experiences of “feeling the beat” as she played the drum in music therapy, Barbaraella also revelled in the characteristics of rhythmic play. Yet unlike Pauline who found that this offered mental clarity, Barbaraella loved the physical sense of connecting with the beat; the beat is something that she “needed” in play. During her younger days as a dancer when she was well perhaps the musical beat was an important way that she kept on track in dance.

A type of fusion ran through Barbaraella’s hands when she played a percussive instrument. This was something “powerful” to her. This offered Barbaraella a form of rhythmic grounding provided not only through the process of listening, but also through repetitive physical contact with the instrument. She “needed” the self-sufficiency she could demonstrate in generating the beat in the group.
Barbaraella’s self-directed action achieved health promotion goals in using music as a “driver of mood”. Using music to alter her emotional state was important for Barbaraella because she was in a setting where “people suffer from mood disorders”. She preferred to be in a “good mood” so that she could enjoy music therapy but if feeling frustrated she could “bang on the drums” in sessions. This indicates how Barbaraella used music for the purposes of mood regulation as discussed by Garrido, Davidson & Odell-Miller (2013). Each of the examples relating to rhythmic grounding and the altering of emotional state support Gibson’s notion of affordances as described by Stige (2002). This has been discussed in the music therapy literature to describe how the musical environment can offer the individual what it provides in ways that can promote wellbeing.

**Carma**

Carma’s experiences in music therapy particularly emphasise the idea of sound. Her initial experiences within her first session were “daunting” due to the sound of drumming and so much noise. Such a choice of word indicates that all instrument sounds are not experienced as music within sessions. Other service users have also used the word noise to describe what they have heard in music therapy (Carr et al., 2011; Stige, 2012). Carma’s daunting experience of drumming illustrates how its sound presence was palpable and even perhaps imposing during her earliest experiences of improvisation in sessions. Similarities can be found with descriptions of drumming within the literature which suggest that this form of musical play has the capacity to create a sense of unease among some service users (Carr et al., 2011; Hammel-Gormley, 1995). Hammel-Gormley (1995) recounted how one service user thought that she was playing “evil words” on the drums in music therapy (p. 185). Although the musical characteristics of drumming in this literature were not detailed, it is possible that the strength and audibility of the sound from these instruments might influence how such a stimulus is received by its listeners. Carma explained that when unwell she
experienced sensitivity to noise. As she became more acquainted with improvisation in music she learnt to cope with this sensitivity by being able to disregard certain sounds. This was a way of overcoming her earlier daunting experiences of hearing the drums and indicates that over time she was able to control her perception of sound in sessions.

Carma recommended music therapy for children due to her early child-like experiences of improvising in a manner similar to a group of children playing pots and pans in a kitchen. These perhaps required liberation from the type of adult interactions with which she was most familiar. This indicated that improvisation has the capacity to evoke not only play in a musical sense but also as a type of interaction that, in developmental terms, is viewed as a power site for learning social skills, communication, regulation of emotion and behaviour and the understanding of another’s point of view (Schaffer, 2004). Carma found a sense of enjoyment within such musical exchange which brought her to the conclusion that music therapy would be a worthwhile pursuit for children.

Laura

Although one of the shorter interview discussions in this research, Laura’s experiences of music therapy stood apart from those of other service users in terms of the way in which she visually engaged with instruments in sessions. In music therapy, particular instruments resemble objects that she has encountered in her past. She took note of considerable detail about the physical appearance of instruments including their size and colour. This suggested that the physical environment of music therapy and objects featured within were for Laura a source of visual stimulation. Laura’s research contribution turns attention away from primarily focussing upon the sound world in music therapy towards inquiry into the visual environment as it is experienced by service users.
Summary of Unique Contributions

Each of the six summaries above feature both personal and distinctive descriptions of music therapy as contributed by Luke, Ollie, Pauline, Barbaraella, Carma and Laura. These portray idiosyncratic accounts of music therapy in the context of this research. Some features of these accounts are unfamiliar to existing descriptions of service user experience in music therapy in mental health. However, other themes that arose within the interviews complement previous descriptions of music therapy as offered by the service user community. Thus, the interview findings both augment and enhance existing knowledge of service user experience of music therapy in mental health.

Overall Interview Themes

Eight super-ordinate themes were revealed through analyses of ten semi-structured interviews with six participants who described their experiences of individual or group music therapy in mental health. These included; ‘The music therapy context makes a difference’; ‘Music therapy brings challenge’; ‘Music therapy makes a positive impact’; ‘Group music therapy fosters contribution’; ‘Music therapy is person-centred’; ‘Music therapy creates a sensory world’; ‘Music is bound in meaning’; and ‘Frustrations and tensions can occur in music therapy’.

The Music Therapy Context makes a Difference

All service users, to varying degrees, described the circumstances in which they commenced music therapy. They shared the need for occupation or for having “something to do”, as also noted by Carr et al. (2011). Music therapy served as a way of filling this void, particularly for those who were hospitalised and who found themselves spending long periods on the ward where a sense of time can drag and there might be few other ways to be kept occupied. Upon commencement of sessions, it would seem that the prevailing view of music
therapy was that it offers a form of occupation and activity. The starting premise for music therapy among some service users was that it offered a form of occupation that differs from that of music therapists who facilitate sessions on the basis of providing a form of psychological therapy. Music therapists can sometimes feel stung or overlooked when their expertise in leading groups is diminished by referring to it as a form of recreational activity. However, the motivations for participation by service users may come from this premise. The service users involved in this study also described how encouragement from others such as their doctor, occupational therapist or family member, motivated them to attend their first session which was regarded as an innocuous endeavour.

A number of service users shared details about their mental, emotional and physical state when beginning their first session. These revealed the severe impact of mental illness upon their life which highlighted the taxing starting point from which music therapy might begin. These descriptions served to increase appreciation for the magnitude of an endeavour that can be involved in commencing therapy at a time when illness prevails. This recalls Emma’s experience of daring to make music “irrespective of whether I’m having a hard day or a good day” (Rolvsjord, 2010, p. 165).

**Music Therapy brings Challenge**

Challenge in music therapy was revealed at three different levels. These related to the unknowns about its role and process, the impact of the past upon one’s musical engagement and the interpersonal challenges that can arise in sessions. Challenge can be aroused among service users in advance of commencing music therapy as they try to comprehend the requirements of participation and the processes that might be involved in sessions. Such efforts to _make sense_ of music therapy in advance of commencement can be made in comparison to other _activities_ that are offered at the facility such as cookery and art. This sense making process can induce an array of emotions including doubt and scepticism.
Therefore, the first steps in commencing music therapy can be approached with much ambivalence.

Another aspect of challenge in music therapy was found in relation to service users’ previous engagement with music. The way in which musical processes are approached from the perspective of the service user can be heavily influenced by previous musical encounters. The interviews unveiled how past experiences of performance, learning and enjoyment in music can impact upon engagement in and acceptance of musical processes in music therapy. This was particularly relevant to the process of improvisation that requires service users to accept a new music, usually characterised by spontaneity, flexibility and an absence of defined structure which can be quite different to preceding traditional musical experiences. This is an issue that has previously been discussed by Hibben (1999) who considered service user accounts of music therapy and found that initial struggle in improvisation was common. These remind me of past experiences of practicing music therapy in mental health during which I encountered similar reactions when first introducing improvisation in sessions with many service users initially sharing their reluctance to play unfamiliar instruments and engage in unchartered musical territory. One service user previously reasoned such reluctance by saying “it took time before I felt safe” (Hibben, 1999, p. 4). The findings from this research show that the meeting of past musical experiences with those encountered in music therapy can create challenge for service users. Time is required for integration of old and new musical experiences in order to adjust to the music therapy process.

A final facet of challenge was described by service users in relation to interpersonal issues that can occur within group music therapy. Some relayed how restlessness among fellow group participants can be off-putting and distracting during the session. Others recounted how it was necessary to be tolerant of others, particularly in instances when group members made musical contributions that fell short of the listener’s expected standard of
musical skill. Like any other group process where individual values and beliefs are played out, the experience of such interpersonal relating is also be found in music therapy. However, although much has been written about relating between therapist and service user in mental health and the demands of functioning within a group context has been acknowledged (Jampel, 2006), little has been documented about how service users’ experience each other within group sessions.

The theme of challenge among service users in music therapy is one that has been considerably overlooked in the literature and little is known about the obstacles faced from the point of view of those who attend sessions. These findings provide a tentative start from which this topic might be further explored so that music therapists who practice in mental health can consider further supports that may be required to sustain and promote involvement in music therapy.

**Music Therapy makes a Positive Impact**

A resounding characteristic of all interviews was how music therapy’s impact upon service users was positively described. Each service user relayed the personal benefits of music therapy in various ways. Some related these to their overall experience of the music therapy, others specifically spoke about the benefits of participation within a musical process, while others focused upon the rewards that were garnered from the music creations as a result of improvisation.

Overall descriptions of music therapy portrayed it be “positive”, “helpful”, “de-stressing and tension relieving”, and something that can be adapted to one’s own worries. These resonate with previous first-hand accounts of music therapy as presented in the literature (Ahessy, 2013; Ansdell & Meehan, 2010; Baines, 2003; Baines & Danko, 2010; Carr et al., 2011; Clemencic-Jones, 1999; Dye, 1994; Grocke et al., 2009; Hammel-Gormley,
1995; Heaney, 1992; Hibben, 1999; Jampel, 2006; Silverman, 2006, 2010; Solli, 2014; Solli & Rolvsjord, 2014; Stige, 1999, 2012; Thaut, 1989; Tyson, 1981). Yet, however positive these overall descriptions are, they tell us little about how particular aspects of the music therapy process can aid the individual. A possible reason for this was offered by Carma who noted how music therapy’s assistive nature can almost go unknown to her. This is similar to experiences of other service users who have described how they missed music therapy despite not fully appreciating or figuring out its true benefits (Hibben, 1999). This phenomenon might partially be explained by two theories that consider “salient properties of music in something other than its aesthetic or cultural value” (Aigen, 2014, p. 182). These theories have frequently appeared alongside each other in the developmental literature. The first is that of communicative musicality that theorises the intrinsic musical nature of human interaction first played out within the parent-infant dyad (Malloch & Trevarthen, 2010). Related to this concept is the notion that such innate musicality attunes people for human forms of vitality associated with good feelings, where there is a link between one’s inner experiences and expressions in music (Stern, 2010). It would therefore seem plausible that efforts made to reason the mechanism and cause for such ‘good feelings’ from music may not be readily definable due to the intuitive processes that they arouse within the human condition. An interesting feature of this study’s findings was that service users still reported music therapy’s overall positive impact despite meeting challenges within its associated processes.

As improvisation was a primary method used within the music therapy practices described, many service users focussed upon their positive experience of playing instruments within sessions. Some commented that improvising with others was: “enjoyable”; “fantastic”; “great”. These are similar to earlier service user accounts of improvisation (Ansdell & Meehan, 2010; Carr et al., 2011; Thaut, 1989). One service user described how she felt
stimulated and motivated within improvisation which might also be an example of music’s vitality affects. Others related improvisation to a spiritual domain, describing it as “heavenly” and “soulful” which thus links experiences of play to other service user accounts of musical processes (Sharma, 2014; Thaut, 1989). These spiritual references are reminiscent of an early narrative around the application of music in mental health care, one that seems to have been lost along the developmental trajectory of the music therapy profession (McCaffrey, in press-b). Music therapy’s diminished interest in spirituality may have been due to the illusive nature of this concept that does not lend itself easily to the quantifiable agenda of evidence-based medicine. As spirituality is a feature of wellness that is advocated by recovery-oriented practice in mental health (Mental Health Commission, 2008), it might be timely for the music therapy profession to renew interest in this concept that seems to have been abridged in recent discussion.

Another noteworthy description of music therapy’s positive impact related to the concept of hope within improvisation as Pauline described how she hoped that something good would come out of play. This is an example of what Ansdell (2014) has termed as musical hope. Music’s ability to offer such hope resonates with recovery in mental health where hope is regarded to have the ability to mobilise action in order to re-orientate both service users and providers towards a more rewarding way of living life (LeCroy & Holschuh, 2012). Therefore, it would seem that musical hope in improvisation might have something meaningful to offer service users along their recovery journey.

In considering these various positive descriptions of music therapy and the process of improvisation offered therein, it seems that for service users, the musical and the beneficial are interlinked where there is no clear distinction between the two. This seems to support similar research by Ansdell and Meehan (2010) who found that “in music therapy the
qualities of the ‘musical’ and the ‘therapeutic’ dimensions are often experienced as a unity” (p. 33).

**Group Music Therapy fosters Contribution**

Music therapy was described as a place in which contribution is fostered. This was relayed by service users in various ways—through accounts of supporting the music therapist and others in sessions, but also through their descriptions of playing music where outward gestures to others are practiced and witnessed. Each of these accounts illustrated music therapy’s capacity to stimulate activity and behaviour that can serve to the benefit of others within sessions. Although the concept of contribution emerged in Luke’s interviews that described his experiences of individual music therapy sessions, it is important to note that this did not arise not from his experiences of therapy but instead his experience of contributing to this study. Therefore, there was a stronger sense of contribution among those who experienced group play or improvisation in music therapy. This may be because they are among social witnesses to the processes that occur.

Some service users described how their participation in music therapy was premised upon their wish to support their music therapist as they try to earn a living while others shared how their leadership in play could help “draw out” fellow group members. A number of descriptions of playing music or involvement in improvisation highlighted the interpersonal nature wherein active participation is encouraged. Such participation is primarily through the processes of playing and listening which provides a space where one can “listen out” and respond to another in ways that establish social connections. This has been highlighted in earlier service user descriptions of music therapy such as that of Edwin who said that “when you’re making music you really need to concentrate … you need to listen to the other person, what they are doing, what their sounds are. You have to put two heads together to make music together” (Ansdell & Meehan, 2010, p. 36). This provides
support for the notion that music provides a bridge for relating with others (Hammel-Gormley, 1995). The consequences of playing and listening have not only been discussed by Stige (1999) but also by Jampel (2006) who considered “the conscious knowledge of playing music in the presence of other people in music therapy group” (p. 7).

A striking feature of accounts relating to musical play was that activity in music was not carried out for the purposes of personal benefit but instead most often performed with the intention of providing support to fellow group members. This presented the music therapy environment as a place in which altruistic acts can be practiced and witnessed. Such acts are not only tied to an understanding of the role of the therapist (Bruscia, 1998) but also to that of service users who can become active agents in the social recovery of others within group music therapy. This presents a more egalitarian view of therapeutic transformation in which therapist and service user(s) can play an active role in aiding others.

The service users involved in this study not only described the various ways that they make selfless contributions in music therapy but also the impact that such actions have upon their individual being. Feelings of satisfaction, goodness, self-worth, happiness and a sense of belonging were revealed in interviews that illustrated the gains of giving to others in music therapy. These are reflective of earlier service user descriptions of music therapy that have highlighted a sense of fulfilment as a result of participation in sessions (Ansdell & Meehan, 2010; Rolvsjord, 2010). The accounts of music therapy offered in this study indicate that service users are not only part of their own personal therapeutic process but also that of others. Furthermore, they describe the rewards of making contributions in music therapy for the benefit of others in a way that highlights an empowering and enabling role on behalf of service users. This subscribes to the notion that shared musicking generates a form of social capital that is linked to the idea of repairing communicative musicality that has “been compromised by disability, illness, trauma, deprivation or social exclusion” (Procter, 2011, p. 7).
It also builds upon the idea that group music therapy can offer service users opportunities to experience “miniature social systems” (McCaffrey, in press-a).

**Music Therapy is Person-centred**

Although never explicitly labelled *person-centred* by the service users who partook in this research, analysis of their interviews revealed that music therapy was experienced as a place in which people feel acknowledged, respected and accepted. Service user accounts illustrated how the music therapy environment offers: flexibility; adaptability; freedom in direction; support; positivity; a sense of control; and joint decision making between service user and therapist. In addition, music therapy was also described as a place where openness was encouraged and where people could come together without needing to rely upon the use of words. These features were particularly apparent through Luke’s recounting of previous healthcare experiences that were rigid and directive compared with those he has encountered in music therapy. A central metaphor featured within his interview was that when in music therapy he is in the “driver’s seat”, a figure of speech that has previously been used by other service users when describing their experiences of sessions (Solli, 2014, p.16). Each of these descriptors of music therapy resonate with the central hypothesis of Roger’s person-centred approach that every person has within themselves “vast resources for self-understanding, for altering his or her self-concept, attitudes, and self-directed behaviour – and that these resources can be tapped only if a definable climate of facilitative psychological attitudes can be provided” (Rogers, 1986, p. 197). From the accounts offered in this research it would seem that music therapy can provide a climate that is flexible, tolerant and free of authoritarian tendencies in which service users are encouraged and supported to draw on their self-resources. This climate resonates with the environment that has been advocated in literature concerning person-centred psychotherapy (Nelson-Jones, 2000; Rogers, 1967/2004, 1986).
Music therapy’s person-centredness is a familiar idea within the literature (Bunt & Stige, 2014; Ridder, Stige, Qvale, & Gold, 2013). Features of this concept have been implicitly discussed within service user accounts that have described how music therapy encourages choice-making and self-direction in an empowering manner (Solli, 2014). Music therapists have also discussed how sessions can be facilitated in a way that respects and upholds value-systems, even when those of service user and therapist are considerably different (Stige, 1999). The crucial role of the therapist in providing a person-centred environment was illustrated in service user accounts in this research. These highlighted how the music therapist assumes a role that is non-directive, encouraging, and supportive to the contributions of those who attend sessions. Descriptions of the therapeutic relationship highlighted a meeting of two human beings where equality, mutual respect, reciprocity and an “open-ear” feature. These are traits that closely align with person-centred notions of empathy, congruence and unconditional positive regard as described by Rogers (1967/2004). Earlier service user accounts of musical relating in music therapy also resonate with these attributes which led to the suggestion that the therapist is an equal “musical companion” in play (Ansdell & Meehan, 2010, p. 33). Therefore, it would seem that the findings of this research offer further support to previous notions of equality as put forward in earlier music therapy research. They also resonate with the collaborative egalitarian relationships promoted in recovery-oriented practice between individuals who live with mental illness and health practitioners (Le Boutillier et al., 2011).

It is important to acknowledge that in the context of this research there are aspects of service user descriptions of person-centredness that are congruent with key concepts of other defined models of music therapy practice. Similarities can be found with central tenets of resource-oriented music therapy (Priebe et al., 2014; Rolvsjord, 2010) and culture-centred music therapy (Stige, 2002). However, upon consideration of musical and non-musical
features of person-centred relating, it was found that the descriptions offered by service users in this research most closely aligned with that presented in the psychotherapy literature as defined by Rogers (1986).

**Music Therapy creates a Sensory World**

The findings from four service user accounts in this research highlighted a sensory world in music therapy where sight, sound and touch were stimulated. This presents a contribution to understanding service user experience of music therapy in mental health where little is known about the sensory life-world therein. What was particularly interesting about these descriptions is that they moved beyond more familiar descriptions of auditory experiences in music therapy to those that pertain to the senses of sight and touch. Together, these service user accounts illustrated a sensory life-world in music therapy which was stimulated not only by the music featured in sessions but also by the visual presentation of instruments therein. Service users recounted how these had the capacity to evoke vivid imagery and in the case of music—physical feelings of “warmth”, in a manner that transported the individual to *another place* during sessions. In addition, one service user described how he could “get something out” of his body during play, thus suggesting that there are embodied aspects of engagement that are beyond those relating to the physical sensation of touch when playing an instrument. Each of these descriptions revealed a rich sensory world in music therapy that can be experienced in highly personal and unique ways.

A particularly interesting facet of these sensory descriptions was the way in which some service users could use the processes of listening to and playing music to mentally transport themselves from the therapy room to different favourable locations. This was thought provoking given the way that service users depicted the clinical environment as a place where there was little to keep them occupied. Having relayed such descriptions of the inpatient environment, Carma shared how music brought her to different countries and
described in detail the imagery that this evoked in her mind. It could be suggested that this served for the purposes of escapism from her present circumstances but an alternative interpretation of this experience may be that she could use music and its evoking imagery as a resource to foster mental well-being. In looking beyond the descriptions offered in this study, one can find similar reports from other service users who have also commented on music’s capacity to mentally transport the individual. In a consumer based evaluation of a music therapy song group in mental health services in Canada, one service user said that music therapy allowed them to “travel to a better place” (Baines, 2003, para. 29). A similar service user evaluation of group music therapy in mental health carried out by the author also found qualitative reports to support this idea of mental transportation as one service user said that music therapy “is like time travel and can be very powerful” (Ahessy, 2013, p. 277). These collective accounts indicate that within music therapy, service users may demonstrate self-agency by using their engagement within music to provide them with stimulating and satisfactory sensory experiences that evoke positive emotional response.

**Music is Bound in Meaning**

Analysis of three service user interviews revealed how music is an entity that is bound in personal meaning. This became apparent through analysis of some cases in which it was difficult to discern between the boundaries of musical experiences and those within music therapy as service users interwove both within conversation. Yet all of these experiences were set within the context of one’s life which is itself one entity. Therefore, it can be concluded that for some service users there is no distinction between musical experiences and those in music therapy. This would seem plausible if one considers the universal nature of music and its positioning within the vernacular. In these cases involvement in music therapy was regarded as an extension of everyday experiences with music rather than an exclusive therapy that is clinically defined.
In the context of recounting experiences of music therapy in mental health a number of service users associated music with their relationships with other people in addition to its role within significant life events. This highlighted how music can be embedded within unique personal and social meaning that has the potential to play an important role in keeping one’s personhood in being but also in fostering one’s recovery journey (Le Boutillier et al., 2011). Such a social-psychological view of music within music therapy is inherent particularly when one’s personhood or identity is threatened as a result of mental illness. Accounts within this study suggest that music has the capacity to connect service users with pre-illness experiences within times of un-wellness. This has been discussed by Ansdell and Meehan (2010) in addition to Hays and Minichiello (2005) who carried out a qualitative investigation with older people to find that music can offer a helpful way of reflecting upon one’s personhood. Although musical association has been recognised by service users who have attended music therapy in mental health (Carr et al., 2011; Thaut, 1989) these associations can also be experienced outside the therapeutic milieu. There is a growing body of literature that advocates the use of music to promote wellness in everyday life (Ansdell, 2014; Batt-Rawden, DeNora, & Ruud, 2005; Edwards, 2011; Ruud, 1997).

Discussion of and experiences in music can elicit painful memories of loss. This phenomenon has been reported by other service users (Tyson, 1981), indicating that while music has the capacity to promote personhood, this process is not only interesting and enjoyable but also can be experienced as difficult. It is perhaps in recounting such painful experiences that the psychological support of the music therapist can come into play.

**Frustrations and Tensions can occur in Music Therapy**

The frustration and tension reflected in some of the interviews merits further attention. Feelings of frustration and tension with music therapy were implicitly, rather than explicitly shared in the interviews. It is important to consider the possible impact of my role
upon such tacit expression, having identified myself as a music therapist to those who participated in the interviews. This might have influenced service users to reserve outspoken difficulties with music therapy for the sake of minimizing perceived upset on my behalf.

Feelings of frustration and tension with music therapy manifested through statements about one’s wish to learn an instrument and acquire musical skill in sessions. However, as the music therapy service described primarily employed the method of improvisation, these hopes to receive some formal tuition within a group context could not be realised. The implications for these unrealised expectations were that improvising or playing the *music of the moment* was experienced as frustrating due to its lack of structure and formal direction. This can create something of a dilemma for practitioners of music therapy as they not only choose methods that are consistent with their personal approach and orientation but also as they employ suitable methods that can promote the aims of therapy for multiple participants within a group setting. Plener, Sukale, Ludolph, and Stegemann (2010) have proposed that blending different therapeutic approaches might be suitable in tailoring effective music therapy programmes in working with certain client groups. McCaffrey (in press-a) has recommended that choice of method should “begin and end with the person with whom the therapy is for and it is the role of the qualified therapist to identify indications and contra-indications for employing certain methods in practice”. Although difficulties with improvisation (Hibben, 1999) and difficulties of using particular instruments have previously been noted in music therapy (Carr et al., 2011), to date these have not been considered in relation to service user expectancy of sessions. Furthermore, while it is largely accepted among the music therapy profession that improvisation is a form of music, the findings from this research indicate that service users do not necessarily agree with this conceptualisation. This was expressed by Laura who after experiencing group sessions, spoke of her wish for music therapy to “give us a bit of music”. These inconsistencies in expectations and
perceptions of music therapy among service users and music therapy practitioners have not featured in the mental health literature to date. Yet it would seem plausible that these are not the first instances of such experiences among recipients of music therapy in mental health. These findings emphasise a need to engage in further dialogue with service users about the possible negative aspects of music therapy which in turn may offer valuable insight into reasons for some service users’ discontinuation of sessions.

**Summary of Overall Findings**

The eight overall themes described above offer a rich illustration of service user experience of music therapy in mental health. This started with a description of the context from which those involved in this study commenced music therapy to an account of the challenges that were involved along the way. Service users also described the positive gains that they have experienced from music therapy and the various ways that their contributions are encouraged therein where they felt acknowledged as unique individuals. The sensory world of music therapy was also revealed in a manner that extends beyond description of sound to accounts of how touch and sight are also stimulated within sessions. The personal meaning of music was also presented and revealed that for some service users, there is no distinction between life experiences in music and those encountered in therapy. The final theme revealed some of the implicit frustrations and tensions that service users can experience as a result of unrealised expectations about the nature and content of music therapy. These overall themes enrich current understanding of personal experience in sessions and also offer new and unique insights into what it is like for service users to attend music therapy.
Arts-based Contributions

The following section considers four arts-based materials that were created by three service users in a series of focus groups about lived experience of music therapy in mental health. The mediums of visual art and song were offered to Shady, Jack Sparrow and Dreamer who partook in these focus groups in which one piece of visual art and three songs were created. In order to deepen my understanding of these arts-based materials about lived experience in music therapy, a reflexive process was pursued in which relative service user commentary from focus group transcripts and reflexive journal notes were considered. These, along with my own impressions of each of the arts-based materials, were triangulated in order to compose a song response to the visual image and three songs produced by service user participants. This process of triangulation served as a means of drawing multiple and relative sources together in a way that allowed for a more contextual and holistic portrayal of these materials (Fenech Adami & Kiger, 2005). The merging of these data sources occurred within a song writing process that deepened my understanding of the arts-based materials generated by service users. Song writing provided me with a platform from which to offer my own interpretations of these artistic materials in a way that distinguished my views from those of the service users who had created them. As Barone and Eisner (2011) have pointed out that “notions of persuasion and truth” take on “radically different meanings” in arts-based research (p. 15). The purpose of these song writing endeavours was not to produce definitive findings about service users experience of music therapy in mental health but instead to offer an interpretive response that could serve as a point of discussion. This does not diminish the capacity of the original art-based materials to speak for themselves but rather allowed for a deep reflexive process to occur that considered contextual issues around their creation that otherwise would have gone unnoticed. The following section presents a discussion about some of the main points that arose from this reflexive process in response to the nameless
visual image and the three songs entitled: Wednesday; When I play Music; and Music Therapy Rap.

**Visual Image**

Writing a song that focussed upon Jack Sparrow’s visual image revealed his lived experience of music therapy as rooted in a love of music. Although the caption ‘I love muics’ featured on his visual image, the message that it relayed initially seemed to be lost among the multiple sources of data involved in this reflexive process including commentary from focus group transcriptions, reflexive journal notes and my own thoughts and impressions about this image. However, as each of these sources were carefully considered it became clearer that Jack Sparrow wished to use this self-portrait to demonstrate his love of music and presumably, music therapy especially because it improves his mood. These arts-based findings are reflective of other service user accounts of music therapy within the literature that highlight aspects of enjoyment and satisfaction (Grocke et al., 2009; Heaney, 1992; Silverman, 2006; Solli & Rolvsjord, 2014) but also improvement in mood (Ansdell & Meehan, 2010; Thaut, 1989). Although this image relays a simple or even obvious message about people’s love and enjoyment of music and music therapy, it also may evoke tension as it indicates that Jack Sparrow did not come to music therapy because it offers a form of psychological therapy that will in some way *treat* or *help* him. Instead it suggested that his starting point for music therapy was premised on an interest or desire in music as an entity that is pleasurable, motivating and fun. This offers a description of service users’ experience in music therapy that contrasts the prevailing clinical view of providing sessions for the purposes of reducing symptomatology or providing treatment. In this case Jack Sparrow’s visual image and the reflexive song writing process that this encompassed disrupted such an assumption about music therapy by “re-casting the contents of experience into a form with
the potential for challenging (sometimes deeply held) beliefs and values” (Barone, 2001, p. 26).

Other service user descriptions support the notion that music therapy is not necessarily perceived as a form of treatment by service users (Ansdell & Meehan, 2010; Rolvsjord, 2010; Solli & Rolvsjord, 2014). The central message of Jack Sparrow’s visual image seems to situate music therapy in a wellness paradigm that is far removed from a deficit-based approach to treatment as is often encompassed by a medical model of practice that has been criticised by proponents of mental health recovery (Davidson, 2003; Davidson & Roe, 2007). This merits further thought as one considers the potential conflict that can occur in the event of a service user and music therapist commencing sessions from opposing ends of this wellness-illness polarity. In such instances it would seem plausible that opportunities for therapeutic gain may be diminished if those who provide and attend music therapy commence from very different starting points.

**Wednesday**

The original concept for *Wednesday* originated from suggestions by Shady. However, it was Jack Sparrow who took a leading role in creating this song in the first two arts-based focus groups, the second of which Dreamer also attended. This song parody was the most challenging of all the arts-based materials because of its content about the therapeutic relationship in music therapy which depicted scenes of a service user and therapist hitting each other with a stick. It warranted a most careful and considered song response that aimed to explore the nature of the meaning behind *Wednesday* and how this could contribute to an understanding of service user experience in music therapy. Service user commentary, as extracted from focus group transcripts, proved valuable in this regard as it relayed the perspectives of those who had created this song and helped offer some clarity about its intended message about music therapy. Although I was initially concerned about the imagery
that was being depicted in this song, Jack Sparrow explained that it was about having “the

craic” (or fun) and joked that his music therapist, Johnny, would “kill him” when he heard
this composition. These comments, coupled with my own reflexive notes that documented a

jovial and playful atmosphere at the time *Wednesday* was written, brought me to the idea that
this song relayed some notion of reciprocity or *give and take* between service user and
therapist as promoted in recovery-oriented practice (Le Boutillier et al., 2011). It also

suggested that Shady and particularly Jack Sparrow, had a relatively strong relationship with
their therapist that they did not envisage being jeopardised as a result of the playful and

joking nature of this song.

The process of writing a song response to *Wednesday* offered a means of exploring

both Shady and Jack Sparrow’s perspectives about their composition. It also presented a way

of considering my views as someone who professionally and personally knew the music
therapist described, but also as researcher who was obliged to be open to both the literal and
hidden meanings about service user experience in music therapy. Therefore, the song
response allowed me to voice my concerns about *Wednesday’s* depicted imagery and set
these against other relative information that enhanced my understanding of service users’

arts-based song material. The most insightful lyric of this song response was one that features
on the last line: “can I take this away, show it to the lads?” This refers to Jack Sparrow’s
request at the end of the second focus group to take a written copy of the lyrics of *Wednesday*
in order to show them to his friends in the pub with the intention of *having a laugh*.

In reviewing the small body of literature that exists around service user experience in
music therapy, little is explicitly featured about particular qualities of the therapeutic
relationship. While Ansdell and Meehan (2010) found that the therapist’s role is experienced
by service users as an equal, there seem to be no other accounts that portray this aspect of
relating in music therapy in the mental health. In this case, the arts-based medium of song
provided an avenue in which service users could relay aspects of how they relate with their music therapist. It also appeared to capture aspects of the *liveliness* that feature within this relationship.

**When I play Music**

The idea for the original song entitled *When I play Music* came from Dreamer who used lines of his own poetry to write this song. He shared his wish to write a mellow song which, at the time of the focus group, struck me as being quite apt to his appearance in mood on that occasion. When requested to describe his experiences of music therapy using arts-based methods, he chose to pursue a song creation that referred to his experiences of music. This created some ambiguity during reflection upon this composition, where it was unclear as to whether Dreamer’s descriptions were related to those in music therapy, music in general, or if he made any distinction between these situations in the first instance. However, more apparent features of this song were that music offered him a means to improve his mood, in addition to providing him a place in which he could see clearly and be reminded of “the world as I know best”. The description about improvement in mood is congruous with those of other service users involved in this study as well as being an aspect of personal experience that has previously been highlighted in the music therapy literature (Ansdell & Meehan, 2010; Thaut, 1989). Similarly, Dreamer’s reference to clarity of thought is also reflective of other participant contributions within this research.

Through the process of reflexive song response Dreamer’s service user identity and my researcher role were explored. The commentary from group transcripts featured in the lyrics emphasised how Dreamer experienced skill and achievement in music. They also demonstrated his eagerness to be involved in a creative process through contributing his thoughts about particular aspects of the musical style of the song and independently composing song lyrics between focus groups. As I continued with this reflexive process I
wondered if *When I play Music* captured inseparable aspects of music and music therapy? Remaining open to this stance, I also wondered if the allure of music therapy for Dreamer was exclusively based on his passion for music? These questions prompted further conjecture about Dreamer’s motivation to partake in this research as I speculated whether his involvement had been premised on his wish to relay his experiences of music therapy or if this had more so been about being presented with an opportunity to write a song. I also thought about how Dreamer had taken a leading role in creating *When I play Music* up until the very end of composing the lyrics when Jack Sparrow contributed the song’s final line. Dreamer responded to this by becoming very quiet and momentarily withdrawing from the song writing process. This made me speculate as to whether one of the positive aspects of his experience in music was related to a sense of being in control and distanced “in the clouds” from the distractions of others which somehow seemed to intrude upon him in the focus group. These questions are posited rather than answered within this reflexive process of song response and stand as testament to the ambiguity that can arise in arts-based inquiry (Barone & Eisner, 2011).

**Music Therapy Rap**

The idea for *Music Therapy Rap* arose from Jack Sparrow who enthusiastically spoke about liking the artist Eminem and his wish to write a rap on several occasions. Composed in the closing stages of the final focus group within a short space of time between Jack Sparrow, Dreamer and I, it is a relatively short rap that was performed with a simple percussive accompaniment. Jack Sparrow initiated much of the lyrics which appeared to carry a *cool* vibe. These described one Wednesday at the mental health facility where he met Dreamer and I. The lyrics also recount meeting his music therapist Johnny for a session in which he played the drum and guitar, in addition to singing and listening to the song *Hotel California* (Felder et al., 1976). His words also included how his experience in music therapy gave him a buzz
and Dreamer added lyrics about improving one’s mood. The rap presents singing as a form of therapy and it recommends music therapy to others.

In reviewing various data sources while writing a song response to *Music Therapy Rap*, I recalled how when writing the rap lyrics Jack Sparrow made a fleeting remark about Johnny (his therapist) and Julie (pseudonym) “roarin’ and shoutin’” at him. Although these lyrics did not feature in the final rap, I thought it important to include these in the song response while wondering if these words were said in truth or jest or somewhere in between. My interpretation of this was that as a jovial character, Jack Sparrow was someone whose groove could be interrupted by rules and regulations set by others. I also recounted his initial lyric contributions that referred to smoking with Dreamer and I, which spurred my suggestion to rephrase this line for the purposes of accuracy because I do not smoke. Another point of reflection was our discussion about whether lyrics should feature one’s day being “up” or “down” with reference to improvement in mood. Each of these examples, whether relevant to notions of truth, imagination, or literary convention suggest that this rap and all other arts-based materials in this study are subject to multiple interpretations. Rather than trying to find answers to these issues that arose within the creation of this rap, its song response poses relevant questions that may be discerned by its listener.

The relevant song response aims to capture the prevailing mood that surrounded the composition of *Music Therapy Rap*. Like each of the other responses it puts forward the perspectives of the service users who, initially unsure of what to include in the song, described the “buzz” they experience in music but also the positive benefits of composing a song in the arts-based focus groups. The researcher perspective outlines a wish to learn more about the benefits of these experiences while also relaying a quintessential message of this research that pertains to transfer of the findings. Although many unanswered questions arose from *Music Therapy Rap* and its ensuing reflexive process, it does offer some sense of clarity.
about Jack Sparrow’s and Dreamer’s lived experience in music therapy. This relates to improved mood as a result of participation in sessions which re-echoes similar descriptions of other mental health service users in the literature (Ansdell & Meehan, 2010; Thaut, 1989).

**Summary of Arts-based Materials**

Four arts-based materials that portrayed lived experience of music therapy in mental health were created by three service users in a series of focus groups. These included a visual image and three songs entitled Wednesday, When I play Music and Music Therapy Rap. Each of these was considered within a congruently fitting arts-based reflexive process that employed song writing as a means of exploration and response to the distinctive content and features of these arts-based materials. A number of observations and thought-provoking questions were raised through this creative process that drew upon personal impressions but also service user commentary from group transcripts and notes from my reflexive journal. These provided contextual information about the creation of the arts-materials presented in a song format which was used as a means of providing insight into how the image and song portrayed lived experience in music therapy. Concluding thoughts derived from this reflexive process of the visual image included how service users may commence music therapy from a perspective of enjoyment and love of music rather than with the view to receiving a form of mental health treatment. The song Wednesday appeared to capture the interpersonal nature of the therapeutic relationship where reciprocity, humour and friendship featured. It suggested that there is a sense of equality within this relationship which can be tested and challenged during the course of music therapy. When I play Music aroused many questions rather than concluding thoughts. These related not only to lived experience of music therapy where the lines between music and music therapy appeared indistinct, but also to service user motivation for taking part in this study as the attractiveness of arts-based processes was
conjectured. Finally, *Music Therapy Rap* seemed to portray the positive aspects of engaging with music that service users can experience within sessions.

**Contribution of the Service User Findings**

The nine service user perspectives as shared in this study offer rich and insightful descriptions of music therapy in mental health. Review of the overall findings generated from individual interviews and arts-based focus groups provided an illustration of the life-world in music therapy in which some familiar concepts were augmented and unfamiliar ideas emerged. These culminated findings bring one closer to understanding lived experience of music therapy. More importantly, they serve for the purpose of amplifying the voices of a minority group that has been underrepresented in the music therapy and mental health research base to date.

Some of the findings from this study are reflective of service user views and those of practitioners of music therapy that have previously highlighted in the literature. A prime example reflected in the service user findings is the often discussed idea of music’s connection with well-being (Ansdell, 2014; Batt-Rawden et al., 2005; DeNora, 2000, 2013; Edwards, 2011; Grocke, 2009; MacDonald, Kreutz, & Mitchell, 2012). Service user contributions supported music’s relationship with well-being in various ways. This featured in verbal accounts that portrayed how musical engagement can serve for the purposes of reminding the individual that they are “young at heart”. The significance of this being that one’s youth was a time of wellness and fulfilment in life. This subscribes to the notion that music therapy can help remind people of music as a health promoting resource (Ansdell & Meehan, 2010). Further association with wellness was also promoted in arts-based materials as the notion of commencing music therapy upon the premise of loving music was suggested. Instead of beginning music therapy from a needs-based or deficit-based starting point as is
common within the medical model, this portrayal positioned music therapy within a wellness paradigm. It supports previous service user accounts that have rejected the notion of music therapy as a treatment (Ansdell & Meehan, 2010; Rolvsjord, 2010; Solli & Rolvsjord, 2014). It also aligns the music therapy services described in this study with recovery-oriented practice that embraces a holistic rather than clinical approach to supporting people with mental health problems. These findings provide food for thought to service providers who advocate music therapy practice purely within a clinical or psychiatric model of care. A more enlightened way of conceptualising music therapy in such instances may be to celebrate and promote the profession’s capacity to occupy a middle ground between “the starched white coat[s]” of medics and “the ragged fur wrappings of the shamans and drumming healers” who engaged in more holistic practices (Priestley, 1975, p. 264).

The concept of holism was further uncovered through accounts where musical practices and activities were inseparable and indistinct from those offered in music therapy. Rather than setting music therapy apart from other experiences of music within one’s life, some service users revealed how music therapy played one part of a much larger whole that is one’s musical life. Such verbal and arts-based portrayals highlighted how music therapy, because of its employment of music as a colloquial and cultural tool, is for some service users an extension of one’s musical narrative that is set upon the platform of life. This was reflected through descriptions of music therapy in which service users implicated personal everyday experiences of music that were related to family, friends and significant life events. It also provides sustenance to why some service users in this and previous studies reported being alleviated of illness within music therapy (Ansdell & Meehan, 2010; Clemencic-Jones, 1999; Solli, 2014; Solli & Rolvsjord, 2014), because the music featured in sessions offered them a bridge away from the abnormality of a mental health diagnosis to more culturally accepted experiences in everyday life. This situates music therapy within the landscape of
culture-centred music therapy where implications of practice are conceptualised far beyond the boundaries of the therapy room (Stige, 2002). A commonality can be found within this approach to practice and that pertaining to arts initiatives that promote mental health and social inclusion (Dyer & Hunter, 2009; Hacking, Secker, Spandler, Kent, & Shenton, 2008; Secker, Hacking, Kent, Shenton, & Spandler, 2009).

An illuminating feature of the service user findings in this study related to the person-centred nature of music therapy. Although a concept about practice that is not unfamiliar within the music therapy literature (Bunt & Stige, 2014; Ridder et al., 2013), the subjective first-hand accounts of service users that portrayed music therapy’s person-centredness were insightful. They revealed how the individual can be placed at the very heart of music therapy practice where their identity as a unique human being is acknowledged and promoted. Ingredients offered by the therapist in nurturing one’s self-concept included gentleness, support and flexibility, where choice and self-direction featured. The importance of the therapist’s authenticity was also highlighted by one service user. Together these factors created an environment in which the service user was an active and equal partner alongside their therapist. Of utmost importance is that this was described by service users as a valued process. An intriguing feature of this study’s investigative process related to how some service users wrote a jovial and joking song about their music therapist. This was interpreted as providing testimony to the strength and reciprocity of the therapeutic relationship. In considering these attributes of the therapeutic environment in relation to established models of care, one finds that this not only mirrors central tenets of person-centred practice in psychotherapy (Rogers, 1986), but also those of resource-oriented music therapy where empowerment and collaboration in the therapeutic relationship are quintessential (Rolvsjord, 2010). These models of practice can offer some guidance as to how music therapy can be
delivered in mental health care in a way that speaks to aspects of practice that are valued by service users.

A number of findings from this study offered personal and rich descriptions of improvisation in music therapy that are otherwise rare within the literature. Together these presented unfamiliar aspects of involvement in this process. These described the initial draw towards one’s choice of instrument, the notion of working out a sense of musical direction and the possibility of being absent-minded or present-minded in play. Practical ramifications of these findings emphasise the importance of offering service users a broad array of instruments to choose from in sessions. Such variety can open up the possibility to choose an instrument that best meets expressive needs in accordance to one’s mood or mental state.

The sensory world of improvisation emerged from this study’s findings. This relayed a life-world where multiple senses can be stimulated relating to those of sound, sight and touch. Interesting accounts of sound in improvisation were offered that related to the importance of rhythm and how this had the potential to positively impact upon one’s thought process. In contrast to this others noted how on one occasion, the experience of listening to the playing of drums was daunting because they were sensitive to noise. Therefore caution is warranted when introducing instruments that have the potential to be received as overpowering or intrusive. In this case, one individual continued to share an empowering account of how she learnt to block out a drum sound and take control over what she heard during play in improvisation. Other facets of involvement in this music-making process described the imagery that can be evoked during play which can mentally transport the individual to better place beyond that which related to their present circumstances. Additional sources of stimulation were traced to the physical appearance of instruments that triggered personally significant memories and experiences. Overall descriptions of experience in improvisation relayed how it offered service users a forum where new possibilities for self-experience can
be found. Such self-experience was sometimes accompanied with feelings of wonder and surprise as people were reminded of the concept of being able through the process of active music making.

Outcomes of participation in music therapy were positively described by all service users who contributed to this study. Benefits of participation were recounted in various ways that related to overall experience of sessions, engagement within a musical process, but also in relation to the outcomes achieved through such musical and creative involvement. These re-echo descriptions of music therapy as previously offered by other service users. Although most often expressed in emotional terms through the interviews and arts-based materials, some service users made specific reference to feelings of hope, spirituality and soulfulness. While hope is a concept that has been subject to some discussion in the music therapy and mental health literature (Ansdell, 2014), ideas relating to spirituality and soulfulness have been largely overlooked in the literature in recent decades because they lack relevance and impact within the dominant scientific paradigm in healthcare (McCaffrey, in press-b). The findings from this study highlight that spiritual experiences are important for some service users in attending music therapy.

Further benefits of music therapy were described in terms of improved thought processing as a result of playing music. Considered alongside the reported emotional benefits of participation, these suggest that music therapy’s outcome domains are varied and that more global mechanisms of change are at play. Maratos, Crawford, and Procter (2011) postulated about global mechanisms of action in music therapy for people with depression and have suggested that there are opportunities for “new aesthetic, physical and relational experiences” in active music making (Maratos et al., 2011, p. 92). An intriguing account was offered by one service user in this study who spoke about the benefits of music therapy and yet of being unaware of how it assists them. This comment gives some support to the idea that music
therapy may activate innate mechanisms for which the human condition is hard-wired, as put forward by the concept of *communicative musicality* (Malloch & Trevarthen, 2010). Despite the many complexities that arise in considering the outcomes of participation in music therapy, the service user findings in this study were unanimous that their experiences therein were positive and valued.

Some of the most interesting findings generated from the service user perspectives in this study relate to unfamiliar aspects of the life-world in music therapy in mental health. Although commencement of a new programme for occupational reasons is not an unfamiliar idea in the mental health literature (Carr et al., 2011; Stickley & Hui, 2012), consideration of this finding illuminated the context surrounding the making of such a decision. This revealed how some service users have to grapple with disabling aspects of mental illness in order to take the first steps of beginning a new therapeutic process such as music therapy. Through these descriptions new perspectives of the life-world in music therapy were highlighted and a deep appreciation grew on my behalf for the tentative steps people may take in commencing their first session. Further insight was gained into these early stages of therapy as many service users recounted the challenges they face in beginning sessions, particularly because this creates many unknowns. This disclosed that service users may commence music therapy with many questions and curiosities that demand a tolerance of ambiguity and, that even when prepared with some information it is impossible to conceptualise what participation in sessions will involve. This illustrates that for some service users, music therapy may be more readily experienced than explained. Another aspect of challenge that impacted engagement in music therapy pertained to service users’ past experiences of music. In some instances such past musical experiences were uncovered as having the potential to hinder acceptance of the therapeutic process of improvisation. This was partly because improvisation can demand acceptance of a new music that is set apart from more traditional and ingrained concepts of
music in society. Although service users toils of improvisation have previously been documented (Hibben, 1999), these findings are the first to present reasons from the perspective of the service user as to why such obstacles are encountered. One final dimension of challenge revealed in this study that has also gone unrecognised in the music therapy literature to date is that which relates to the interpersonal challenges that can be encountered within a group context. Although Jampel (2006) has acknowledged the demands of group functioning for some service users in music therapy, this study appears to be the first to present first-hand accounts of how such demands are experienced. These cumulative findings about challenge are insightful, and yet perplexing as one wonders why discussion about this topic from the perspective of service users has not been previously highlighted.

The findings in this study revealed challenges experienced by service users in music therapy and also experiences of frustration and tension. Although never explicitly stated, analysis of some interviews disclosed how unfulfilled expectations of music therapy cause irritation for service users. This partially linked back to the finding of challenge that can arise from previous musical experiences and how these can frame one’s expectancies of what should be involved in music therapy. In this study it was found that some people attend music therapy with the view to acquiring musical skill and mastery. However, when these expectancies are unrealised service users can experience feelings of frustration and tension, particularly when alternative methods and techniques of practice are pursued in sessions. Improvisation was revealed as particularly frustrating in such instances because engagement in this demands flexibility and flow which is set against the service user’s wish for musical instruction and structure. Furthermore, the findings showed that not all service users regarded improvisation as a form of music and spoke about their wish for “real music” within sessions. This is contradictory to the viewpoint of music therapists who regard improvisation as a form of live music making and a method that is traditional to practice (Bruscia, 1998). Implications
of these findings point to a need for further exploration of service user’s expectancies and perceptions of music when commencing music therapy where possible. Such collaboration between service user and therapist can not only determine shared and realistic goals of music therapy but also ascertain which methods of practice would be most suitable in this regard. This might prove more manageable in cases of individual work that is tailored to suit particular needs. Yet, consideration of individual perspectives within a group context can also be of merit. This has the potential to establish personal conceptualisations of music that can inform one’s willingness and openness to engage in productive music-making methods such as improvisation. These conversations are more viable in light of research which proposes that successful working with service users can not only come from the employment of production and reception techniques but also those relating to the reproduction of music (Mössler, Assmus, Heldal, Fuchs, & Gold, 2012). However, it must be acknowledged that such conversation rests upon verbal domains that might not be always be accessible on behalf of the service user. Nevertheless, consideration of these findings and related practical implications have something to offer discussions that have ensued around music therapy’s suitability for certain patient groups both within and beyond the mental health arena (Burton, 2009; Mössler et al., 2012).

One of the most powerful findings that emerged from this study is that group music therapy offers service users a platform for contribution. Many involved in this study revealed how they actively support and encourage others in group music therapy. This not only extended to fellow service users but also to their music therapist whom they equally wished to support. Contributing for the benefit of others was most evident in descriptions of active music-making where service users listened out and tried to “draw out” others in play. These accounts illustrated the group music therapy environment as one where a high degree of inter-personal relating takes place through the medium of music. A strong sense of shared
humanity was portrayed in these descriptions where personal desire to help and assist others shone through. Gains from such giving were also reported by service users who shared that such acts instil a sense of self-worth and goodness. This supports the view of Yalom and Leszcz (2005), who in considering group psychotherapy said of service users that “the experience of finding that they can be of importance to others is refreshing and boosts self-esteem. Group therapy is unique in being the only therapy that offers clients the opportunity to be of benefit to others” (p. 13). Of particular relevance to group music therapy is that it offers a public stage for music making or musicking to be shared and witnessed among human beings (Pavlicevic & Ansdell, 2004b). It has been proposed that this form of creative expression is a musical capital that can have a reparative function on communicative skills which can indirectly promote engagement in society (Procter, 2011). The findings from this study show how service users value the act of contributing in music therapy. These are powerful findings in the sense that they provide insight into the empowering role of the service user in the music therapy process. These align with the central concept of anti-oppressive practice which promotes the disruption of oppressive barriers that “negatively affect our universal developmental potential” (Baines, 2013, p. 4). They also remind mental health professionals that ingredients of personal and social recovery originate not from a service or facility but from the very people who use them.

**Contributions and Limitations of the Methods**

The impetus for this research stemmed from a desire to turn open ears and eyes to the lived experience of those who have attended music therapy as part of their mental health care provision. This was informed by the recovery approach in mental health that advocates for collaboration between service users and professionals at each stage of healthcare delivery and planning. It is also based on the notion of service user inclusion that has been promoted by statutory mental health services nationally and internationally. At the time of this study’s
commencement it was hoped that the prospective findings would be used to develop further understanding about service user experience among the music therapy and mental health communities. The research was also carried out with the intention of designing both traditional and new means of carrying out service user evaluation in an inclusive manner that would honour both verbal and non-verbal means of expression as employed by those who attend music therapy in mental health. This research was designed with awareness that there are few mental health services in Ireland in which music therapy is offered to service users. This meant that from the onset, this research would most likely focus upon the experiences of a small number of mental health service users in music therapy. Therefore, this study was carried out with the aim of presenting detailed accounts of individual experience. It was concerned with issues of depth and richness rather than quantity so as to reflect the complex nature of such phenomena. It did not seek to extrapolate the findings from a specified sample to the wider music therapy and mental health population but rather “show that findings can be transferred and may have meaning or relevance if applied to other individuals, contexts and situations” (Finlay, 2006, p.320).

The findings presented in this research were garnered through interviews and focus groups at two mental health facilities, including an inpatient unit at a hospital and a day centre situated within the community. Although familiar with such contexts through my former role as music therapy practitioner in mental health services, my arrival at the inpatient unit and day centre for the purposes of data collection marked a transition from being helper to inquirer. Such a shift from practitioner to researcher is one that has been discussed by Ledger (2010b). Entry into these facilities very much relied upon my respected reputation as a mental health professional. Yet I was aware of my survival as a sole music therapy practitioner within a large mental health service which aligned me closely to the role of service user/survivor. As a result, this transition brought back a range of emotions about my
personal experience of working in mental health where I encountered many positive and negative experiences of engaging with the system. This made me aware of the meaningful work that can take place within the mental health environment but also of the ‘microaggressions’ or subtle insults (Pierce, 1995) that can diminish one’s sense of self-worth and confidence within a system that can sometimes seem over-powering and neglectful of the minority view. I hoped that these various experiences had encouraged an open-minded perspective on my behalf towards the views of those who attended music therapy. I also hoped that the information garnered could be used in a way that would develop and enhance the provision of music therapy in mental health.

**Interview Method**

The semi-structured interview method was employed in this study as a means of offering service users an open way of recounting their experiences of music therapy in mental health. Crucial to the success of carrying out these interviews was the role of the gatekeeper who introduced me to potential participants and advised me on practical issues related to the research. This was an invaluable asset as I sought to orientate into a busy hospital setting that relied upon routine and procedure for its successful operation.

Using the interview schedule as a broad guide, the flow of discussion moved in a manner that the service users directed when sharing their personal accounts. This flexibility allowed for unfamiliar material to emerge that enriched descriptions of music therapy and honoured the subjective nature of lived experience. This resulted in not all questions featured in the interview schedule being asked of each service user. Although the interview schedule was helpful during in the earlier interviews, its use was later considered if this had constricted the discussions in some way. Another variable factor of the interviews was the length of their duration which ranged from approximately 20-55 minutes, reflective of the varying needs and wishes of service user participants.
A challenge encountered within the interview process concerned gently encouraging focus on the topic of music therapy, particularly when discussion wandered onto subjects that did not appear related such a focus of interest. In this regard there sometimes was a fine balance between staying on topic and disrupting the service user narrative but after listening to the audio-recordings of the interviews, I am reasonably confident that such instances were skilfully managed.

The follow-up interviews were an important aspect in the promotion of inclusivity as a central theme of this research. I noted how these commenced with a sense of familiarity and allowed opportunity for service users to debrief about our first discussion. Arrangement of these second interviews required close contact with the research gatekeeper who updated me if the service users had been discharged from the inpatient unit. In one such instance arrangements were made to meet the service user at a mental health day centre located some distance from the hospital. A further reminder of the dynamic nature of the hospital environment occurred after arranging to interview two service users one particular day. However, upon arriving to the hospital I discovered that these interviews would not be possible to carry out for various reasons beyond my control. Both of these experiences reminded me of the importance of flexibility when carrying out research in a mental health setting and being acceptant that plans might not always turn out as one might hope.

**Arts-based Processes and Outcomes**

The arts-based focus groups offered creative pathways in the pursuit of a ‘different way of knowing’ about lived experience in music therapy (Liamputtong & Rumbold, 2008). Often used to capture the views of marginal groups who might otherwise remain voiceless in health care research (Ledger & Edwards, 2011), the arts-based methods employed in evaluation in this study aimed to broaden previous understanding of the personal experience in music therapy through artistic means. Such design was not only fitting to creative avenues
offered in music therapy but also inclusive of the notion that there are different forms of acquiring knowledge. This embraced “the notion that meaning can not only be fostered through words but also through creative pathways” (McCaffrey, in press-a). In terms of fostering engagement and inclusivity (McDaid, 2009), the focus groups were designed to offer service users a form of peer support when engaging with visual art and/or song writing. These created a dynamic environment in which many aspects of the creative process had to be figured out along the way rather than imposing an instructive and limiting approach as cautioned by Liamputtong and Rumbold (2008).

I debated about how best to set-up the room so as to facilitate ease of accessibly for those who participated in the research. For practical reasons the art materials were placed on a large table in the centre of the room while the musical instruments were left to its side around a keyboard that was sitting against a wall. Before the final focus group it occurred to me that this positioning had been in some ways bias towards the use of visual art materials. This was addressed by placing some musical instruments in the middle of the table alongside the paper, paints, markers etc. Yet despite my perceived bias as a result of the placement of materials, it struck me how the music or more specifically song writing, had been a preferred method of choice of service users in reflecting upon their experiences of music therapy in the focus groups.

Facilitating both song writing and visual arts processes within the groups was more challenging than I had originally anticipated. This occurred to me within the first focus group as Jack Sparrow had completed his visual image and sat quietly watching Shady and I as we collaborated on a song writing project. It not only illustrated the varying levels of input that might be required with these different arts-based mediums, but also how individual pursuits within a group environment might mitigate group cohesiveness. From this point onwards service users were encouraged to engage in more collaborative endeavours for which they
chose to use song writing. This was not particularly surprising due to their established motivation for music as evidenced through their on-going attendance of music therapy.

It is important to acknowledge gender issues within the group that might have influenced the creative processes pursued as exemplified by Jampel (2006). All those who participated in the arts-based focus groups were male, one of whom joked about marrying me at the beginning of the first focus group. I recall being somewhat startled by the imagery described in the song Wednesday that depicts a service user and music therapist beating each other with a stick. Upon discussion of this with my supervisor, we reflected upon this rather male-oriented imagery and postulated whether it unconsciously served as a means of shocking me as a sole female collaborator within this creative process. This experience not only increased my awareness of gender issues in the group but also reinforced the importance of the researcher’s availability and openness to the artistic creations that unfolded therein (Bagnoli, 2009). Pertinent to Dewsbury’s (2003) notion of witnessing, my role did only involve facilitating the fabrication of these creations but also being an attentive witness to “truths folded into the fabric of the world itself” (p. 1908). This in many ways mirrored the role that I had previously assumed as music therapist; primarily concerned with the dynamic of the musical interaction in which I engaged with service users rather than what this musical interaction represented.

Some theoretical issues relating to notions of mastery and skill arose as a result of these focus groups. Among the reasons for choosing arts-based methods was that these did not require prerequisite skill on behalf of those who participated in the research. However, at the same time these methods of visual art and song writing were selected upon the recommendation that the researcher exhibit mastery in their chosen method of inquiry (Barone & Eisner, 2011). This seemed somewhat contradictory to the inclusive nature of arts-based inquiry and yet I could not overlook how I had drawn upon my skills as both musician
and therapist to facilitate these creative pursuits. This presented something of a quandary in this study that is premised upon emancipatory principles.

The most poignant dilemma over the course of this study related to the treatment of the visual image and songs created by the service user participants. Unsure of what to even call such arts-based entities, I noted the divergence in terminology in the literature that featured terms such as ‘traces’ (Aldridge, 2008), ‘communication tools’ (Fleury, 2011), ‘metaphors’ (Bagnoli, 2009), ‘products’ (Boydell et al., 2012; Lafrenière et al., 2012) and ‘representations’ (Barone & Eisner, 2011). Based on my perspective that the visual image and songs were fabricated of many constitutive parts and in adaptation of similar terminology as used by Gerstenblatt (2013), the term materials was chosen to represent such entities in the context of this study. The next issue arose in how to process the visual image and songs.

Because service users had consented to have their visual images and songs presented to others rather than analysed by the researcher, I was hesitant to perform an analysis of these materials with the intention of arriving at conclusive findings. Instead it was decided to embark upon a reflexive process that engaged with the complexity of artistic creation but also illustrated my “humanistic commitment … to study the world always from the perspective of gendered, historically situated, interacting individual” (Lincoln & Denzin, 2000, p. 1047). It was with this intention that the song responses were composed so that the inescapable aspects of context and situatedness in the creation of the arts-based materials could be articulated, acknowledged and undefined. There were many unknowns involved in this reflexive process, at the centre of which lay the philosophical question of whether the arts-based materials were cultural artefacts or presentational symbols of lived experience in music therapy. Assuming the view that these were presentational or symbolized forms of knowing (Liamputtong & Rumbold, 2008), various sources of contextual data were consolidated within the song structure to develop a deeper understanding of service user experience. It was interesting that
the navigational concept of triangulation (Ramprogus, 2005) was employed in this process at a point when I felt quite confused about which direction to next pursue. In hindsight, it could be argued that this process of triangulation was merely a complex merging of different information sources that offered a contextual meaning of the service users’ arts-materials. The songs present a form of embodied responses to these materials that mirror particular moments or snapshots of lived experience in music therapy that cannot easily be put into words (Bagnoli, 2009). Their true subjective meaning is beholden to those who created them and thereafter they may offer points of debate and discussion in the minds of those who review them (Barone & Eisner, 2011).

An irony emerged during the reflexive process involving song writing where my dependency upon language seemed to override the original intention of employing arts-based methods to alleviate the use of words in describing lived experience. In exploring the many unknowns about the service users’ arts-based materials, I turned to verbal sources such as reflexive journal notes and commentary from group transcripts to try to enhance insight. This highlighted my own dependency upon verbal means of expression but also the verbal dominance that is deeply ingrained in the transfer of knowledge. However, the composition of the melody and musical aspects of these songs offered exciting possibilities to convey meanings and emotions that seemed elusive to that of lyrical content. This reminded me of the affordance of music to express facets of my lived experience within the focus groups in which I witnessed service users create their arts-based materials. Although beyond the scope of the ethical protocol for the arts-based focus groups, I considered with my supervisor as to whether the service user participants should have been given opportunity to listen to the song responses to their materials. However, upon discussion it was agreed that such contact would extend beyond the boundaries of the defined expectancies of participation as the reflexive process had not been anticipated at the time participants consented to partake in the research.
It was also agreed that further contact could unnecessarily conflate the research feedback process. Instead participants were informed about the main thoughts arising from the arts-based processes through the final edition of the research newsletter.

Overall, the arts-based methods employed in this study offered a creative ways of viewing and treating knowledge. Although an intriguing and invigorating process of inquiry, it also required a tolerance of ambiguity and a willingness to explore a complex web of personal and intrapersonal interactions that on many occasions aroused a sense of wonder and curiosity. It is my hope that this sense of wonderment rather than that of bewilderment will be encountered by those who reflect upon the materials created in this study. These have not generated a form of knowledge that can neatly fit into the demands and needs of system, service and service user. However, these arts-based materials may serve to broaden avenues of investigation for future researchers who wish to learn further about service user experience in music therapy in mental health.

**Overall**

The interview and arts-based methods employed in this research were collectively chosen because of their capacity to offer rich ways of accessing experiential knowledge across traditional and alternative means of expression. Together they served for the purposes of eliciting the views of a diverse group of service users across both an inpatient and outpatient setting. This provided a listening ear to the voices of service users who have remained in a minority within a growing body of research that relates to music therapy and mental health.

Fundamental to this research was the promotion of inclusivity as advocated in recovery-oriented practice in mental health. This was achieved through employment of a diverse range of methods of inquiry that offered a broadened conception of knowledge.
creation across two mental health settings. It was also fostered through the research newsletter that kept participating service users and research stakeholders updated on the progress of the research and shared feedback about its findings. It is my intention to return to both of the facilities involved to present the findings in further detail to mental health stakeholders. The next and final chapter will critically reflect upon the role of service users in this research process in addition to framing the study findings in relation to the practice of music therapy in mental health.
Conclusion: Reflection on the Research Process and Findings

Meaningful involvement and inclusion of service user perspectives in the evaluation of health services can occur through thoughtful application of accessible methods. Situated within the context of music therapy practice in mental health, this study has illustrated how service users can provide valuable sources of information about the lived experience of health provision which can amplify current understandings of practice. This rich experiential information is only available via close consultation with those who have direct involvement in music therapy provision. This source of valuable knowledge has been largely overlooked in music therapy research in mental health. This concluding section of the thesis reflects upon the lasting thoughts and impressions that have arisen from the findings with particular reference to the role of the service user. Further framing of the findings in relation to music therapy practice in mental health is presented, along with recommendations relating to future music therapy provision and evaluation.

The Role of Service Users in this Research

This research was approached with an awareness of the dynamic and multifaceted nature of working with people with mental health difficulties. It is based on my prior work for four years in a sole full-time music therapy position situated in a complex adult mental health service with inpatient and community-based services. I was particularly aware of some of the challenges involved in engaging service users, particularly when complex mental health needs are present. However, my experiences of engaging service users in this research did not encounter the challenges that other researchers have reported (Mulder, Ruud, Bahler, Kroon, & Priebe, 2013). This was perhaps due to drawing on my implicit skills as a trained music therapy practitioner but also because those who participated in this research could be
regarded as having a shared enthusiasm to relay their experiences of music therapy in mental health. With the vantage point of hindsight, it is important to thoughtfully reflect upon the collective role and outcome of service user involvement within this study. Such reflection can inform future mental health and music therapy studies that wish to foster inclusive research and evaluation processes.

Each of the nine mental health service users who participated in this research shared personal and unique perspectives providing engaging insights into the lived experience of music therapy sessions. Overall consideration of these findings provided awareness of service users as individuals who used and accessed music therapy in a manner that responded to their own personal needs. Examples of this included: using music therapy for the purposes of improving one’s mood; gaining mastery and skill; reconnecting with music; engaging in relaxation; and being reminded of one’s personhood. Furthermore, it was found that within some descriptions of processes that occurred within sessions, concepts such as self-sufficiency and self-determination were described by many of the participants as they outlined how in music therapy they: could use music to change their mood; play music in a way that responded to what they needed at a particular time; and listen to certain sounds of instruments and block out others. The most poignant is that these descriptions portray a group of service users in music therapy who are empowered and enabled through their participation in music therapy programmes.

Many of the findings presented here illustrate how service user information can bolster and enhance the existing music therapy knowledge base. A relatively recent concept that is developing in the literature and supported by those involved in this study is the starting point from which service users begin therapy. Many described commencing sessions due to having an interest in music or wish for occupation while receiving inpatient care. This re-
echoes other findings in the emerging music therapy mental health service user literature (Ansdell & Meehan, 2010; Rolvsjord, 2010; Solli & Rolvsjord, 2014). Together these present an empowered position on behalf of the service user as they suggest that people do not come to music therapy because it offers a form of psychological therapy that will in some way treat or help them (Edwards, 2006; Erkkilä et al., 2008; Unkefer & Thaut, 2005). Instead their starting point for participation is referenced to an interest or desire in music as an entity that is pleasurable, motivating and fun. This finding contrasts to the idea of music therapy provision for the purposes of symptom reduction and treatment of a mental disorder, which may diminish the self-efficacy of the service user as it places music therapy as the means by which healing occurs rather than activating a service user’s own resources. This view has the potential to reframe the foundations of music therapy, placing service users on a more egalitarian footing with their therapist when commencing sessions. Furthermore, this highlights how service user involvement in research can challenge “some very basic assumptions concerning the process of music therapy” (Rolvsjord, 2010, p. 43).

The service users involved in this study not only provided testimony to confirm previous descriptions of music therapy in the literature. They additionally voiced unique themes that have the potential to amplify practitioner understanding and negotiate change in music therapy practice. Descriptions of the context surrounding one’s decision to attend sessions portrayed how some service users have to overcome some of the challenges of their mental health experiences in order to be able to commence music therapy. This awoke a deep appreciation on my behalf for the hurdles that sometimes need to be overcome before ever a service user sits in the music therapy room. Another unfamiliar aspect of experience in music therapy was that of challenge which was described by service users as relating to the following aspects: the many unknowns about music therapy’s role and process; the impact of past musical experiences upon the music therapy process; and the interpersonal challenges
that can be encountered within a group context. Discussion of these types of challenges from the perspectives of those who use music therapy services has yet to be explicitly addressed within the mental health literature. Music therapists may have been reticent to discuss this issue as it may disrupt the contemporary received view that music therapy is an accessible and manageable forum for communication and dialogue (McCaffrey, in press-a). These findings illustrate the need for such meaningful discussion which not only has the potential to improve and support overall service user experience in music therapy but also provide further insight to practitioners as to reasons why people may discontinue sessions.

Improvisation practices described in the verbal interviews revealed new and thought-provoking findings about lived experience of these processes. Transition into and participation within this musical forum can provide a stimulating sensory world that not only relates to sound but also to sight and touch. Service user accounts illustrated how feelings of frustration and tension can sometimes be experienced within group improvisation because its lack of structure and direction can conflict with service user expectations of musical processes with therapy. This represents one of the most challenging findings in this study as it provides critique of a commonly used method in music therapy that has been described as the locus of the therapeutic experience (Bruscia, 1987). The service user perspectives disrupted the imperative of improvisation as a music therapy method by showing that improvisation is not always be suitable as it cannot always adequately ground or hold them when they are feeling fragile.

All service users who attended group music therapy described how they acknowledged, supported, and listened out for their fellow group members. This image of a group of service users helping and nurturing each other’s contributions in music therapy is one that will remain with me as I conclude this research. It is an empowering vision that
serves as a reminder that in music therapy people can be agents of wellness for themselves and others, even when faced with personal challenges and struggles. This too recasts a prevailing view in music therapy. It translates from the notion of what group music therapy can provide for service users in mental health and amplifies what those within group music therapy in mental health can provide for each other. This repositions service users as active agents within their own and others’ therapeutic process.

In order to enhance understanding of how emancipation of service users can disrupt central assumptions about the music therapy process, reflection upon this practice’s relationship with empowerment is essential. Through exploration of the literature and consideration of clinical vignettes, Daveson (2001) suggested that empowerment is an intrinsic process occurring as consequence of music therapy in all fields of practice. However, this viewpoint has been challenged by other music therapists who have argued that such a suggestion is based on “a vague and perhaps overly comprehensive understanding of the concept of empowerment” (Rolvsjord, 2010, p. 42). Townsend (1998) has suggested that helping others in mental health can sometimes have the potential to disempower, stating that: “what seem like positive helping strategies often subordinate people’s own experience to professional expertise, so that professionals end up in positions of dominance, even when working for and with those who are oppressed” (p. 16). Embracing a philosophy of empowerment in therapy is not a straightforward process. Such a step implies a readiness for broader social change where oppressed individuals and groups are positively repositioned (Procter, 2004). Therefore, an empowering process cannot take place without the willingness to challenge the locus of political power. It is hoped that the findings from this study prompt further political discourse in music therapy to engender a more empowered position of service users in practice and research.
A key point of reflection in relation to the role of the service users in this study relates to the emancipatory framework in which this research was conducted. Critical Theory served as a way to consider the empowerment of service users through the promotion of their active involvement within the research process (L. T. Smith, 2005). While such active participation in mental health research was encouraged through interviews and arts-based focus groups, it is also necessary to reflect upon how, if at all, this research has encouraged emancipation of the service user body in relation to music therapy. Service user consultation with Paddy McGowan as Expert by Experience, took place at the beginning stages of this project. Paddy provided valuable advice around engagement of service users in the research process before data collection but for a number of reasons his input was not possible until the initial ethical clearance application had been submitted. This resulted in the research being predominantly designed from a practitioner perspective; the traditional stakeholder lens for research development. Future emancipatory investigation in music therapy could ensure that service user involvement is engaged at all key stages of the research process from identification of the research topic to dissemination of the findings. More active and power-sharing involvement such as that discussed by Sweeney and Morgan (2009) could be realised in future projects.

A further aspect of consideration in this research relates to the gains of service users and the researcher from being involved in such research. Many service users spoke of their enthusiasm to participate in this study in order to contribute to the practice of music therapy in mental health. Others described how their participation was partly in response to their dissatisfaction about music therapy services being discontinued and their wish to vocalise their disappointment. Reflection upon the arts-based processes and outcomes also brought me to the conclusion that one service user had participated in this research because of the opportunity it presented him to be involved in a creative process. These reflections suggest
that some benefits were gained on behalf of service users who participated in this research. However, it could be argued that these gains did not outweigh those made on my behalf as this research was carried out for reasons of academic and professional training. This once again re-echoes earlier discussions in this thesis that considered the complex and sometimes hidden power dynamics that can occur within the mental health and research contexts.

Having considered this and each of the points above, I consider that the role of service users in this study was positioned somewhere between “passive suppliers of opinion” and “active negotiators for change” (Pilgrim & Waldron, 1998, p. 95). Researchers in the mental health arena are encouraged to consider how their processes of involvement of stakeholders is negotiated, for example being aware of who is involved in determining who the stakeholders are. This can only further bring to awareness the hidden landscapes of politics and power.

**Findings in Relation to Music Therapy Practice in Mental Health**

Service user interviews and interpretations of arts-based materials offered an engaging picture of the life-world in music therapy as experienced in mental health services. Having considered above the individual findings elicited from these investigative processes, it is equally important to now reflect upon the overall context in which these are framed. Aigen (2005) highlighted the significance of context in music therapy where relationships between culture, theory and practice are considered. In reflecting upon the surroundings of this study’s findings it is helpful to consider the term “music therapy in context” as put forward by Rolvsjord and Stige (2013, p. 8). The three different music therapy practices portrayed by service users in this research were offered in two medical contexts, one in an inpatient unit and the other in a community day centre. These practices varied in therapeutic approach and encompassed a range of principles from psychodynamic, humanistic, person-centred and/or GIM traditions. It was not the intention of this research to explicitly relate service user descriptions of music therapy to specific models of practice. However, it is important that the
context surrounding such descriptions is reflected upon in order to garner a closer understanding of the ecological framework in which those involved in this study placed music therapy.

A helpful point for contextual consideration of the study findings may be found in relation to the medical model as it is regarded as the “prominent meta-perspective in various health-care practices” (Rolvsjord & Stige, 2013, p. 5). The medical model has been criticised for overly emphasising ideas relating to mental disorders, pathology and symptomatology while overlooking social and cultural factors that can impact upon mental health problems (Davidson & Roe, 2007; Fox, 2012). In taking such critique into account in relation to this study’s findings, it was found that service user descriptions of music therapy in mental health were quite removed from the language of a medical model. Unlike previous research into service user experience in music therapy (Ansdell & Meehan, 2010; Solli & Rolvsjord, 2014), the participants in this research did not use pathological or symptomatic discourse in describing their experiences of music therapy. On the contrary, they conveyed experiences in music therapy that were characterized with a focus upon normality rather than abnormal pathology. A possible reason for this difference may be because the service users involved did not value or conceptualise music therapy in the same way that those from a medical perspective may assume (Ansdell & Meehan, 2010). It would be rather convenient however, to simply apportion blame towards a dominant medical model for the incongruence in terminology that has emerged from this study’s findings when compared with more treatment based descriptions of music therapy as offered in the literature (Edwards, 2006; Erkkilä et al., 2008; Unkefer & Thaut, 2005). It is possible that these variations arise from a lack of initiative on behalf of the music therapy profession to closely tune in to the perspectives and understandings of those who use music therapy services in mental health. Pedersen (2014) has acknowledged this need by calling for increased and inclusive dialogue concerning music
therapy practice in psychiatry. The challenge for music therapy in this regard is best described by Thornicroft and Slade (2014) who recommended that future mental health practice focusses on “understanding what matters most to people using mental health services, and on the use of measures rated by service users as the primary approach to evaluating outcome” (p. 118).

Similarities between the service user portrayals of music therapy in this study and those described in other established music therapy models and approaches in mental health can be drawn. Such humble efforts can provide an outline of a possible framework around which service user experience of music therapy can be scaffold. This can help identify shared contextual factors that are related to perceptions and understandings of therapy (Wampold, 2001), but also a common language in which perspectives of both service users and practitioners can be conveyed as suggested by Moss and O'Neill (2014). It is fitting to begin such discussion in relation to recovery-oriented practice in which the inclusive and collaborative ideals of this research are situated. In reviewing the experiences of music therapy as relayed through interviews and arts-based materials, key processes of recovery as identified by the CHIME framework were found (Leamy et al., 2011). These pertained to notions of connectedness, hope and optimism, identity, meaning in life and empowerment. Similarly, features of service user experience in music therapy also resonated with recovery-oriented practice guidelines that relate to social inclusion, meaningful occupation, individuality, partnerships, inspiring hope but also with approaches of a strengths-focussed and holistic nature (Le Boutillier et al., 2011). The goal to improve well-being was also shared among the findings and central notions of recovery-oriented practice (Schrank et al., 2014). More nuanced features of service user experience in group music therapy were connected to factors of social recovery as described by Tew et al. (2012). Overall, the service user findings, as relayed through interviews and arts-based materials, reflected many of the
central principles of recovery-oriented practice. This resemblance has also been recognised by other music therapists (McCaffrey et al., 2011; Solli & Rolvsjord, 2014) who have proposed that the rationales of recovery can inform the future development of music therapy in mental health.

The findings of this study mirror central notions of recovery-oriented practice in mental health as well as established models of practice in music therapy where a stronger sense of unity between service user and practitioner views can be found. In reviewing service user descriptions of agency, ability, equity and empowerment, many of the key facets of ROMT shone through (Rolvsjord, 2004, 2010). This embraces the philosophy of empowerment as a “participatory process of learning to critique and transform individual feelings, thoughts, and actions, as well as the organization of society, so that power and resources can be shared equally” (Townsend, 1998, p. 13). ROMT emphasises strengths and potentials in a therapeutic relationship that is based upon collaboration and equality (Rolvsjord, 2004). It is also informed by the common factors approach that “implies a change of interest and focus from the specific ingredients of psychotherapy to the extratherapeutic factors and to the factors that are common to all psychotherapeutic models” (Rolvsjord, 2010, p. 46).

A further important theoretical framework that informs ROMT is that of positive psychology. Rooted within the ideas of Maslow who accused the science of psychology of being far more focussed on negative rather than positive aspects of life (Lopez & Gallagher, 2009), positive psychology values both subjective and shared experiences in the promotion of wellness on both an individual and community level (Ruud, 2010). This is a field of psychology that has flourished in recent years (Seligman, Steen, Park, & Peterson, 2005). Furthermore, it is one that is seen to hold many possibilities for music therapy, whether this
be indirectly through its influence upon ROMT or as an independent approach to practice (Ruud, 2010).

Review of the descriptions of music therapy from the interviews and arts-based materials also resound with practices of music therapy situated in culture as described by Stige (2002). This connection was apparent through service users’ conveyance of cultural aspects of their being that encompassed notions of health, humanity and music. Together these offered constructions of meaning where symbols of one’s culture were presented. Most exciting and perhaps radical of these practices is that they bring a willingness to “go beyond the adjustment of existing models of music therapy to individuals and local context, and may result in completely new ways of practice and in new music therapy theories” (Stige, 2002, p. 42). When adopted in consultation with service users, such a flexible and open approach can open up new possibilities to types of organic practices in mental health that are beyond the walls of the institution. One service user involved in this study shared his dissatisfaction that there was no music therapy provision available to him once he was discharged into the community. This caused him to question why this support was lacking, particularly at a time when he wished to reconnect with music outside of a hospital setting. This illustrates a possibility for community music therapy (CoMT) as an approach where the needs of clients, contexts and music guide. Although CoMT is not easily defined as it is model resistant (Pavlicevic & Ansdell, 2004b), it has been put forward as a way of musicking with people along a continuum that ranges from the individual to the communal (Ansdell, 2002). In this sense “community is not only a context to work in but also to work with” (Stige, 2004, p. 93). Thus with such wide borders, CoMT holds many opportunities for development of music therapy beyond the boundaries of traditional health provision.
This research has presented a rich, in-depth and animated description of service user experience in music therapy. These portrayals of experience through the mediums of art, songs and words, resonate with a number of theoretical approaches to music therapy practice in mental health. The various theoretical frameworks considered relay some of the components of music therapy that are recognised and valued by service users in mental health. While it would be hasty and restrictive to exclusively align such descriptions to one particular model or approach, this exploratory discussion can be used to direct the music therapy and mental health communities towards a closer understanding of how this healthcare practice is received among service users.

**Recommendations**

The need for service user evaluation of music therapy in mental health is particularly propelled by the recovery approach in mental health that advocates for multiple stakeholder involvement in service design and provision. This thesis presented two means of service user evaluation of music therapy that employed verbal and arts-based methods in order to illuminate lived experiences of programmes. These exemplified that service users can provide valuable knowledge about their experiences of music therapy which can be used to inform and enhance service provision. As music therapy practice in mental health continues to develop, it is essential that practitioners in the field not only evaluate the programmes that they provide, but also pursue evaluation in terms of gaining the perspectives of those who attend such programmes.

Without service user evaluation there is risk of professional dominance in relation to the practice of music therapy in mental health. This is problematic when considering the direction in which mental health service development is progressing, particularly in relation to the inclusive and collaborative ethos of recovery that underpins mental health policy in
many countries. Further accounts of service user evaluation of music therapy in mental health will ensure that the voices of those who attend sessions will be amplified within the literature. These will help strengthen the notion of collaborative working between multiple stakeholders as music therapy practice in mental health continues to be defined and developed. Service user evaluation not only offers a means of capturing the views of those who attend music therapy, it also opens up possibilities to uncover unfamiliar aspects of experience in sessions that otherwise would remain unnoticed. Therefore, music therapy practitioners in mental health are encouraged to carry out service user evaluation as a central tenet of their practice.

This study illustrated that service user evaluation of music therapy in mental health is a complex process. It is dependent upon the types of feedback mechanisms used and the willingness of service users to engage with such mechanisms. In order to be effective in terms of capturing the views of those who attend music therapy, it is crucial that such processes are designed with the communicative abilities and preferences of the intended service user group in mind. This can inform the methods of evaluation employed and the means by which such evaluation is conducted. It is recommended that future evaluation processes be collaboratively designed by music therapy practitioners and service users so as to realise both expertise by training and/or skill and expertise by experience. A partnership approach can also be encompassed when considering how the elicited findings will be presented and to whom these will be presented. This study has illuminated potential areas of collaboration between music therapy stakeholders in this area of practice.

Some recommendations can be garnered from the descriptions of lived-experience in music therapy as offered by the nine service users who participated in this study. The findings support an emerging idea in the music therapy literature which suggests that service users commence music therapy because of their love or interest in music. This displaces the idea that people attend music therapy because they have a need to be helped or that they wish to
receive a form of mental health treatment. While there may be many reasons for attendance of music therapy, practitioners in the field are encouraged to explore such motivations with service users so that sessions commence upon a shared starting point that has the potential to reinforce therapeutic alliance between both parties. It is also recommended that where possible, music therapists consider service users’ expectancies of music in sessions. While improvisation is a commonly used method in music therapy practice, this study has revealed that it is not a preferred method of participation for all service users. Improvisation can create feelings of frustration and tension among those who have an expectancy of more conventional forms of music making. Within a recovery ethos the therapist’s training in improvisational methods and preference for improvisational processes should not usurp the opinion or preferences of the service user or group. It is suggested that where service users do not want to participate in improvisation or describe their frustrations with it, the therapist must give pause to reconsider the chosen method.

A final recommendation relates to further inquiry into the challenges encountered by service users in music therapy. This study revealed that challenges can be faced on multiple levels related to the many unknowns about music therapy’s role and process, one’s past experiences of music, or inter-personal challenges within a group music therapy setting. Further exploration of this aspect of experience in music therapy is required so that an increased understanding can be gained of how music therapists can support service user participation in sessions. This may be particularly insightful into reasons for some service users discontinuing music therapy and yet also illuminate transformative aspects of the therapeutic process for those who have sustained engagement in sessions.
Conclusion

This research was carried out with a wish to develop high quality processes for service user evaluation of music therapy in mental health. It also aimed to gain a deeper understanding into the experiences of how music therapy is received among mental health service users. Based upon principles of inclusivity and emancipation that aimed to amplify service user perspectives in the research base, I encountered first-hand the willingness of this often marginalised group to meaningfully contribute to the development of music therapy practice in mental health. Through this creative approach to service evaluation I encountered a wealth of knowledge and expertise among those who have lived experience of music therapy. This brought me closer to appreciating the reasons why people engage in music therapy and the music experiences and meanings that they meet within these sessions. At the centre of these descriptions was how music therapy can acknowledge one’s personhood and also encourage a range of positive experiences within the individual. One of the most insightful findings illuminated how through the process of musical giving within group music therapy, service users can find and offer sources of wellness for both themselves and others. In addition, service users relayed some of the challenges and frustrations that can arise for them in music therapy. This is an aspect of the findings that merit reflection by music therapists who practice in mental health as they consider how to support and encourage service users.

This form of service user evaluation of music therapy in mental health employed both traditional and emergent methods to access experiential knowing. Collectively these pathways to human knowledge offered complex descriptions but also animated materials that in many ways, retained the spirit and voice of the service users who created them. Furthermore, they encompassed verbal, visual and musical domains that have enlivened the research process while still maintaining some sense of wonder. As the inclusion of
stakeholder views is increasingly being emphasised in philosophies and practices of mental health, this music therapy research has revealed the possibilities that arise in embracing familiar and newer forms of inquiry while reflecting upon the views of experts by experience. Music therapy is a profession that engages in healthy debate concerning its future direction (Bunt & Stige, 2014). It is hoped that its future pathway in mental health will involve continued efforts to *tune in* to those who use its services.
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Yuen, F. C. (2004). "It was fun... I liked drawing my thoughts": Using drawings as a part of the focus group process with children. *Journal of Leisure Research, 36*, 461-482.
Appendix A: Poster Advertisement for Interviews

Have you attended music therapy as part of your treatment in mental health services?

Would you consider taking part in research about music therapy?

<table>
<thead>
<tr>
<th>WHAT DOES PARTICIPATING INVOLVE?</th>
<th>WHO SHOULD TAKE PART?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Meet with researcher Tríona McCaffrey, for two occasions for approximately 20-50 minutes to discuss music therapy</td>
<td>Inpatients or outpatients of the Psychiatry Unit at the Adelaide &amp; Meath Hospital Dublin, Incorporating the National Children’s Hospital who have attended music therapy within the past six months</td>
</tr>
<tr>
<td>• Confidentiality assured</td>
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</tbody>
</table>

Tríona McCaffrey works at the University of Limerick and is conducting this research as part requirement for her Doctor of Philosophy degree supervised by Professor Jane Edwards.

If you have any questions or queries please contact Tríona on 085 7841129 or Catherina Brady, Art Therapist, on 01 4143320 at the National Centre for Arts and Health. This study received Research Ethics Committee approval from the AMNCH on 20/06/2012.
Appendix B: Information Sheet for Interviews

September 2012

Information Sheet

Study title- Music therapy in mental health care: Listening to the voices of experts by experience.

Introduction- You are invited to take part in a research study to find out what people who have participated in music therapy offered at AMNCH experienced during sessions. The research will involve two meetings with Tríona McCaffrey in which you will be given the opportunity to describe your experiences of music therapy. Both of the interviews will be recorded to allow for recall of important information.

You will meet with Tríona for 20-50 minutes on two occasions that are convenient to you. If you are an inpatient at AMNCH Tríona can meet you in the hospital. If you are discharged from AMNCH Tríona can meet you at another agreed location. In the first interview you will be asked to discuss your experience of attending music therapy at AMNCH. In the second interview Tríona will show you a summary from the first interview and discuss this with you. Within one week of the second interview Tríona will phone you to follow-up on your participation.

Background to the researcher- Triona McCaffrey is a qualified music therapist who works as a lecturer in music therapy at the Irish World Academy, University of Limerick. She is conducting this research as part of her Doctor of Philosophy degree, supervised by Professor Jane Edwards. She is interested in working with service users to find out more about their impressions of services in which they participate.

Procedures- In order to be selected to take part in this study you must;

- Be 18 years of age or over
- Be an inpatient or discharged patient of the psychiatric unit at the Psychiatry Unit at AMNCH
- Have attended a music therapy sessions at AMNCH within the past six months
- Be willing to speak about your experiences of attending music therapy at AMNCH

Benefits -There are no direct benefits of you taking part in interviews with Tríona, however you may benefit by talking about your own unique experience of music therapy. This will be an opportunity for you to educate others about what it is like to attend music therapy and co-produce knowledge with Tríona that will inform the mental health community.

Risks- There are no anticipated risks related to this research. However, there is a slight possibility that you may become upset when discussing personal experiences in the interviews.
Exclusion from participation- You would not be able to take part in this study if you cannot understand the nature or purpose of the study enough to make an informed decision about agreeing to participate.

Confidentiality- Your identity will remain confidential to Tríona and Catherina Brady of the National Centre for Arts and Health. A recording of your interview will be made on a portable recording device and brought to the University of Limerick. Your name will not be published and will not be disclosed to anyone other than Tríona and Catherina. A false first name will be assigned to your interview when it is talked or written about so as to ensure that your participation will remain anonymous. All documents and recordings will be kept in a locked filing cabinet in Tríona’s office at the University of Limerick. These will be accessed by Tríona, Jane and possibly by an external examiner.

Compensation- Triona is covered by standard public liability and professional indemnity insurance. Nothing in this document restricts or curtails your rights.

Voluntary Participation- You have volunteered to participate in this study. You may quit at any time. If you decide not to participate, or if you quit, you will not be penalised and will not give up any benefits which you had before entering the study. If you decide to take part you will be asked to sign an ‘Informed Consent Form’.

Stopping the study- You understand that your participation in the study may be stopped at any time without your consent.

Permission- This study has Research Ethics Committee approval from the AMNCH.

Further information- You can get more information or answers to your questions about the study, your participation in the study and your rights from Tríona McCaffrey who can be telephoned at 085 7841129 or emailed at triona.mccaffrey@ul.ie

Or alternatively

Professor Jane Edwards who can be emailed at jane.edwards@ul.ie

Or alternatively

Catherina Brady who can be telephoned at 01 4143320

Thank you for taking the time to read this information.

Yours sincerely

Tríona McCaffrey
Doctoral Candidate, Music & Health Research Group
Irish World Academy
University of Limerick
Appendix C: Informed Consent Form for Interviews

Informed Consent Form

Study title: Music therapy in mental health care: Listening to the voices of experts by experience.

This study and this consent form have been explained to me. The researcher, Tríona McCaffrey, has answered all my questions to my satisfaction. I believe I understand what will happen if I agree to be part of this study.

I have read, or had read to me, this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I am aware that I can withdraw from this research study. I have received a copy of this agreement.

Participant’s name: ____________________________

Participant’s signature: _________________________

Date: ________________________________________

Date given form: _______________________________

Statement of investigator’s responsibility: I have explained the nature, purpose, procedures, benefits, risks of, or alternative to, this research study. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely give informed consent.

Researcher’s signature: _________________________

Date: ________________________________________
Appendix D: Recording Consent Form for Interviews

Recording Consent

Study title- Music therapy in mental health care: Listening to the voices of experts by experience.

I give consent to the researcher, Tríona McCaffrey, to audio-record my interviews as I take part in this study.

Participant’s name: ________________________

Participant’s signature: ________________________

Date: ________________________
Appendix E: Poster Advertisement for Arts-based Focus Groups

Have you attended music therapy as part of your treatment in mental health services?

Would you consider taking part in research about music therapy?

WHAT DOES PARTICIPATING INVOLVE?

Partake in 3 focus groups lasting 60-90 minutes with the researcher Tríona McCaffrey.

Use music and/or art to think about your experiences of music therapy.

Confidentiality assured.

WHO SHOULD TAKE PART?

Service users of Inis Cara Day Centre who have attended music therapy within the past six months.

Tríona McCaffrey works at the University of Limerick and is conducting this research as part requirement for her Doctor of Philosophy degree supervised by Professor Jane Edwards.

If you have any questions or queries please contact Ailbhe Dunne or Pat Croker at the Inis Cara (phone 061 312552). This study received ethical approval from the HSE Mid-Western Regional Hospital Research Ethics Committee on 05/09/2013.
Appendix F: Information Sheet for Focus Groups

October 2013

Information Sheet

Study title - Evaluating music therapy through an arts-based focus group.

Introduction - You are invited to take part in a research study to find out what people who have participated in music therapy offered at Inis Cara experienced during sessions. The research will involve three focus groups facilitated by Tríona McCaffrey in which you will be asked to make an artwork or write a song that reflects upon your experiences of music therapy. These focus groups will be recorded to allow for recall of important information. Photographs of the artworks and recordings of the songs will also be made.

You will meet with Tríona and other group participants for 60-90 minutes on three occasions at Inis Cara. During these groups you will be asked to think about your experiences of attending music therapy. Tríona will ask you to use art-making or song writing in thinking about these experiences and offer you help in creating an artwork or song which will be used to inform the mental health community about ways in which service user views can be included in healthcare.

Background to the researcher - Tríona McCaffrey is a qualified music therapist who works as a lecturer in music therapy at the Irish World Academy, University of Limerick. She is conducting this research as part of her Doctor of Philosophy degree, supervised by Professor Jane Edwards. She is interested in working with service users to find out more about their impressions of services in which they participate.

Procedures - In order to be selected to take part in this study you must;
- Be 18 years of age or over
- Be an outpatient of Inis Cara
- Have attended a music therapy session at Inis Cara within the past six months
- Be willing to reflect on your experiences of attending music therapy at Inis Cara

Benefits - There are no direct benefits of you taking part in interviews with Tríona, however you may benefit by reflecting upon your own unique experience of music therapy. This will be an opportunity for you to educate others about what it is like to attend music therapy and produce knowledge that will inform the mental health community.

Risks - There are no anticipated risks related to this research. However, there is a slight possibility that you may become upset when thinking about personal experiences in the focus groups.
Exclusion from participation- You would not be able to take part in this study if you cannot understand the nature or purpose of the study enough to make an informed decision about agreeing to participate.

Confidentiality- Your identity will remain confidential to other participants, Tríona, Ailbhe Dunne and Pat Croker of Inis Cara. Recordings of the focus groups will be made on a portable recording device and brought to the University of Limerick. Your name will not be published and will not be disclosed to anyone other than Triona, Ailbhe and Pat. A false first name will be assigned to your artwork or song when it is talked or written about so as to ensure that your participation will remain anonymous. All documents and recordings will be kept in a locked filing cabinet in Triona’s office at the University of Limerick. These will be accessed by Triona, Jane and possibly by an external examiner.

Compensation- Triona is covered by standard public liability and professional indemnity insurance. Nothing in this document restricts or curtails your rights.

Voluntary Participation- You have volunteered to participate in this study. You may quit at any time. If you decide not to participate, or if you quit, you will not be penalised and will not give up any benefits which you had before entering the study. If you decide to take part you will be asked to sign an ‘Informed Consent Form’.

Stopping the study- You understand that your participation in the study may be stopped at any time without your consent.

Permission- This study has ethical approval from the HSE Mid-Western Regional Hospital Research Ethics Committee.

Further information- You can get more information or answers to your questions about the study, your participation in the study and your rights from Triona McCaffrey who can be telephoned at 085 7841129 or emailed at triona.mccaffrey@ul.ie

Or alternatively

Professor Jane Edwards who can be emailed at jane.edwards@ul.ie

Or alternatively

Ailbhe Dunne or Pat Croker can be telephoned at 061 312 552 at Inis Cara Day Centre.

Thank you for taking the time to read this information.

Yours sincerely

Tríona McCaffrey
Doctoral Candidate, Music & Health Research Group
Irish World Academy
University of Limerick
Appendix G: Informed Consent Form for Focus Groups

Informed Consent Form

Study title: Evaluating music therapy through an arts-based focus group.

This study and this consent form have been explained to me. The researcher, Tríona McCaffrey, has answered all my questions to my satisfaction. I believe I understand what will happen if I agree to be part of this study.

I have read, or had read to me, this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I am aware that I can withdraw from this research study. I have received a copy of this agreement.

Participant’s name: ____________________________

Participant’s signature: _________________________

Date: ____________________________

Date given form: ____________________________

Statement of investigator’s responsibility: I have explained the nature, purpose, procedures, benefits, risks of, or alternative to, this research study. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely give informed consent.

Researcher’s signature: _________________________

Date: ____________________________
Appendix H: Recording Consent Form for Focus Groups

Audio-recording consent

**Study title**: Evaluating music therapy through an arts-based focus group.

I give consent to the researcher, Tríona McCaffrey, to audio-record the focus group as I take part in this study.

Participant’s name: __________________________

Participant’s signature: _______________________

Date: ______________________________________
Welcome to the first edition of this newsletter called ‘Voices of experts by experience’. The newsletter aims to update participants and collaborators on the research in which I am involved that is exploring service user experience of music therapy in mental health care. This is a topic that I have been interested in for quite some time. Before I came to work at the University of Limerick I worked as a music therapist in mental health services for four years. During this time I was privileged to have worked with service users who taught me a lot about what it is like for them to attend music therapy and indeed shared their experiences of the mental health services as a whole. This is where the idea to conduct research about service user experience of music therapy started. It has been wonderful for me to officially start this project in January this year with the supportive supervision of Professor Jane Edwards, and with the help and collaboration of colleagues at Tallaght Hospital. Much has happened since then so I have taken some time to fill you in on where this research is to date.

The early days of the project

‘Voices of experts by experience’ began with a lot of reading about what is happening in Ireland and indeed in other countries with regard to the inclusion of service user voices in mental health care. I wanted to learn more about what people have to say about using mental health services and what has been happening within the field of music therapy in this regard. I was surprised to see that there is very little information available that describes people’s experience of music therapy in mental health care. This highlighted the need for further investigation of the topic.

After gathering my thoughts on what I had read I presented a paper about my initial research plan at the Nordic Music Therapy Conference in Finland. It was really encouraging to see that there was a lot of interest among music therapists in this topic and to also find out that there are other researchers currently working on similar projects in Norway and the UK.
After a lot of time spent reading at my desk in Limerick I arranged a number of meetings with various people to discuss possible next steps in the research. I was keen to involve a service user perspective during all stages of the project. To this end I met with Paddy McGowan, a lecturer at the School of Nursing, Dublin City University. He has personal experience of recovering from a mental health diagnosis. I was delighted that Paddy agreed to become an advisor to the project and offer his guidance on how best the research may move forward.

Recent events

A crucially important task was had in identifying a mental health care facility in Ireland that offered music therapy. This was central to the possibility of being able to talk to people who might have something to say on the subject so I met with Hilary Moss and Catherina Brady from the National Centre for Arts and Health who have offered a great deal of support, information, advice and access for the project. After a massive effort by all parties our application was successfully approved by the Tallaght Hospital Ethics Committee and we got the green light to begin recruitment for interviews at Dublin West and South West Mental Health services which started in September and will run until late November this year.

It is hard to believe that what was once a small seed of an idea is now turning into a reality. This is a really exciting time as I now get a chance to hear what all of you who have agreed to be involved have to say about what it is like to attend music therapy in mental health care. I am really grateful for the chance to listen to you, and I look forward to updating you on my progress and findings along the way.

More to follow . . .
This is the second newsletter sent to people who have expressed an interest in the progress of my PhD research on service users’ experience of attending music therapy in mental health. My intention is to keep research participants and collaborators up-to-date on this research project that commenced in January 2012.

It has been a busy year since I sent my last update. Last Winter I carried out a number of interviews with music therapy service users at the Psychiatric Unit at Tallaght Hospital, Dublin. This would not have been possible without the willingness of staff who facilitated this research namely; Hilary Moss, Catherina Brady and Rory Adams from the National Centre for Arts and Health. The service user interviews have offered fascinating descriptions that have broadened my perspective of what it is like to attend music therapy. It took some time to transcribe the recordings of the interviews but doing so increased my familiarity with the views of people who took the time to speak with me. Over the summer I made considerable progress in analysing these interviews and I’m happy to report that this stage is now complete. The next steps involve considering all the interviews as a whole to see if there are differences or indeed similarities in how people have described their experiences of music therapy.

Last August I travelled to the European Music Therapy Congress in Oslo, Norway and was honoured to present at the very first symposium on Music Therapy in Mental Health Recovery. The Recovery model in mental health promotes the active engagement of those who use services at each and every stage of healthcare planning and delivery. This is a central theme of my research which I discussed in relation to music therapy. It is not only important to consider how service users describe music therapy but it is also important to consider the ways in which such descriptions are sought. A number of other researchers partook in this joint discussion including; Professor Randi Rolvsjord (University of Bergen, Norway), Professor Jane Edwards (University of Limerick), Dr Alison Ledger (University of Leeds), and Hans Petter Solli (University of Bergen). A highlight of the presentation was
when Ingvild Oda Frobøse Moss spoke about her personal experience of attending music therapy for the last number of years.

Last September I presented an overview of my research to the PhD Progression Panel at the University of Limerick. This gave me an opportunity to take stock of the project and think about next steps. The panel was very supportive and asked lots of interesting questions that helped me to think about the research in new ways. They were also impressed by the rich descriptions offered in the interviews about music therapy and shared my hope that these will offer new and exciting knowledge to the mental health field.

Inis Cara Day Centre, Limerick Mental Health Services is currently hosting the next and final phase of this research. Thanks are due to Dr Seamus O’Flaithebheartaigh, Tommy Hayes, Sally Howard, Ailbhe Dunne and Pat Croker for their involvement in this. Service users who have attended or are attending music therapy at Inis Cara have been invited to describe and represent their experiences of participating in music therapy through arts-based focus groups in which they will be offered the opportunity to make music and create art. The visual images and music made within these groups will be used to consider ways that service user feedback can be sought beyond the use of words. This is a unique way of seeking feedback in mental health services and it will be interesting to see what the final art works may discover.

The next task ahead in this PhD journey is to put all the findings together and write the final thesis. This will be my primary goal for the year ahead and I hope to share with you some of the main findings a little further down the line when I’ve had some more time to reflect on them.

Finally, I’d like to acknowledge my PhD supervisor, Professor Jane Edwards, for her support and encouragement throughout the year. I’d also like to thank all of the research participants and facilitators who have helped make this project a reality.

Best wishes

Tríona McCaffrey
Doctoral Student
Music & Health Research Group
University of Limerick
‘Voices of experts by experience’

Newsletter 3: July 2014

By Triona McCaffrey, Music & Health Research Group, Irish World Academy, University of Limerick. Email: triona.mccaffrey@ul.ie

Welcome to the third and final edition of this newsletter called ‘Voices of experts by experience’, written to update participants and collaborators on my PhD research about service user experience of music therapy in mental health. As I come to the end of this investigative journey I wish to inform you about some of my recent research activities and also share some of the findings that have resulted from interviews and focus groups with mental health service users about their experiences of music therapy.

Last January I visited the Leeds Institute of Medical Education, University of Leeds (UK), where I was hosted by Dr Alison Ledger who encouraged me to think about how I could use artistic methods to help me reflect upon some of the research findings. This was a fascinating process that inspired me to write a series of songs about service user views of music therapy. It encouraged me to look beyond more traditional ways of developing knowledge and made me think about the role of artistic practices in reflecting upon research findings.

In March I travelled to the Grieg Academy at the University of Bergen, Norway, to work with Professor Randi Rolvsjord and Hans Petter Solli who have also carried out research into service user experience of music therapy. It was a pleasure to present my research at the Grieg Academy Music Therapy Research Centre while also being invited to host a meeting with local music therapists who practice in the area of mental health. I also had an opportunity to teach some of the music therapy students at the Grieg Academy about music therapy practice in mental health recovery and speak at a ‘sofa seminar’ about the topic of service user evaluation. Other notable events of the past few months include my visit to Professor Mike Slade at Kings College London, who is an international leader in recovery research in mental health. Another highlight included my presentation at the recent ‘Refocus on Recovery Conference’ at Kings College London which provided me with lots of interesting ideas as I set about the task of writing my PhD thesis.
Findings

Various rich and in-depth findings arose from my individual interviews with service users about their experiences of music therapy. Many service users explained that they initially went to music therapy because they wished to do something that would keep them occupied. They also reminded me that there are often many challenges and unknowns when first starting sessions. This can be influenced by one’s musical history and other service users within a group setting, but also by the degree to which music has meaning in one’s life. These reminded me that music can be highly personal and something that has the ability to activate both painful and pleasurable memories. Once service users overcame the challenge of starting a therapy that they knew very little about, they described their experiences of sessions as helpful, de-stressing, tension relieving and healing.

It was interesting to note that service users did not talk about music therapy in terms of treating their illness or related symptoms but instead described how experiences of music in sessions can be very emotive and stimulating in terms of sight, sound and touch. They reported that playing music in sessions provided them with an opportunity to make a meaningful contribution in a way that makes them feel connected with others. However, improvisation that involves playing the ‘music of the moment’ can sometimes be frustrating because of its lack of structure. This became evident in instances where service users described their expectation that music therapy should provide them with some form of musical instruction. This suggests that there are different opinions about improvisation among service users which may be related to what they wish to achieve in sessions. Finally, music therapy was described as a service that is person-centred because it addresses the personal needs of the individual. Service users explained how they can adapt their involvement in accordance to how they are feeling on any particular day. They particularly referred to the role of their therapist in this regard who presented sessions in a way that is accessible and manageable.

Interesting accounts were also revealed in the arts-based focus groups that involved the use of drawing and song writing to represent service users’ experiences of music therapy. Reflection upon one visual image and three songs created by service users in these groups, brought me to some simple yet significant conclusions. The first is that service users may attend music therapy not because they wish to be ‘treated’ but instead that they have an interest or love in music that they wish to nurture. This is particularly relevant to recovery in mental health which encourages that service users engage in forms of activity that promote wellness. Another conclusion from this stage of the research was that music therapy involves an interpersonal relationship between service user and therapist that requires both compromise and collaboration. This too is relevant to recovery in mental health that promotes meaningful relationships between service users and providers.
Thank you

This research would not have been made possible without the many people who supported me since this project began in early 2012. These include my supervisor Professor Jane Edwards, the service users who partook in the research and those who offered advice and assistance along the way- my sincere thanks to you all.