"Music therapy helped me get back doing": Perspectives of music therapy participants in mental health services.

Introduction

Recovery is a leading approach in modern mental health care that endorses the inclusion of the service user as an expert-by-experience in the planning, delivery, and evaluation of services. Recovery 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 et al., 2012), and The Mental Health Action Plan 2013-2020 (World Health Organisation, 2013) emphasizes the recovery ethos in mental health services. Anthony (1993) has described recovery 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” (p.7). The narratives of people who have experienced mental health services provide a means by which human diversity can be illuminated. They also personalise the experiences of people with mental health difficulties so that they can be involved as active agents of change within mental healthcare systems (Smith, 2005).

Individual Voices in Music Therapy

In the past decade discussion about the potential role of music therapy as a recovery-oriented practice has occurred (for example, Chhina, 2004; Eyre, 2013; Kaser, 2011; Kooij, 2009; McCaffrey, Edwards & Fannon, 2011; McCaffrey, 2014). 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” (McCaffrey et al., 2011, p. 187). Solli, Rolvsjord and Borg (2013) considered the resonances between music therapy and recovery-oriented practice concluding 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” (p. 244). There is a small body of literature that records and reflects service user experience of music therapy (Hammel-Gormley, 1995; Rolvsjord, 2010; Solli, 2014; Solli
and there is some evidence that service user evaluation of services has been undertaken (Baines, 2003; Baines & Danko, 2010; Carr et al., 2011; Dye, 1994; Heaney, 1992; Reker, 1991). This body of work provides opportunities for deeper learning about music therapy’s impact on individuals, and offers insight into personal processes engaged in the journey towards wellness.

Personal accounts based of lived experience can disrupt or challenge dominant narratives that have emerged within practice. For example, Ansdell and Meehan (2010) interviewed 19 service users with chronic mental health problems and found that service users “do not necessarily experience (and value) . . . therapy in the way referring clinicians, and researchers defining ‘outcomes’ and ‘effectiveness’ in this clinical area may perhaps anticipate” (p.35).

A recovery approach in mental health service provision emphasises the expertise of the service user in being able to indicate their needs in relation to wellness and recovery. Music therapists have heeded the call to include the voices of service users in multiple ways. A small number of reports have indicated service users’ conceptualization and engagement with music therapy. Nine inpatients were interviewed about their music therapy experiences with the researchers concluding that in many situations in which therapy experienced music therapy service users described it as the “opposite of treatment” (Solli & Rolvsjord, 2014, p. 18). Their findings cautioned about the risk of “pathologizing” or “medicalizing” the processes that occur within sessions (Solli & Rolvsjord, 2014, p.18). Hammel-Gormley (1995) stated that “we need to illuminate how our patients use music and view music therapy. After all, our patients are the ‘experts’ themselves; they know themselves better than we do” (p.5). Such illuminating may uncover existing unknown implications while also prompting new directions for practice.

This paper presents the first author’s PhD research, supervised by the second author, that focussed on service user evaluation of music therapy in mental health. This evaluation specifically focussed on personal lived experience of music therapy in order to gain a deeper understanding of how such a service is received among those who have attended sessions in mental health. Both
Method

Participants

A statutory mental health provider of music therapy agreed to host this study in an inpatient hospital setting in **** [country de-identified to preserve anonymity]. Ethical approval from the relevant hospital ethics committee was attained to carry out individual interviews with service users who attended music therapy at this hospital. Inpatients and outpatients were included so as to allow follow up if a change in patient status occurred between initial information and informed consent stages of the research. The main inclusion criteria were that participants were over 18 years of age and were willing and able to speak about their experiences of voluntarily attending weekly music therapy in a verbal interview in the English language for approximately 20-50 minutes duration. Each participant was an inpatient or discharged patient of the psychiatric unit at the hospital who had attended a minimum of two music therapy sessions within the past six months. The exclusion criteria applied 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 interview and any consequences.

The Researchers’ Lens

Both authors of this study have experience in music therapy service provision in mental health services, and expertise in service development. The first author previously worked in a recovery-oriented mental health service where the importance of meaningful collaboration between service users and providers was emphasised. It was this author’s experience that individual perspectives of treatment have a valuable and influential role to play in service development in mental health. As recovery-oriented practice underpins adult mental health services in the country that this study was undertaken, research that involved listening to stakeholder perspectives was deemed timely. At the time the research was conducted there were few music therapy mental health services in
existence in this small country. The music therapy service evaluated in this study was provided by two music therapists professionally known to both authors. Their practices in the inpatient setting described varied in therapeutic approach and encompassed a range of principles from psychodynamic, humanistic and person-centred traditions. The nature of the music in group or individual sessions is primarily focused on clinical improvisation.

Procedure

Methodology

Interpretative Phenomenological Analysis or ‘IPA’ (Smith, 2004; Smith, Flowers & Larkin, 2009) offers an approach to qualitative, experiential, and psychological research by which to investigate human experience (Eatough & Smith, 2006; Owens, Crone, Kilgour, & El Ansari, 2010; Pothoulaki, MacDonald, & Flowers, 2012). IPA has been used in service user evaluation in mental health research (Fortune et al., 2010; Furness, Armitage, & Pitt, 2011). 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. Together these elements conceptualise lived experience in a way that acknowledges the subjective nature of human existence and the interpretative function of research in responding to and representing participants’ experiences.

IPA endorses the one-to-one interview as the most appropriate way to foster rapport between the interviewer and participants. The interview aims to elicit the participant’s thoughts, stories and feelings with the aim of providing a deep understanding of the phenomenon under investigation (Smith et al., 2009). It is a “dialogue whereby initial questions are modified in the light of participants’ responses, and the investigator is able to enquire after any other interesting areas which arise” (Smith et al., 2009, p. 57). The interview involves a process of active participation where the participant is regarded as “the experiential expert on the topic in hand” (Smith et al., 2009, p. 58). Participants were invited to participate in two face to face interviews with the researcher. Two interviews provided participants with an opportunity to clarify, contest, confirm or elaborate upon
earlier discussions for the purposes of clarity and transparency, credibility and trustworthiness (Telford & Faulkner, 2004; Finlay, 2006; Kowlessar & Corbett, 2009).

**Data Collection**

Poster advertisements were placed on notice boards in the unit. A research gatekeeper, as the main point of contact for research related issues at the hospital, handed information to people who had attended music therapy. There was a three month window during which interviews could be conducted due to the availability of the research gatekeeper at the service. Recruitment continued until expressions of interest around involvement ceased. A total of two men and four women, agreed to participate in the interview stage of this study. These included Luke, Ollie, Pauline, Barbaraela, Carma and Laura (participant chosen pseudonyms), each of whom were attending music therapy at the time of recruitment. This sample size fitted the small participant pool available at the hospital and provided a group sufficient to undertake a quality IPA study.

The location of the interviews depended upon participants’ status within the service. Five of the six participants were interviewed in a private room at the psychiatric unit of the hospital. One participant who had been discharged from the hospital was interviewed in a community mental health day centre. After being provided with an opportunity to ask questions and clarify that they agreed to participate, each participant was given an informed consent and audio-recording consent forms to sign.

The direction of the IPA interview is co-determined in situ prefaced with the leading statement of “I am interested to learn about your experience in music therapy”. Overall, the researcher’s main focus during the interviews was upon being open and available to participants in a way that would encourage them to discuss and reflect upon their personal experiences (Ezzy, 2010). This included being open to the possibility that participants may wish to share their dislikes or annoyances regarding music therapy. The duration of each of the six initial interviews varied approximately between 18-55 minutes.
At the end of the first 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. These have been used successfully in previous research with which the authors have been associated (Ledger, 2010). Provisional arrangements were then made for follow-up interviews to which four participants agreed (Luke, Ollie, Pauline and Barbaraella). Carma chose not 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.

Audio-recordings of the first interviews were listened to and transcribed before carrying out the follow-up interviews. 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.

Trustworthiness

Follow-up interviews provided participants with an opportunity to clarify, contest, confirm or elaborate upon earlier discussions. After contributing to the study all participants were given an opportunity for a debriefing about their experience of being involved in this research. Participants were either phoned or visited on the ward by the first author or gatekeeper. Having previously carried out a music therapy study that employed IPA, the first author was familiar with utilizing this methodology (Author, 2013). However, as a means of creating greater trustworthiness the first author continually checked all emergent themes with the second author throughout the analysis stage of the interviews.

Analysis

Audio-recordings of all interviews were transcribed verbatim. 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. As advocated by 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 (language) 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 (Smith et al., 2009). Each comment category required a separate reading of the transcript.

5. The researcher’s thoughts and impressions were noted while reading and analysing the transcripts. These were written in a reflexive journal and also inserted in comment boxes in the interview transcript.

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 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. Photographs of the super-ordinate themes were taken and transferred onto a 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.

9. 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.

**Findings**

Ten interviews with six participants who described their experiences of individual or group music therapy in mental health were transcribed and then analysed. These interviews provided insights into lived experience of music therapy in mental health. A selection of the main super-ordinate themes in relation to each participant’s interview are presented below. Some of the interview dialogue reflections are reported in present tense. This can have the effect of making the information more immediate and compelling to the reader. After presentation of the main themes a brief summary is provided that reflects the distinctive contributions made by each of the service users in the context of this research.

**Luke**

Luke described his experiences of attending individual music therapy as an outpatient. Some of the main themes found across his two interviews included; ‘Being introduced to music therapy’; ‘Person centred nature of individual music therapy’; and ‘Music in music therapy’.

**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, 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.

Luke alludes 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.

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 “bettering yourself 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:

Researcher: 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 highlights 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.

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 ‘draw’ 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 recalls how sometimes he and his therapist “would jam around” in a casual manner whereas on other occasions a highly interpersonal process can be 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”. When engaged in play he sometimes feels “quite soulful in a happy way” in addition to being “comfortable” and “ecstatic”. 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”.

Summary

According to Luke, the rigid and depersonalised culture of previous healthcare services viewed him 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. He 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).

**Ollie**

Themes found across two interviews with Ollie described his experiences of attending group music therapy sessions in an inpatient setting. These included ‘Finding a voice in play’ and ‘Music therapy reignites a spark for music’;

**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 recalls 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 past 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 …

Thus Ollie can find a means of communicating with others using music.

**Music therapy reignites a spark for music**

Ollie recalls 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 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”.

Summary

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.

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) defined the “music-health-illness narrative” (p.32) 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, Bird, Le Boutillier, Williams, & Slade, 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.

**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. Such distinctive themes included ‘Music therapy is about one’s life in music’ and ‘Shared improvisation is interpersonal’.

**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. This was undertaken in the hope that the instrument 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”. Although Pauline wishes to keep the past and present separate, her memories of music therapy are blended into the other musical memories in her life. This makes it difficult to distinguish which of these memories were related to music experiences in her life, and which related to music therapy. It leads to the conclusion that these are 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.

**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 explains 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. These 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 explains 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”.

**Summary**
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. This is 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).

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.

**Barbaraella**

Themes found across two interviews with Barbaraella described her experiences of attending group music therapy sessions in an inpatient setting. Some of these included: ‘Ability replaces disability in music therapy’ and ‘Music is a reminder of youthful wellness’.

**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”.

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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 it was unclear if Barbaraella was referring to music or music therapy in the lines above. However, upon reflection it was 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.
Researcher: So it keeps you young?
Barbaraella: That’s the way I look at it.
Researcher: 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. Group music therapy sessions 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 the 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:

Researcher: Is that fair to say Barbaraella about music being important about identity?
Barbaraella: Maybe not for everybody, maybe not to everybody.
Researcher: Ok
Barbaraella: To me certainly yeah.
Researcher: Yeah.
Barbaraella: That’s the way I would say now.
Researcher: 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 led 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.

**Summary**

*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). This 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 experienced 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).

**Carma**

Carma described her experiences of attending group music therapy sessions in an inpatient setting. One poignant theme emerging from her interview included ‘Experiencing sound in music therapy’.

**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  
Researcher: 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  
Researcher: 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”.

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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”. Carma’s perspective is reminder that music comprises of many sound components and that elements of sound can be quite selectively experienced in music.

Summary

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 experiences when hearing the drums and indicates that over time she was able to manage her perception of sound in sessions.

Laura

Themes found in Laura’s interview describe her experiences of attending group music therapy sessions in an inpatient setting. Some of these included: ‘Context of the music therapy setting’ and ‘Instruments visually stimulate’.
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 [a term of endearment for someone who is mischievous] knows what … but I’m the same meself sometimes”. Therefore, Laura’s experiences of music are set within a restless environment.

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.

Summary

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.

Limitations of the Study

Some limitations arose over the course of this research. It was designed with awareness that there are few mental health services in ***** [country removed to preserve anonymity] in which music therapy is offered to service users. Therefore, this study was carried out with the aim of presenting detailed accounts of individual experience to highlight what can be offered and how it is experienced. It concentrated on depth, richness and complexity of the experiences of the participants. Additionally, some participants were still attending music therapy and some were in the process of termination. There may be unaccounted factors that are present in these accounts that might not be evident if participants were reflecting on their experience at some remove. Furthermore, as participants self-selected to be part of this study, their enthusiasm to do so may indicated a positive bias towards music therapy. Other possible limitations of this research design include the variable duration of interviews which ranged from approximately 20-55 minutes, reflective of the varying needs and wishes of service user participants. The first author also notes the challenge encountered within the interview process, particularly when discussion wandered off-track from the topic of music therapy.

Conclusion

Each of the six summaries and their related themes above, offer rich snapshots into the lifeworld of people who participated in this music therapy programme. Rather than presenting a form of evaluation that measures programme performance, the form of evaluation employed here is described as a process of asking questions which focus on the impact of care on the individual (Barrett, 2008). Such evaluation also provides a way of gaining perspective through open dialogue (Fortune et al., 2010). Placing such service user perspectives “in context” as suggested by Rolvsjord and Stige (2013, p. 8), the two practices described in this study varied in therapeutic approach and
encompassed a range of principles from psychodynamic, humanistic and/or person-centred traditions. This provides some dimensions of the ecological context highlighting the unique and varied perspectives of music therapy among a group of mental health service users in ***** [country anonymized].

**Implications for service and practice**

This study serves to illustrate the rich information and learning that service user evaluation can offer practitioners in the development of music therapy practice. Pedersen (2014) has called for further inclusive dialogue concerning music therapy practice in psychiatry. Similarly, Thornicroft and Slade (2014) have recommended that future mental health practice focus 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). This research shows that a person not associated with the therapy who carefully listens to the accounts of service user participants can elicit valuable information to support the ongoing provision of services. In everyday service evaluation procedures by which a manager or even a practicum student involved in another area of the service can take notes of verbal accounts of participation by service users should be developed.

**Implications for research**

Engaging service user evaluation of music therapy responds to the impetus of the recovery approach in mental health in which stakeholder involvement in service design and provision is endorsed. As music therapy practice in mental health continues to develop, it is essential that practitioners in music therapy continue to evaluate the programmes that they provide, and pursue this evaluation through gaining the perspectives of those who attend. Without service user evaluation there is risk of professional dominance in relation to the practice of music therapy in mental health. This is no longer a feasible position in recognition of recovery which promotes the involvement of service users at each and every stage of service provision (WHO, 2013). A broader concept of evidence is
needed to ensure that the voices of those who attend music therapy are consistently included in future service development.

References


