Musical Recovery: The Role of Group Singing in Regaining Healthy Relationships with Music to Promote Mental Health Recovery

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Abstract

This thesis describes an emergent project which investigates the role of group singing in inpatient and community mental health settings. Music therapy has previously been identified as a way to foster processes of mental health recovery (Hense, McFerran & McGorry, 2014; McCaffrey, Edwards, & Fannon, 2011; Solli, Rolvsjord, & Borg, 2013). However, little is known about the specific factors apparent in group singing which promote recovery. This project aimed to address this gap by exploring the role of group singing in promoting recovery through a small mixed methods study and a larger grounded theory study. Adults aged between 18 and 72 years who were in mental health recovery participated in this research and were recruited from a number of different inpatient and community contexts around Melbourne. Key principles of recovery-oriented philosophy (Slade, 2009) and resource-oriented music therapy (Rolvsjord, 2010) were adopted.

An initial mixed methods study was conducted which aimed to both explore experiences of group singing and measure outcomes of belonging before, during and after a 10 week community group singing program (Bibb, Baker, Tamplin & McFerran, under review). The qualitative analysis revealed that being with others, being heard, having a sense of purpose, achieving something and group size and setting contributed to participants experiences of the group. However, little could be concluded from the quantitative data, since for individual reasons, each of the four participants reported difficulty completing the measures. This led to a change in focus of the study to include an additional interview question asking participants to specifically reflect on their experience of completing the self-report outcome measures (Bibb & McFerran, under review). In addition, a need to critically examine
the measures used in mental health research and the assumptions surrounding their ‘reliability’ was identified. A method of Critical Interpretive Synthesis was used to interrogate the most commonly used self-report outcome measures in mental health research in the last ten years (Bibb, Baker & McFerran, 2016). The results of the critical synthesis indicated that many of the measures most commonly used in mental health research do not align with the contemporary recovery-oriented philosophy of mental health care.

The second study of this thesis adopted a grounded theory approach to explore the conditional and contextual factors involved in group singing. Collaborative interviews allowed for the participant and the interviewer to be active in making meaning of the participant’s experience (Holstein & Gubrium, 1995). The findings of this study, after 29 interviews, impelled the development of a new term, ‘musical recovery’ which depicts a process of regaining healthy relationships with music to promote mental health recovery. A number of factors are identified as promoting and interfering with musical recovery within a group singing context. The musical recovery framework illustrates how music therapy practice can be a process of recovery in itself.
Declaration

This is to certify that:

i. This thesis comprises my own original work towards the degree of Doctor of Philosophy except where indicated in the Preface,

ii. Due acknowledgement has been made in the text to all other material used,

iii. The thesis is fewer than 100 000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed: __________________________________________

Name: Jennifer Bibb
Date: 09/12/2016
Preface

This thesis includes an extended version of a published article and two articles currently under review. Authorship of these works has been determined in discussion with the supervisory team.

Paper 1 in Chapter 3


This co-authored paper reports the method and findings from the first study of this project. It is under review with a music therapy journal.

Paper 2 in Chapter 4

Bibb, J., & McFerran, K. S. (under review). The challenges of using self-report measures with people with severe mental illness: Four participants’ experiences of the research process.

This co-authored paper reports the method and findings from the first study of this project. It is under review with a community mental health journal.

Paper 3 in Chapter 5

This paper reports on the method and findings from a Critical Interpretive Synthesis of outcome measures used in mental health research. It was published in a peer-reviewed mental health journal in January, 2016. An extended version of this paper is presented in Chapter 5.
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Chapter 1

Introduction

Motivation for the study.

This study arose through my work as a music therapist with people experiencing mental illness. I work in both inpatient and community mental health settings at a number of different mental health services in Melbourne. My work consists mainly of groups in these settings as this is what is prioritised by the services who employ me. I have a background of classical training in singing and throughout my life I have participated in choirs and singing groups. In my music therapy work I also use singing and songs and encourage the singing and discussion of pre-composed songs as a way of promoting recovery. The approach I bring to my work with people in recovery is broadly resource-oriented (Rolvsjord, 2010) and humanistic, as described by Abrams (2015).

The work that prompted this study began in 2010 with the establishment of a community choir within a community-managed, social housing estate in the outer eastern suburbs of Melbourne. The estate was for people experiencing mental illness to live in if they had previously been homeless and were dependent on the government for financial support. The 150 residents of the housing estate were actively engaged in the creation of the space that was their home - it was a cooperative. A local community health service managed the housing estate in which residents were supported to develop leadership skills so they could facilitate the cooperative themselves, together as a community. The cooperative was a new concept in social housing at the time and was considered an Australian government initiative. I became involved with the community health service in the months following the cooperative’s opening and was employed to ‘build a sense of community’ in the
newly established building through facilitating a small choir. While working with the group, many participants shared their previous experiences of feeling isolated while living in the community and being disconnected from others with lived experience of mental illness. They described the choir as offering them a place to ‘be with others’ who understood their experiences as well as the opportunity to connect with people in the housing estate. Some participants also reported how singing together acted as a motivation to participate in a social activity and to begin interacting again with their social environment. Participants of the group made their own logo and t-shirts for the choir, organised a fundraiser to purchase musical instruments and performed to their peers at community events, taking ownership and pride of their group. Over time the group became self-sufficient and they used the skills and confidence gained from this experience to attend other groups and make connections outside of the housing cooperative within their new local community.

This experience raised questions for me. Although these experiences may not have been unique to participation in singing groups, I wondered what is was about singing together with others that motivated these people to connect socially with one another? It led me to pose more general questions, such as: how and why can singing in a group facilitate this sense of feeling connected with others? And, is this experience particular to certain groups? I began to think that if singing in a group had a particular capacity to facilitate connections with others, this could be a way of promoting music and music therapy within mental health services around Australia. After I had finished working with the choir (they became self-sufficient and received ongoing support from the community health service), I continued working in inpatient and community mental health settings with people in recovery and to use group singing within my work to promote recovery. A desire to understand the factors that
were important in promoting recovery through singing together prompted me to embark on this research project.

**Aim.**

The aim of this research was to understand the role of group singing in mental health recovery in a number of community and inpatient contexts in Melbourne, Australia.

**Scope.**

This study includes 27 adults aged between 18 and 72 years who are in mental health recovery. Participants were recruited from a number of different inpatient and community contexts within different health and not-for-profit organisations around Melbourne. These people were either interested in attending a singing group through their community mental health service (study 1) or currently participating in singing groups with a music therapist or community musician (study 2). A variety of contexts where people in recovery participate in singing groups were chosen so that the different conditions that foster recovery through group singing could be explored.

In Australia, music therapists commonly use group singing in their work with people in mental health recovery in both inpatient and community health settings. These programs are commonly funded by government health organisations. Community musicians or mental health workers also facilitate singing or choir groups of people in recovery living in the community. These groups are often financially supported by community mental health services or local council or church organisations.

**Overview of the Thesis**

**Structure.**

This thesis is being submitted ‘with publication’, meaning that several
chapters comprise published articles or unpublished articles that have been formatted for publication while others comprise unpublished pieces formatted in a traditional thesis structure. A thesis with publication differs from a traditionally formatted theses since instead of containing a comprehensive literature review, method, results and overall discussion, many of the chapters (that are formatted for publication) contain a brief and targeted literature review, addressing the literature most relevant to the particular phase of the thesis. The chapters formatted for publication also contain a discussion that contextualises those particular findings within literature that is specifically relevant to that topic. Each chapter also contains its own reference list, tables and figures. Tables and figures are numbered according to each chapter rather than consecutively throughout the thesis.

Although I am the main author of this thesis, some chapters that are written for publication have co-authors listed in order to recognise the contributions of my supervisors. This has resulted in some difference in voicing across the thesis, between singular and collective. The relationship between myself and my supervisory team who were co-authors of many of the chapters in this thesis was collaborative. The diverse perspectives of my supervisors were greatly valued. The iterative nature of this thesis and the way it emerged based on the outcome of each phase required a short reflexive piece be written between each chapter to guide the reader, titled ‘bridging material’. Each piece is written in a reflective style influenced by Linda Finlay (2008)’s theoretical position on reflexivity and describes the way findings and learnings from each chapter influenced the design and approach of the next chapter.

**The emergent story.**

When this study began I was clearly located in an objectivist position with the aim of exploring group singing in relation to feelings of belonging in adult mental
health recovery. Chapter 2 presents a systematic review of the literature where we attempt to provide a basis for the study in the objectivist position by examining the current state of research on the area of group music therapy in mental health settings and the conditions that contribute to promoting belonging in this context. It became clear through this review that there were minimal quantitative music therapy studies which measure belonging in mental health settings. It was also apparent that belonging was a subjective concept, difficult to measure and there were few reliable self-report tools specifically designed for use with people in mental health settings. It was also apparent that social withdrawal and isolation significantly impact people’s ability to live with mental illness in the community. Therefore, the role of music therapy in fostering social connection seemed an important area of research for further exploration.

Chapter 3 describes a mixed methods study (study 1) where I attempted to measure belonging before, during and after a 10 week group singing program and interview participants about their experience of the program. I was interested in both measuring and understanding the experience of belonging through participation in group singing within a therapeutic context, in order to determine the feasibility of a larger controlled study. It was important, from an objectivist standpoint, to use validated and reliable tools to measure belonging, but I was also conscious of not placing unnecessary burden on participants by using too many tools or those which were cognitively challenging.

Once data collection began, my concerns about the cognitive challenges of completing the measures were confirmed. For individual reasons, each of the four participants in my study found the research process challenging. Participants described finding the measures unclear, difficult to understand and tiring to complete.
I was the group facilitator, researcher and data collector for the study so I observed these challenges first hand. One participant told me that he had ‘guessed’ the answers while completing the tools, and another voiced her experience of disempowerment from not understanding the questions. I began to have doubts about both the accuracy of the data I had collected and the ethical nature of what I had asked participants to do. After significant contemplation and ongoing discussions with my supervisors and postgraduate research group, this led to a significant inclusion of an additional question in my interviews with participants: I asked them to specifically reflect on their experience of completing the self-report outcome measures. This data is described separately in Chapter 4 of the thesis. Privileging and acknowledging these experiences felt necessary despite realising that their responses might challenge my ability to maintain the philosophical stance I had consciously adopted at the beginning of the study. After exploring participants’ experiences of the research process further, I chose to reposition myself and reconceive subsequent stages of the research. I was not able to continue the study within an objectivist frame after doubting the accuracy and process of using outcome measures in research. It must be noted here that many researchers believe that paradigms cannot be combined or shifted within a single study (i.e. Guba & Lincoln, 1994). I fundamentally disagree with this and consider myself an Australian, pragmatic early career researcher in the field of music therapy and mental health (Bibb, Castle & Newton, 2015, 2016). Pragmatism offers a useful tool for addressing the philosophical issues which may arise when integrating research methodologies and paradigms (Biesta, 2010; Dewey, 1920). Pragmatic researchers understand truth as contextually based in one’s interaction with the world and therefore believe research must be adapted in response to this interaction. I
discuss the philosophical issues that emerge with combining paradigms further in the next section of this chapter.

After observing the participants responses so closely, I decided to critically examine the measures used in mental health research and the assumptions surrounding their ‘reliability’. I used a method of Critical Interpretive Synthesis that had been developed within our graduate research group and interrogated the most commonly used self-report outcome measures in mental health research in the last ten years, which is described in Chapter 5 of the thesis. The results of the critical synthesis indicated that many of the measures most commonly used in mental health research do not align with the contemporary recovery-oriented philosophy of mental health care which emphasises lived experience and user input.

After gaining some critical insights about the nature of outcome measures that are popular in mental health research, I became interested in finding a more meaningful way to explore the role of group singing in promoting connectedness in mental health contexts. A grounded theory approach was taken in the next study (described in Chapter 6) which allowed for the exploration of likely explanatory models for understanding group singing in inpatient and community contexts. I was interested in a grounded theory approach due to the ways it would focus on the conditional and contextual factors involved in group singing and how these could promote recovery. In the interviews with participants in this study, I initially maintained a broad scope, with the intention of narrowing in on experiences of belonging and connectedness later in the data collection. However, when the first five participants I interviewed placed importance on experiencing and coping with challenging emotions evoked in response to hearing songs in the group, I allowed my focus to shift and began to see this as the central phenomenon for the grounded
theory. The final interpretation of the data, after 29 interviews, presents a theory of the way people experience triggering encounters with memories and emotions after hearing songs in the group singing context and subsequently use the supportive conditions of the group to regain a sense of health.

Chapter 7 provides a discussion of the findings from the second study and the resultant grounded theory. I propose a new term, ‘musical recovery’, which provides a framework for regaining healthy relationships with music to promote mental health recovery. I describe the similarities between musical recovery and mental health recovery and depict musical recovery as a process, rather than an outcome. Factors which interfere with and promote musical recovery within a group singing context are presented, as well as a suggestion for the possibility that musical recovery can occur in many different settings where people in recovery engage in supported music use.

Repositioning and mixing epistemology.

As a clinician-researcher, I believe that knowledge should be based on the practicality of ‘real world’ clinical practice and a study can be feasibly adapted in response to the researcher’s engagement with the clinical world (Biesta, 2010; Robson, 2011). There is great value in comparing and contrasting the implications that result from studies with multiple worldviews and perspectives (Greene, 2007; Creswell & Tashakkori, 2007) and therefore researchers need not adopt a fixed paradigm or definitively exclude the combination or change of worldviews over the course of a study. Pragmatism provides a tool for solving the philosophical issues which may arise when integrating research methodologies and responds to the practicality required when conducting clinical research. John Dewey (1920)’s theoretical work is the most influential strand of pragmatism in the development of 20th century philosophy of science. Dewey’s theory of knowledge depicts ‘truth’ as
contextual, meaning that knowledge cannot be a passive depiction of reality, but rather is a human construction. As humans, we learn and develop knowledge through our transactions or experience with the environment. Through this experience, we learn a complex and flexible set of tendencies for action which can be understood as our experience and the way the world responds to us. In this way, the world appears as a function of what we do and how we interact with it. Thus, pragmatic researchers tend to reject the alleged hierarchy between objectivism and subjectivism instead believing that no knowledge can provide us with a deeper or more true account of the world (Johnson & Onwuegbuzie, 2004). Rather, since we have different ways of engaging with the world and different approaches eventuate in different outcomes, it is just different knowledge that results from adopting different approaches. The notion of ‘truth’ is rejected within this approach and instead importance is placed on the context in which knowledge is developed. Therefore, mixed methods researchers who adopt a pragmatic stance, make claims of knowledge which are considered pragmatically in relation to the context and ways in which the knowledge has been generated.

A number of authors have introduced key philosophical ideas from pragmatism to the field of mixed methods research (Greene & Hall, 2010; Johnson & Gray, 2010; Johnson & Onwuegbuzie, 2004). One theorist, Gert Biesta (2010) offers an interesting perspective on how pragmatism offers a deeper understanding of the strengths and weaknesses of mixed methods approaches, rather than a paradigmatic underpinning or justification for conducting this type of research. He argues that the notion of paradigms are unhelpful to researchers integrating methodology, suggesting that paradigms are ‘container concepts’ that are associated with many ideas, concepts and assumptions grouped together under one heading that do not necessarily always
have to go together. Many researchers tend to think that different aspects of paradigms, such as views and assumptions of ontology, methodology or epistemology, cannot be adopted individually but instead are parts that make up a whole point of view that must be adopted or rejected in itself. Biesta argues that this leads novice researchers to believe that paradigms and the views grouped below them must be accepted or rejected in their entirety, resulting in a polarisation of the discussion around paradigms rather than an interaction and exchange between researchers from different traditions. However, as I have discovered through the course of this research study, a researcher and their research could fit many different aspects grouped in a paradigm concept. By recognising that the concept of paradigms is not always useful, a wider range of combinations of epistemology and methodology become available to researchers.

In an attempt to move away from the restrictive qualitative or quantitative binary positions, mixed methods researcher Onwuegbuzie (2012) refers to mixed methodology as the “radical middle” (p. 193), a third research space where qualitative and quantitative traditions intersect creating the potential for authentic interaction (Gutiérrez, Baquedano-Lopez & Turner, 1997). Moving towards the radical middle means rejecting the idea that single research methodology realities exist. Instead, the radical middle represents an anti-dualistic stance where paradigms are considered false and research binaries are replaced with a shared continuum (Johnson & Gray, 2010; Newman and Benz, 1998). In music therapy research, energies have been spent arguing which research tradition is best utilised in our field (Aigen, 2015; DeNora & Ansdell, 2014). Yet, other authors argue there is an increasing need to conduct music therapy research which integrates several forms of evidence that can easily be applied to clinical settings (Bradt, Burns & Creswell, 2013). I believe research should be
designed and adapted to suit the current clinical situation in order to truly represent ‘real world’ music therapy conditions. Adopting a pragmatic stance in the ‘radical middle’, has allowed me to conduct a study that implements the epistemology and methodology best suited to the aims of each phase of the project, while also importantly addressing the philosophical issues that come with combining research traditions.

The Theoretical Context of This Study.

A recovery-oriented approach.

The field of mental health care has traditionally been based around illness and medicine. In the last ten years, recovery-oriented philosophy has changed the direction of mental health care around the world, embedding a user led perspective into policy, research and practice (Anthony, 1993; Deegan, 1996; Slade, 2009, p. 3). There are several reasons to adopt a recovery-oriented approach in this study. In Australia, mental health care is governed by National Mental Health Plans which are key policy documents aiming to provide a vision for mental health service delivery across Australia. The current National Mental Health Plan (in draft stage) 2015 –2019 identifies recovery philosophy as underpinning care and acknowledges that the mental health care system in Australia must continue to privilege lived experience and collaboration with people with mental illness to best address their needs (Commonwealth of Australia, 2016, p. 16). The research detailed in this thesis takes place within services that adhere to this policy.

The recovery movement advanced from within the ‘survivor movement’ in the 1960s and 1970s. It was seen as a means of responding to the way psychiatric treatment was provided within a biomedical model that traditionally understood people as passive recipients of mental health treatment, and service providers as
experts and holders of knowledge and power (Slade, 2009, p. 3). William Anthony (1993) and Patricia Deegan (1996) are considered pioneers within the recovery movement and propose that recovery is based on the simple beliefs that people with mental illness need more than symptom relief (Anthony) and that people with mental illness are human beings (Deegan). Symptom reduction is not considered unimportant in recovery-oriented practice, but is subordinate to personal and social aspects of recovery. Thus, recovery represents a paradigmatic shift in focus for mental health services, from treating illness to achieve ‘clinical recovery’ and symptom remission, to a new focus on supporting personal recovery by promoting well-being (Slade).

Further, unlike clinical recovery, mental health recovery is increasingly understood as a fluctuating process over time, rather than an outcome (Davidson, 2012). Within a biomedical model of mental health care, diagnosis is considered important for safe, effective treatment. In addition, diagnosis is often the only way to gain access to local services in Australia. The multi-disciplinary team working in mental health settings are expected to be aware of people’s diagnoses, and may plan their intervention on the basis of it (Proctor, 2001). However, people in recovery have explicitly criticised the representation of consumers’ experiences in pathological terms, which has been described as disempowering and stigmatising (Stanton, 2001).

One consumer advocate (Boevink, 2012) argues that in its aspirations to be a medical science, mental health care has become concerned only with pathology and no longer recognises the person behind the illness label. Boevink describes her experience as a person entering the medically-oriented mental health care system for the first time stating, “we are reduced to the status of carriers of a mental illness, or we are even seen as the illness itself” (p. 19). For this reason, the use of labels of diagnosis and symptoms to describe people with mental illness or their experiences are not
prioritised in this thesis, unless these descriptions are used by the participants themselves. By consciously de-emphasising labels and symptomology, it is hoped that the reader will recognise and acknowledge the ‘people’ that are represented in this thesis, and their own stories of recovery.

A commitment to representing ‘people’ not ‘problems’.

As well as being based in recovery-oriented philosophy, this thesis is strongly influenced by a resource-oriented approach to practice in music therapy. This approach emphasises user participation, equality and promotes agency by encouraging people to use their own resources in their health and music experiences (Rolvsjord, 2010, p. 181). Like recovery-oriented practice, Rolvsjord’s description of resource-oriented music therapy emphasises equal relationships between therapist and participant and shared responsibility where they collaborate together on improving the person’s wellbeing. Rolvsjord (2006) advocates for shifting power from therapist to consumer in an attempt to recognise the way the person with mental illness can use the resources around them to improve their own health and wellbeing.

Ansdell (2002) argues that the ‘consensus model’ of music therapy has traditionally focused on improvement of deficits and reduction of symptoms. Others claim that there has been a tendency within music therapy practice and research to write about people with illness or disadvantage at the expense of their strengths and resilience (Procter, 2001; Rolvsjord, 2015). In a recently published position paper, Rebecca Fairchild and I (2016) consider whether the predominantly problem-focused language often used to describe and represent people in music therapy research and practice is congruent with the strengths-based way in which many music therapists work. In this article we draw on our experiences of research and practice to reflect on the language used to represent the people we work with. Fairchild and I argue the
need for a better balance in representing ‘people’ not ‘problems’ in music therapy case studies, presentations and articles.

When representing people with mental illness in an academic setting, there is a tendency to ignore “all that makes [a] person human,” their strengths and weaknesses (Slade, 2012, p. 83). Language is often used that represents the therapist as powerful and the person they work with as weak and powerless (Duncan & Miller, 2000). Our representations of people and their experiences contribute to the way they are viewed by others (Hall, 1997). Therefore, the way mental health consumers are represented, influences the way they and the music therapy process is perceived (Fairchild & Bibb, 2016). Throughout this thesis I have made conscious choices of the language I use to represent people with mental illness, focusing on their strengths and capacities over their symptomology and difficulties. I attempt to represent participants through their individual difference, rather than through group membership (clinical labels of diagnosis), and when presenting participants I include information and labels that they themselves identified as representing their own recovery experience. This is defined by Slade (2012) as “self-knowledge” and is included in an attempt to privilege the lived experience that participants bring to this research (p. 87). I also acknowledge that although I attempt to represent the voices of participants as accurately as possible, I inevitably interpret their contributions through my own lens as a person without a lived experience of mental illness.

Key terms.

The clinical terms used to refer to people accessing mental health services are often debated (Aldaco-Glass, 2014; Deber, Kraetschmer, Urowitz, & Sharpe, 2005). Terms such as ‘patient’ and ‘client’ have been challenged for the embedded power imbalance associated with these roles and even the more recent use of ‘service user’
has been critiqued for its generality (McLaughlin, 2009). In the Australian government’s national framework for recovery-oriented mental health services (Commonwealth of Australia, 2013), it is recommended that the terms ‘person’, ‘person in recovery’ and ‘person with lived experience’ are used wherever possible when representing people accessing mental health services (p. 8). Where these terms cannot be used, it is noted that the term ‘consumer’ is preferred by people with mental illness. These terms have been adopted in this thesis and are prioritised over the terms ‘clients’, ‘service users’ or ‘patients’, which focus on peoples deficits or relationships to services. Further, since mental health recovery is understood as a process, rather than an outcome, participants in this thesis are described as ‘being in recovery’ rather than ‘recovering from’ illness (Davidson, 2012).

In a recovery-oriented framework, conscious attempts are made to reduce the power divide between people accessing mental health services and service providers (Commonwealth of Australia, 2013; Slade, 2009). Power laden terms such as ‘professionals’, ‘clinician’ and ‘expert’ are exchanged for ‘workers’ which implies the person is there to do a job rather than to occupy a position (Slade, 2012). In this thesis, I use the term ‘mental health worker’ primarily to refer to people working with mental health consumers, and ‘facilitator’ to refer to workers who are facilitating singing groups.

In this thesis ‘mental health’ is understood within a salutogenic model, separating health and illness and emphasising factors supporting health, wellbeing and health promotion, rather than pathology (Antonovsky, 1979). I use the term ‘mental illness’ to distinguish work with people in recovery, from the promotion of mental health in the general community. The term ‘mental illness’ is used instead of terms like ‘disorder’ or ‘diagnosis’ which describe the objective label or categorisation of
people’s experiences that are placed on them within a biomedical model of mental health care (Slade, 2012).

**Conclusion**

This chapter has provided a description of the background and context surrounding this project, including the motivation for the study, the setting and the theoretical underpinnings which provide a foundation for this project. The chapter also offered a narrative of the structure of the thesis and the key terms used in an attempt to guide the reader through the remaining chapters. The next chapter details a systematic review of the literature which attempts to provide a basis for the first study in an objectivist position. The review examines the current state of research on the area of group music therapy in mental health settings and the conditions that contribute to promoting belonging within these contexts.
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Chapter 2

Chapter 1 introduced the aim, scope and motivation for this study, and the theoretical context surrounding the project. I also described the layout of this thesis and explained how a number of chapters contain papers with their own targeted literature reviews and discussion sections which are specific to the topic of the paper. This chapter describes a systematic review of the literature which aimed to investigate the effectiveness of music therapy in fostering social connectedness and belonging for adults in mental health recovery. The systematic review was not written for publication and is formatted as a usual thesis chapter. The intention of the review is to broadly introduce the complexity of the topic area and identify where gaps in knowledge could be addressed by the first study in this project. The introduction of the chapter offers an overview of the literature based around music therapy in mental health settings, connectedness and mental health promotion, group therapy in mental health settings and the relationship between connectedness and music. The method for the systematic review is then described and explains how quantitative studies were retrieved through a number of databases using key concepts such as music therapy, social connectedness and mental illness. Last, the results from the review are presented and discussed in relation to relevant literature.
Fostering social connectedness and belonging through group music therapy in adult mental health contexts: A systematic review of the literature

Introduction

Music therapy in mental health care.

Effects of music therapy in the field of mental health care have been articulated through systematic and Cochrane reviews reporting increased motivation, social functioning and global state for people with mental illness (Gold, Heldal, Dahle & Wigram, 2005; Mossler, Chen, Heldal & Gold, 2011). The improvement of social functioning is considered especially apparent in studies where music therapy is conducted in a group setting (Albornoz, 2011; Silverman, 2013; Ulrich, Houtmans & Gold, 2007). One systematic review (Gold, Solli, Kruger & Atle Lie, 2009) which examined the benefits of music therapy through a meta-analysis, assessed study design, diagnosis and number of sessions in quantitative music therapy studies which had been conducted in mental health settings. The authors found that when added to standard care, music therapy has significant effects on global state, symptoms, depression, anxiety, functioning and engagement. The authors also identified significant dose-effect relationships for people with mental illness, proposing that three to ten sessions of music therapy achieves small effect sizes for symptoms and functioning, while 16 to 51 sessions achieves large effects. This finding implies that longer programs and frequent sessions are needed to achieve significant benefits from music therapy in mental health settings. The need to conduct longer programs in order to achieve clinically meaningful benefits however, has been identified as problematic in inpatient settings (Carr, Odell-Miller & Priebe, 2013) where shorter admissions are
increasingly common and single session music therapy is considered most feasible (Silverman, 2009, 2011).

As demonstrated above, effectiveness studies in this field have tended to focus on the reduction of symptoms and improvement in functional ability, along with examining the relationship between the music therapy intervention and symptoms of people with mental illness. However, in Solli and Rolsjvord (2015)’s qualitative study which asked consumers about their own perspective on the role of music therapy in their recovery, reducing symptoms and increasing functioning were not a high priority. Instead, consumers emphasised the importance of music therapy in fostering well-being, hope and meaning in their lives. In some cases, consumers were even resistant to refer to the notion of music therapy as a ‘treatment’ for ‘illness’. Rather, they believed music therapy represented ‘freedom’ from their symptoms, illness and medical treatment and in fact was the “opposite of treatment” (p. 85). This highlights the importance of conducting research on topics that are meaningful to consumers in recovery. It also indicates a need for quantitative music therapy studies which measure subjective experiences of wellbeing in recovery, rather than symptom reduction. One study conducted by Grocke and colleagues (2014), provides an example of the way experimental designs can explore outcomes other than symptom reduction, by measuring quality of life and spirituality. The authors conducted a randomised embedded experimental mixed methods study comparing group music therapy with standard care in 99 consumers in Melbourne and found significant effects in relation to both quality of life and spirituality.

Qualitative music therapy research from the perspectives of mental health consumers has focused on people’s lived experience of participation in music therapy (Ansdell & Meehan, 2010; Silverman, 2006; Solli, & Rolsvjord, 2015; Solli,
Rolsvjord & Borg, 2013). The social aspect of mental health recovery including connectedness and subjective feelings of belonging has frequently been identified by consumers as essential to their recovery (Davidson et al., 2001, 2004; Mazzino et al., 2006; Tew, 2012). Further, through a meta-synthesis of 14 studies examining consumers’ experiences of music therapy, Solli and colleagues (2013) identified that outcomes of music therapy are not limited to symptom reduction. One of the main categories of the role of music therapy in recovery was identified as ‘being together’ with others, demonstrating that music therapy fostered opportunities for social participation in ways that facilitated social inclusion. This illustrates the importance of identifying the social aspects of recovery which can be promoted through music therapy.

**Social connectedness and belonging in mental health recovery.**

Social connectedness is a term that can be loosely defined as the relationships and connections we have with others (Seppala, Rosomando & Doty, 2013). According to Barringham and Barringham (2002), there are three different ways people can experience connection. First, people can connect with their inner selves, to appreciate solitude or experience a clear sense of self; second, people can connect with a greater scheme of things, for example to develop spirituality or find meaning in life through external sources; and third, people can connect with others, for example by building friendships or sharing in experiences with others. Belonging is a related construct to connectedness which relates to the subjective feeling of ‘being part of something’, included and accepted within one’s social connections (Allen & Bowles, 2012). Most people have a fundamental need to feel they belong and experience different levels of belonging in a range of relationships and settings (Baumeister & Leary, 1995; Maslow, 1970). These may include family groups, friendship groups,
religious groups, clubs, work or learning places, and local communities (Crisp, 2010).

The concepts of belonging and connectedness are closely related and are often used interchangeably. Early theorists suggested that connectedness and belonging are intertwined and that connectedness is an important aspect of the overarching feeling of belonging. Kohut's theory of self psychology (1984) in the field of counseling psychology proposed that the ‘self’ was composed of three needs: the need for grandiosity, idealisation, and an alter ego or ‘belongingness’. Together, these three needs provide the structure and motivation for self-expression. Kohut believed that people pursue a subjective sense of belonging or ‘being a part of’ something in order to avoid feelings of loneliness and isolation. The concept of the ‘self’ distinguished Kohut's theory from other psychoanalytic theories during the 1970s and 1980s, as it emphasised the relationship between the self and others. Based on this theory, Patton and colleagues (1982) and later Lee and Robbins (1995) proposed that belonging was composed of three facets: companionship (engaging in relationships and feeling a sense of security), affiliation (peer relationships and engaging in group activities) and connectedness. Lee and Robbins believed that connectedness involved a feeling of being ‘human among humans’ and identifying with those who are perceived as different from themselves. It is evident that historically the notion of connectedness was an aspect of belonging, which could not exist in isolation.

Recent social research suggests that while these concepts may co-exist, connectedness can exist in the absence of belonging and vice versa (Crisp, 2010). In this context, belonging relates to how people participate in social organisations or networks, while connectedness refers to the number and strength of connections in these systems (Seppala, Rossomando & Doty, 2013). Therefore, it is possible to be connected but not to feel the emotional link associated with belonging and equally to
experience a sense of belonging in the absence of any real connections being made (Crisp, 2010). Due to the ongoing disparity in relation to the definition and meaning of these two concepts, within the context of this review, a definition of social connectedness that is inclusive of both connectedness and belonging will be used to ensure that all relevant studies are identified.

Social connectedness is an internal sense of belonging that reflects a person’s subjective awareness of being in close relationship with the social world. Social connectedness encompasses close and distal relationships with family, friends, peers, community and the wider society (Lee & Robbins, 1998, p. 338).

Although social connectedness and a sense of belonging are considered important social necessities in human culture (Baumeister and Leary, 1995; Maslow, 1970), they are needs that are often unmet for people with mental illness who experience high levels of social exclusion (Shevellar, Sherwin & Barringham, 2014). The many symptoms of mental illness can result in feelings of isolation and loneliness. People who experience disconnection can feel distant from other people and may find it difficult to accept social roles and responsibilities, leading to greater isolation (Lee, Draper & Lee, 2001). Symptoms such as social withdrawal and isolation may be further compounded for people living in the community due to potential separation from family and friend supports and difficulties in gaining stable employment (Glynn & Lui, 2007). Thus, social isolation, disconnectedness from society and an inability to re-establish a sense of belonging can be psychologically distressing for people living in a community setting and can lead to an acute psychiatric hospital admission (Lee, Draper & Lee). It is believed that the majority of people admitted to an inpatient unit lack support garnered from relationships with
others in their local community (Lee, Keating, de Castella & Kulkarni, 2010). In Australia, there were 234,008 inpatient mental health admissions reported in 2012–13, (Australian Institute of Health and Welfare, 2014). One may speculate that many of these admissions may have been prevented if people had experienced the social support and connections needed to promote their recovery in the community.

**Group therapy and cohesion in mental health.**

Programs that foster social connectedness are logically best delivered in a group setting. Within inpatient and community mental health settings, group therapy plays a significant role in treatment. Group therapy aims to increase people’s awareness of themselves through interaction with other group members and by increasing interpersonal social skills (Montgomery, 2002). Group cohesion is a related concept to connectedness within a group therapy context. Cohesiveness is characterised by a high level of group participation, positive feelings among members and strong trust between participants (James & Freed, 1989; Yalom, 2005). Psychotherapy and group therapy literature suggests that cohesion within a group is necessary for effective group therapy (Evans & Jarvis, 1980; Yalom). Members of a cohesive group feel warmth, comfort and a sense of belonging, have increased social contact with other group members, and consider the group to be more therapeutic (de l’Etoile, 2002).

There are many components in the formation of therapeutic groups that can impact on cohesion and connectedness, such as the group size, duration, frequency and participant homogeneity. These components therefore must be carefully considered when planning groups that promote connectedness. Very small groups can lack cohesiveness, while large groups can result in participants feeling ‘lost in the crowd’ and therefore more isolated (Yalom, 2005). Yalom has suggested that the
longer the duration of the group, the larger the group must be to ensure effectiveness and maintain cohesiveness. The frequency of group meetings can also differ depending on context and clinical setting. For example, in a community setting weekly group sessions are common. However, in an inpatient setting, the notion of the single session group is becoming increasingly more common due to the short-term nature of admissions. It is likely that people will experience a different ‘level’ of connectedness following a single group session compared to engaging in a number of sessions over a longer period of time.

Many inpatient mental health therapeutic programs utilise open group formats where people may join or leave the group at any given time. As people leave the group and others join, the levels of interpersonal awareness, cooperation, and trust often lapse temporarily (James & Freed, 1989). Thus, it can be difficult to maintain group cohesion when working within a health care facility with continuous and rapid change in consumer numbers (Baker, 2013). Similarly, a fluctuating and wide spectrum of experiences and presentations of mental illness can influence the functioning and stability of a group and can negatively affect group cohesion (Yalom, 2005). Conversely, Baker states that a mix of group participants at different stages in their recovery from mental illness also has the potential to “stimulate dynamic interaction and deep reflection” between participants within a group music therapy context (p. 141). Consideration of the influencing factors of group therapy that foster cohesion and connectedness, aids in the preparation and planning of therapy groups.

**Connectedness and music.**

The use of music in group therapy has potential to further promote cohesiveness and connectedness. Christopher Small (1998) famously redefined the concept of music making as musicking in an attempt to illustrate the action and
process in music making and its potential to create and perform relationships. The music therapy literature demonstrates the role of group music therapy in promoting connectedness in a number of clinical settings. For example, mixed methods studies by Creech and colleagues (2009) and Tamplin and colleagues (2014) report that active music making can facilitate a sense of belonging for people with chronic quadriplegia (Tamplin et al.) and older adults in the community (Creech et al.). These music groups reportedly offered routine and structure to the daily lives of participants, motivation for leaving the house and a sense of being a valued member within their community.

There is a paucity of comparative group music therapy studies conducted in mental health settings. One of the few music therapy studies that examines belonging and connectedness in a mental health context, was conducted by Bensimon and colleagues (2008). The study initially aimed to use group drumming to reduce symptoms of post traumatic stress disorder in six participants. However, the main finding following the 16-week program, was reportedly an increased sense of openness, togetherness, belonging and connectedness. Other studies including people with mental illness have reported on more functional social outcomes of music therapy such as improved social functioning (Mossler, Chen, Heldal & Gold, 2011) and objective interpersonal contact (Hayashi et al., 2002). While these studies do not address connectedness or belonging specifically, they were based on group music therapy and their positive findings suggest that people with mental illness do respond well to group therapy contexts.

It is evident that there is a need for further exploration of music therapy studies which examine the effectiveness of the subjective social aspects of recovery. Isolation and disconnectedness are a genuine concern for this population who so often
experience exclusion and minimal social support. A need to better understand the conditions that promote social connectedness in people with mental illness, such as group therapy composition and context is also apparent. Although the importance of subjective experiences of social recovery have been identified through qualitative case studies, the focus of many quantitative studies has been based on improving symptoms, skills and functioning rather than social connections and support. In order to address these gaps in the research literature, a systematic review was conducted which aimed at answering the question: Is group music therapy effective in improving social connectedness in adults with mental illness?

**Method**

**Search strategy.**

A systematic review of the literature was conducted using a number of electronic databases: MEDLINE Ovid, EMBASE Ovid, CINAHL Ebsco, PsycINFO Ebsco, and The Cochrane Library on 27th of November 2013. Keywords selected were divided into three central concepts: music therapy, social connectedness and mental illness, which were deconstructed and mapped to subject headings within each database. The final search terms included (music therapy OR singing OR music) AND (connectedness OR interpersonal relations OR social behaviour OR interpersonal communication OR human relation) AND (mental illness OR mental disorder). Reference lists from relevant articles obtained from the database search were reviewed to identify any relevant literature not revealed through the database searches. All references resulting from the search were imported into an Endnote library (Endnote X5, Thomson Reuters) and duplicates deleted.

Studies were included if they met the following criteria: a) participants were adults aged 18-65 years with a primary diagnosis of mental illness (not organic mental
disorders i.e. Autism, dementia, stroke), b) the main intervention was group music therapy (if a study included both individual and group music therapy interventions, the study was included), c) included a measure of social connectedness, d) the research was published in English in peer-reviewed journals or conference proceedings, or published full dissertations, and e) evidence ranked at level 3 or higher by the Oxford Centre for Evidence-Based Medicine (2011), i.e. randomised and non-randomised designs. Studies were excluded if: a) music was not the primary focus of the program (i.e. creative therapies studies which included music as secondary to other creative mediums) or if music was used without the development of relationships between participants and health professionals (e.g. background music during participants’ lunch time), and b) they reported social outcomes such as social skills, communication skills or interpersonal skills but did not include a measure of social connectedness.

**Study selection.**

Three stages of screening were applied to determine the final selection of included studies: 1) during stage one, I screened publication titles to determine eligibility for inclusion. Where a decision could not be made based on the title, the item was retained for the next stage of review. Myself and my secondary supervisor (Baker) independently reviewed abstracts to ascertain whether the studies met the inclusion criteria. The final stage involved screening the full text of studies in consultation with another supervisor (Tamplin). Discrepancies between reviewer decisions at all stages were discussed and resolved by mutual consensus.

**Data extraction and quality assessment.**

A data extraction form was created and used to record study data. Myself and a secondary supervisor (Tamplin) completed the quality assessment for included
studies using the Downs and Black (1998) checklist. Another supervisor was available for further discussion and resolution when required. The Downs and Black checklist consists of 27 questions with three sub-sections: reporting, external validity, and internal validity (bias and confounding). The original score range in the checklist was from 0 to 32. However, the last question (relating to statistical power) was modified from a scale of 0 to 5 to a scale of 0 to 1 to bring the scoring in line with the other questions. This modification was based on recommendations for quality assessment from the Spinal Cord Injury Rehabilitation Evidence project (SCIRES, 2010). A score of one was given if a power calculation or sample size calculation was present and zero was scored if not. Therefore, the modified scoring range was 0 to 28, with a higher score indicating higher methodological quality.

**Results**

**Yield.**

Figure 1 illustrates the flow chart for study selection. The initial search yielded a total of 265 studies, after the removal of 43 duplicates. Citation tracking and checking of reference lists of the included studies identified a further 15 studies of potential relevance, resulting in 280 studies. Following stage one screening (title review), 68 studies remained. Forty-eight items were further excluded at stage two screening (abstract review). The full text was retrieved for the remaining 20 studies. A further 17 studies were excluded following the full text review. The remaining three studies were included in this review.
Included studies.

All three included studies measured social connectedness between participants as one of several variables (Cassity, 1976; Choi, Lee & Lim, 2008; de l’Etoile, 2002). Only one study had social connectedness as its primary aim (Cassity). Data extracted from the included studies are summarised in Table 1. All three studies used different designs: quasi-experimental (de l’Etoile), randomised controlled trial (Cassity) and controlled clinical trial (Choi et al.). Only one study (Cassity) randomly allocated
participants and none of the studies reported blinding in their design. The three included studies are summarised briefly here.

   de l’Etoile’s (2002) quasi-experimental study aimed to examine the effectiveness of music therapy in short-term group psychotherapy for adults with chronic mental illness. The study was conducted in a community mental health setting in the USA and measured cohesion along with other outcomes, such as additional curative factors and attitude toward seeking professional help. Eight participants attended a one-hour weekly music psychotherapy session for six weeks. Data was collected via a self-reporting ‘curative factors’ questionnaire (created by the authors) after the first and last sessions. An increase in cohesion (of 0.63 points) was most notable out of all 10 outcomes assessed, with a p value of .078.

   Cassity (1976) conducted a randomised controlled trial to determine the influence of group music activity on interpersonal relationships. The study was conducted in an inpatient psychiatric setting in the USA. Twelve participants were randomly allocated to the music intervention (guitar lessons and performance) or control group (standard care). Participants in the intervention group attended daily one-hour guitar lessons for two weeks (10 sessions). Data were collected from both groups before and after the intervention using a socio-metric questionnaire created by the authors. The questionnaire aimed to measure peer acceptance, group cohesiveness and interpersonal relationships. Results indicated that the experimental group made a significant increase in peer acceptance and group cohesiveness in comparison to the control group (p <0.001).

   Choi and colleagues (2008) conducted a controlled clinical trial in South Korea to test whether group music therapy was effective for improving depression, anxiety, and relationships in an inpatient hospital setting. Twenty-six participants
were allocated to an intervention or control group. Participants in the intervention group engaged in songwriting, singing and playing instruments for one hour per week for 15 weeks, while the control group received standard treatment. Along with other measures relating to anxiety and depression symptoms, data were collected before and after the 15-week program using the Relationship Change Scale (Schlein & Guerney, 1977), a validated self-report tool measuring subjective improvement in relationships between participants. After 15 sessions, the music intervention group showed significant improvements in relationships compared with the control group ($p < 0.001$).

**Participants.**

Participants in two of the studies were admitted to a psychiatric hospital (Cassity, 1976; Choi et al., 2008) while participants in the third study were part of a community mental health service (de l’Etoile, 2002). In addition to mental illness, two participants in one study (Choi et al.) and one participant in another study (Cassity) had a dual diagnosis of drug dependency. Sample size ranged from 8 to 26 participants. Further details for the included studies are presented in Table 1.

**Table 1. Overview of included studies.**

<table>
<thead>
<tr>
<th>Name</th>
<th>de l'Etoile 2002</th>
<th>Cassity 1976</th>
<th>Choi et al 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Design</strong></td>
<td>Quasi-experimental</td>
<td>Randomized controlled study</td>
<td>Controlled clinical trial</td>
</tr>
<tr>
<td><strong>Study Duration</strong></td>
<td>6 weeks</td>
<td>2 weeks</td>
<td>15 weeks</td>
</tr>
<tr>
<td><strong>Intervention length, frequency, duration</strong></td>
<td>1 hour, weekly, 6 sessions</td>
<td>1 hour, daily, 10 sessions</td>
<td>1 hour, weekly, 15 sessions</td>
</tr>
<tr>
<td><strong>Sample size</strong></td>
<td>8 (6 male, 2 female)</td>
<td>12 (all female)</td>
<td>26</td>
</tr>
<tr>
<td><strong>Drop out</strong></td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Chronic mental illness</td>
<td>Mental Illness</td>
<td>Mental illness</td>
</tr>
<tr>
<td><strong>Age range</strong></td>
<td>30 years onwards</td>
<td>18-55 years</td>
<td>Mean ages 35 and 37 years</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Community</td>
<td>Inpatient</td>
<td>Inpatient</td>
</tr>
</tbody>
</table>
### Co-morbidity

<table>
<thead>
<tr>
<th></th>
<th>Nil</th>
<th>1 had drug dependency in addition</th>
<th>2 had drug dependency in addition</th>
</tr>
</thead>
</table>

### No of groups

<table>
<thead>
<tr>
<th></th>
<th>1 group</th>
<th>2 groups</th>
<th>2 groups</th>
</tr>
</thead>
</table>

### No in each group

<table>
<thead>
<tr>
<th></th>
<th>8</th>
<th>7 in ex, 5 in control</th>
<th>13 in exp, 13 in control</th>
</tr>
</thead>
</table>

### Nature of intervention

<table>
<thead>
<tr>
<th></th>
<th>Music psychotherapy</th>
<th>Guitar lessons and performance</th>
<th>Music therapy (songwriting, singing, instruments)</th>
</tr>
</thead>
</table>

### Provider of intervention

<table>
<thead>
<tr>
<th></th>
<th>Music therapist</th>
<th>Music therapist</th>
<th>Music therapist</th>
</tr>
</thead>
</table>

### Nature of control

<table>
<thead>
<tr>
<th></th>
<th>Nil control</th>
<th>Standard care</th>
<th>Standard care</th>
</tr>
</thead>
</table>

### Outcome measures

<table>
<thead>
<tr>
<th></th>
<th>Cohesion (and 9 other curative factors)</th>
<th>Peer acceptance, group cohesiveness, interpersonal relationships</th>
<th>Relationship changes</th>
</tr>
</thead>
</table>

### Data points

<table>
<thead>
<tr>
<th></th>
<th>After session one and post</th>
<th>Pre and post</th>
<th>Pre and post</th>
</tr>
</thead>
</table>

### Instruments used

<table>
<thead>
<tr>
<th></th>
<th>Curative factors questionnaire</th>
<th>Sociometric questionnaire</th>
<th>Relationship change scale</th>
</tr>
</thead>
</table>

### Upper/lower limits

<table>
<thead>
<tr>
<th></th>
<th>0-4 (higher is better)</th>
<th>Nil further details known</th>
<th>Nil further details known</th>
</tr>
</thead>
</table>

### Scale validated?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

### Statistical Tests

<table>
<thead>
<tr>
<th></th>
<th>Repeated analysis of variance</th>
<th>Sociogram, sign test, X2, Mann-Whitney U test</th>
<th>Unpaired t-tests, X2, ANCOVA</th>
</tr>
</thead>
</table>

### Intervention.

All three included studies provided group music therapy sessions of one hour in duration administered by a music therapist. However, the nature of the music therapy interventions differed significantly. One study used music psychotherapy (de l’Etoile, N=8), another study involved group guitar lessons and performance (Cassity, N=5), while the third study used songwriting, singing and playing instruments in their sessions (Choi et al., N=13). Participants in both de l’Etoile and Choi’s studies attended the music therapy intervention on a weekly basis, while participants in Cassity’s study attended music therapy daily for ten consecutive weekdays. The length of the music therapy program ranged from six to 15 sessions.

### Outcomes.

All three studies used self-report tools to measure social connectedness outcomes. Two of the studies measured connectedness along with other outcomes.
such as additional curative factors, attitude toward seeking professional help (de l’Etoile, 2002) and depression and anxiety symptoms (Choi et al., 2008). Social connectedness outcomes measured were: cohesion assessed using a curative factors questionnaire (de l’Etoile), peer acceptance, group cohesiveness and interpersonal relationships assessed using a sociometric questionnaire (Cassity, 1976) and improvement in relationships between participants (Choi et al.) assessed using the Relationship Change Scale (Schlein & Guerney, 1977). The Relationship Change Scale is a validated measure, other measures were created by the study authors.

**Quality appraisal.**

Table 2 details the findings of the quality appraisal. Out of a possible 28 points on the Downs and Black checklist (1998), the studies scored 19 (de l’Etoile, 2002), 18 (Cassity, 1976) and 19 (Choi et al., 2008), indicating moderate study quality. Only two studies presented estimates of variability in data (Choi et al. and de l’Etoile). All three studies reported probability (p) values for the main outcomes and two were statistically significant p<0.001. External validity was low for each of the studies. There was minimal description of participant inclusion criteria and Cassity reported that selection bias might have been present in the allocation of participants in his study. In two studies (Choi et al., and de l’Etoile) it was unclear whether any attempt had been made to blind assessors. Confounding variables compromised internal validity across the studies. Only Cassity used random group assignment, but did not describe randomisation procedures. None of the studies reported power calculations or effect sizes. However, I calculated effect sizes for two studies where sufficient data was provided (See Table 3).
Table 2. Quality assessment for included studies.

<table>
<thead>
<tr>
<th>Study Name</th>
<th>de l'Etoile</th>
<th>Cassity</th>
<th>Choi et al</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score (Downs &amp; Black, 1998)</td>
<td>19/28 (68%)</td>
<td>18/28 (64%)</td>
<td>19/28 (68%)</td>
</tr>
<tr>
<td><strong>Reporting</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Hypothesis/aim/objective of study clearly described?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2. Main outcomes to be measured clearly described?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3. Characteristics of patients included in study clearly described?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Interventions of interest clearly described?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Distributions of principal confounders in each group of subjects to be compared clearly described?</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6. Main findings of the study clearly described?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>7. Does the study provide estimates of the random variability in data for main outcomes?</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8. Have all important adverse events that may be a consequence of the intervention been reported?</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Characteristics of patients lost to follow-up been described?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10. Actual probability values been reported for main outcomes?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>External Validity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Were subjects asked to participate representative of entire population from which they were recruited?</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12. Those subjects who were prepared to participate representative of the entire population from which they were recruited?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13. Were staff, facilities where patients were treated representative of the majority of patients receive?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Internal Validity (Bias)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Was an attempt made to blind study participants?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. Was attempt made to blind those measuring intervention?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16. If any results were based on 'data dredging' was this made clear?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>17. Do the analyses adjust for different lengths of follow up of patients, or is the time period between intervention and outcome the same for cases and controls?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>18. Were statistical tests used to assess the main outcomes appropriate?</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>19. Was compliance with intervention/s reliable?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20. Were the main outcome measures accurate (valid and reliable)?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Internal Validity (Confounder s)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Were patients in different intervention groups or cases and controls recruited from the same population?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>22. Were study subjects in different intervention groups or were the cases and controls recruited over the same time period?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>23. Were study subjects randomized to intervention groups?</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24. Was random intervention assignment concealed from both patients and health care staff until recruitment was complete?</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25. Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26. Were losses of patients to follow-up taken into account?</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>27. Did the study have power calculations/estimate of effect?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>19</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Study</td>
<td>Mean score(s) for PRE</td>
<td>Mean score(s) for POST</td>
<td>SD(s) for PRE</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>de l'Etoile 2002</td>
<td>1.63</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Cassity 1976</td>
<td>No Raw Data Provided</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Choi 2008</td>
<td>Exp: 72.4 Con: 72.5</td>
<td>Exp: 45.8 Con: 66.7</td>
<td>Exp: 1.2 Con: 2.3</td>
</tr>
</tbody>
</table>
Discussion

While literature suggests a need for group music therapy in fostering feelings of social connectedness for participants with mental illness, these outcomes were not frequently measured in the studies included in this review. The small number of included studies, together with the high degree of heterogeneity in terms of setting, music therapy methods and outcome measures made it difficult to draw strong conclusions from the review. Only three studies specifically measured social connectedness and two of these measured social connectedness together with other outcomes. One explanation for the minimal number of studies eligible for inclusion in this review may be the difficulty in defining and measuring social connectedness. A lack of consistent terminology for social connectedness across the three studies highlights the absence of consensus in describing this subjective ‘feeling’ in participants. Cassity (1976) measured interpersonal relationships and defined this as “peer acceptance, group cohesiveness, isolation, or other group phenomena affecting group members’ status” (p. 67). de l’Etoile (2002) aimed to measure cohesion, which she described as “feeling a sense of belonging and being valued” (p. 72), while Choi (2008) and colleagues did not describe their changes in relationships measure.

The variability in defining social connectedness seen across these studies and the subjectivity in reporting makes for difficulty in the quantitative measurement of the phenomenon. Only one of the three tools used in this review to measure connectedness was validated (Choi et al., 2008). This could suggest that existing quantitative measures may not be considered ‘reliable’ or sensitive to change by researchers in this area, or that there is an absence of measures specifically designed for this population. Indeed, existing social outcome measures for participants with
mental illness lack universal guidelines or framework, which makes it difficult to translate findings into practice (Allan & Bowles, 2012). Further, the evaluation of mental health programs has been traditionally based around measures of symptom severity. However, in contemporary mental health practice there is an increasing need for multidimensional outcome measures, such as social inclusion and quality of life. Functional social outcomes such as social and communication skills are of interest to policy makers as they are more objective and therefore easier to measure (Laliberte-Rudman, Scott & Pajouhandeh, 2000). Although the subjective nature of ‘feeling’ connected can prove more difficult to measure quantitatively (Shevellar, Sherwin & Barringham, 2014), the subjective lived experiences of social inclusion are consistently identified as key aspects to personal recovery (Davidson et al., 2001; Mazzino et al., 2006). The absence of the subjective nature of social inclusion in mental health policy causes great difficulty in advocating for the importance of connectedness and belonging within a mental health context, particularly considering the limitations in defining and measuring these concepts.

**Connectedness and context.**

In the current review, two studies were conducted in an acute hospital context and the other was conducted in a community setting. There was minimal discussion about the impact of setting on the study participants or outcomes from any of the study authors. One of the studies conducted within an inpatient setting (Choi et al., 2008) had the longest duration (15 weeks) and also found a significant result. This length of program is unusual in an inpatient setting and consequently may be difficult for future researchers to replicate. The community mental health study which was conducted for just six weeks (de l’Etoile, 2002) only found a small improvement in group cohesiveness. According to the results of Gold and colleagues’ (2009)
systematic review of music therapy in mental health, the effects of music therapy are related to the number of sessions conducted. Between 16 and 51 music therapy sessions are required to observe a large effect on participants. Small benefits of music therapy in this setting can often be seen after just a few sessions, but for stronger and more clinically significant effects, a considerable number of sessions are required. This may suggest that the six sessions provided in de l’Etoile’s study was not sufficient for feelings of cohesiveness to form between the participants.

Both studies with statistically significant results were conducted in an inpatient setting. This could suggest that the acuity of the participant’s mental illness had a positive effect on cohesiveness, or perhaps the ‘live in’ nature of a hospital is more conducive to fostering experiences of connectedness. In an inpatient setting, participants have other opportunities for social contact between each music therapy group session. This sense of connectedness has the opportunity to develop further during other social occasions, such as mealtimes and through participation in other therapeutic groups on the unit. In a community setting however, participants may only meet each other once per week at music therapy group and then return to their individual lives in the community. Therefore, it is possible that in a community setting, a music therapy program needs to be conducted over a longer period of time to observe significant changes in connectedness.

The studies ranged in size of participant groups, from six to 13 participants. The eight participants in de l’Etoile’s (2002) study attended only six sessions and did not find a significant result. This is not surprising, since evidence shows that the longer the music therapy program, the smaller the number of participants required in order to see a positive effect on their mental health outcomes (Gold et al., 2009). These results also provide support for Yalom’s (2005) suggestions for group
psychotherapy, which indicate that the longer the duration of the group program, the larger the group must be to maintain cohesiveness. Thus, along with longer programs in community settings, a smaller number of participants in music therapy groups may offer increased opportunity for fostering connectedness.

**Limitations and implications for future research.**

This review adopted a systematic quality appraisal with rigorous methodology. The review sought studies measuring a specific subjective social outcome, social connectedness. Only quantitative study designs were included, which excluded any case studies or anecdotal material that may have described feelings of social connectedness from participants. The inclusion of qualitative research may have increased the number of studies included for review and may have offered a broader understanding of the role of group music therapy in mental health settings. Further, none of the studies used an active/comparative control group. In the absence of an active control it is difficult to determine whether the music therapy program was the sole factor responsible for improving connectedness in participants. It is possible that any type of group therapy may lead to increased connectedness between participants in comparison with standard care.

This review has highlighted a number of areas for future research into group music therapy for fostering social connectedness for people in recovery. First, there is a need for the development of tools which can reliably measure social connectedness. Although it is difficult to measure the subjective nature of feeling connected, the likelihood of capturing this feeling could be enhanced by clearly defining the concept and developing measures which capture social connectedness through self-report. Second, it is necessary to explore the influence of setting (inpatient versus community) on the effect of group music therapy on social connectedness in mental
health contexts. Finally, the use of more robust research designs could improve the validity and likelihood of finding an effect if it exists. A strong quantitative research design would use larger sample sizes, random group allocation and blind those involved in data collection to group allocation.

**Conclusion**

There is a lack of quantitative research specifically measuring the effect of group music therapy on social connectedness and belonging within an adult mental health context. This review provided preliminary indicators that some group music therapy methods can improve connectedness for participants in inpatient and community mental health settings. Features to emerge from the review were the difficulty in defining and measuring social connectedness, the potential impact of inpatient or community settings, lack of clarity regarding ideal number of sessions which may foster connectedness and a lack of validated measurement tools that are sensitive to change in measuring social connectedness outcomes in the area of mental health. Further research is recommended which investigates how the subjective social aspect of recovery can be captured quantitatively.
References


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doi:10.1093/jmt/43.2.111


Bridging Material

The systematic review described in the previous chapter was conducted in an attempt to scope studies which aimed to foster social connectedness through music therapy in the area of mental health. The review offered insight into the ideal conditions for the first research study in this thesis. The results of the review revealed that there were few quantitative music therapy studies examining belonging in a mental health context. Due to the subjective nature of the phenomenon, there was an absence of a standard definition and few outcome measures that were considered reliable or sensitive to change designed to use with people in a mental health setting. Social connectedness and belonging is difficult to define, capture and measure and yet there remains great potential for music therapy and group singing to foster feelings of connectedness for people who are impacted significantly by social withdrawal and exclusion.

The plan for the next stage of the thesis maintained a clear focus of determining the effect of community-based singing on increasing feelings of belonging for people with mental illness, and remained located within an objectivist position. It was apparent after conducting the systematic review that more quantitative research with stronger methodology and validated measurement tools is needed in this area. Therefore, I aimed to conduct an initial feasibility study with an interest in exploring and measuring the experience of belonging through participation in group singing using different modes of self-reporting. In the months prior to conducting the study, I investigated the possible outcome measures that could be used to measure social connectedness within a community mental health context. I based my decision primarily on the reliability and validity of these measures (which is considered most
important from an objectivist tradition). I also prioritised the shortest and simplest measures in an attempt to not put unnecessary cognitive strain on the participants. The next chapter describes the design of the initial study and discusses the results in relation to both the music therapy and singing and health literature.
Chapter 3

The previous chapter offered a description of a systematic review of the literature which aimed to investigate the effectiveness of music therapy in fostering social connectedness and belonging for adults in mental health recovery. Chapter 3 describes an embedded exploratory mixed methods study exploring a small community-based 10 week therapeutic singing group and its impact on feelings of belonging for four people in recovery. The chapter comprises a co-authored journal publication (Bibb, Baker, Tamplin & McFerran, under review) currently under review with a music therapy journal and is formatted accordingly.

Experiences of belonging within a small community-based therapeutic singing group for four people in mental health recovery

Abstract

Background: Social integration and belonging is an essential resource in the process of mental health recovery.

Objective: This study aimed to understand the experience of a small community-based 10 week therapeutic singing group and its impact on feelings of belonging.

Methods: An embedded exploratory mixed methods design using semi-structured interviews and outcome measures was adopted. Participants were recruited from a community mental health organisation in the North-Eastern suburbs of Melbourne, Australia. Qualitative data was analysed using descriptive phenomenological micro-analysis while quantitative data was observed for trends across three time points.

Results: The qualitative analysis revealed that being with others, being heard, having a sense of purpose, achieving something and group size and setting were important to participants’ experience of the group. Due to a lack of understanding of the measures that was reported by all four participants, little could be concluded from the quantitative data.

Conclusions: The results from the qualitative data imply that a small short-term community-based therapeutic singing group may offer mental health consumers a first step to participation in larger groups in the wider community. Further investigation into the experience of these groups along with the use of measures with consumers with chronic mental illness is needed.

Introduction

Contemporary mental health care has changed direction in the last ten years
and now embeds recovery-oriented approaches into theory, practice and research (Slade, 2012). Mental health recovery is a social movement promoting a paradigmatic shift in mental health care, from a focus on ‘illness’ and pathology, toward health and wellbeing, despite the presence of symptoms (Deegan, 1996; Slade, 2009). Recovery-oriented mental health care emphasises collaboration, empowerment and the lived experience of mental health consumers while acknowledging consumers as ‘active agents’ in their own recovery (Slade, 2009). The recent re-orientation of mental health services has resulted in a shift of services to community-based delivery, which has led to a need for more community-based participation opportunities for people accessing community mental health services (Fieldhouse, 2012).

**Inclusion and mental health recovery.**

Inclusion is often described as being essential in the process of acquiring positive mental health and wellbeing for people in mental health recovery (Andresen, Oades & Caputi, 2003; Ahern & Fisher, 2001; Ridgway, 2001). The many symptoms of mental illness impact on a person’s ability to create social networks and relationships. This can therefore result in experiences of feeling unwanted, excluded, stigmatised and lonely (Erdner, Magnusson, Nystrom & Lutzen, 2005). Social support from family and friends is a major factor in reducing psychotic symptoms (Calsyn & Winter, 2002). Research shows that people with mental illness who have small social networks experience a greater number of symptoms and are more likely to lack insight into their illness than those with larger social networks (Garety, Kuipers, Fowler, Freeman & Bebbington, 2001). For people living with a mental illness in the community, social withdrawal and isolation can be further compounded due to potential separation from support services and difficulty in gaining stable employment (Glynn & Lui, 2007). Social exclusion has been defined as non-participation in key
activities of the society in which a person lives (Burchardt, Le Grand & Piachaud, 2002). In a qualitative study reviewing rates of re-hospitalisation for people with mental illness, consumers described social isolation and exclusion from mainstream social activities as the primary reason for their frequent readmission to hospital (Mgutshini, 2010). This suggests that supporting community participation may be a way of addressing exclusion for people with chronic mental illness.

Belonging is one dimension of inclusion that describes feelings related to participation in social networks (Crisp, 2010). Belonging relates to the subjective feeling of ‘being part of something’, being included and accepted within one’s social connections (Allen & Bowles, 2012). Many theorists have suggested human beings have a fundamental need to feel they belong and have described different levels of belonging in a range of relationships and settings (Baumeister & Leary, 1995; Maslow, 1970). However, belonging is often an unmet need for people with mental illness who commonly experience social isolation and loneliness. While many of the symptoms associated with mental illness contribute to experiences of isolation, it is also likely that limited opportunities to meet others and create friendships due to restricted living arrangements or unemployment status are an added challenge (Forrester-Jones et al., 2012).

**Group singing and mental health recovery.**

Research suggests that group singing can connect people together in shared experiences, reduce isolation, loneliness and provide a sense of unity for adults living in the community (Clift & Hancox, 2010; Clift et al., 2008; Judd & Pooley, 2014; Mellor, 2013). However, for people in mental health recovery, the role of community group singing has received minimal attention. One Australian study exploring the personal experiences of adults with mental illness and other disabilities in an choir
called ‘Transformers’ offers support for the link between group singing and benefits to social wellbeing for this population (Dingle, Brander, Ballantyne & Baker, 2013). Participants in this study described benefits in relation to improved social functioning, a sense of connectedness with co-group members, connection with audience members through performance, and connection with the local community through participation in group singing. This study documented the longer-term benefits of social inclusion following participation in the choir for 12 months. More immediate or shorter-term benefits of group singing in a therapeutic setting have not been documented within the singing and mental health literature. Other studies have reported increased coping, opportunities for emotional expression, reduced negative thoughts and feelings, and enhanced self-esteem for consumers after participation in singing in a group with others in recovery (Clift & Morrison, 2011; Eyre, 2011; Pavlakou, 2009). These outcomes have been reported in studies of large choirs within general community recreational settings (Clift & Morrison, 2011), outpatient mental health settings (Eyre, 2011), and small therapeutic singing groups within inpatient mental health settings (Pavlakou, 2009).

The term ‘therapeutic singing group’ is used in this study to refer to a group that is facilitated by a music therapist with the purpose of singing together to improve health outcomes. Participation in a small therapeutic singing group in the community may offer mental health consumers an opportunity to regain social connectedness and a sense of belonging with others within the safety of those with lived experience of mental illness prior to integrating into a larger choir in the wider community. Participants in a recent qualitative study which explored consumers’ experiences of singing in a community group facilitated by a singing teacher, described participation as an opportunity to collaborate with others and learn social skills prior to
participation in other groups in their local community (Lagace et al., 2016). Further research is needed which specifically explores the role of therapeutic group singing in addressing social isolation for consumers with mental illness in community settings. This study aims to contribute to the knowledge in this area.

**The Investigation**

The aim of this study was to explore community-based therapeutic group singing in relation to feelings of belonging in adult mental health recovery. This aim was two-fold: first, the study aimed to understand how participants describe their experiences of community-based therapeutic singing groups in relation to their recovery; second, the study aimed to determine if participation in community-based therapeutic singing groups increased feelings of belonging. The interest in both understanding and measuring the experience suggested a mixed method approach, using different modes of self-reporting on belonging. Mixed methods research combines qualitative and quantitative approaches in the same research study (Tashakkori & Teddlie, 1998) incorporating philosophical assumptions along with methods of inquiry (Creswell & Plano Clark, 2007). A pragmatic philosophical approach was adopted as a tool for solving the philosophical issues which may arise when integrating research methodology (see Biesta, 2010 for a detailed explanation) and to implement the epistemology and methodology best suited to the aims of this research.

Bradt and colleagues (2013) argue that music therapists are best placed to conduct research that integrates several forms of data so that it can easily be transferable to music therapy clinical settings. They believe that mixed methods research is a way to facilitate this integration. Previous research in the singing and health field also suggests that conceptual and theoretical work should accompany
empirical research since “truly progressive” research demands the development of a theoretical framework (Clift et al., 2008, p. 12). Clift and colleagues suggest that future research is “destined to be haphazard, unconnected and non-cumulative” in the absence of this kind of collaboration (p. 12).

The current study used an ‘embedded’ approach, where qualitative and quantitative data were collected within an exploratory design (Creswell & Plano Clark, 2011). In this case, the combination of both qualitative and quantitative data provided a more complete understanding of the research problem than either approach alone. Two different research questions were developed that required different types of data to answer them:

1. How do participants describe their experiences of group singing in relation to feelings of belonging (qualitative data)?

2. Does short-term therapeutic community based singing improve feelings of belonging in the recovery of adults with mental illness (quantitative data)?

We interviewed participants to generate qualitative data comprising descriptions of group therapeutic singing in their own words (research question 1). We also collected quantitative data comprising participants’ subjective ratings of pre-determined descriptions (validated outcome measures) of whether community-based therapeutic singing improved feelings of belonging (research question 2). The use of an embedded design was important, since the purpose of including quantitative data was linked to, but different from the primary purpose of the study, which was to explore participants’ experience of the community based-singing program. A sequential approach to data collection was taken, where semi-structured interviews were conducted after post- measures had been collected, minimising potential bias. The quantitative element of this study was a quasi-experimental, non-randomised single
cohort pre-post design and did not include a control condition. This was considered an appropriate design because the intention was exploratory rather than experimental.

Method

Recruitment.

Adult consumers living in the community and linked with a community mental health service in the North-Eastern suburbs of Melbourne, Australia were given information about this study. Case managers involved in managing consumers’ community health care were asked to distribute information about the study to as many consumers as they saw fit over a two month period. Case managers were informed about the aims and purpose of the study through education sessions with the first author and were given a flyer about the study to pass on to participants (as seen in Appendix C). Case managers were also informed about voluntary participation to ensure that consumers did not feel pressured to participate. Ethics approval was received for this project by The St. Vincent’s Hospital Melbourne Human Research Ethics Committee A and the University of Melbourne Human Research Ethics Committee.

Participants.

Eight participants agreed to be involved in the study. However, four chose not to commence the program due to a range of reasons including: physical illness (1), work commitments (1) and loss of interest (2). One participant who lost interest in the program before attending the first session expressed concern (at the time of providing consent) about participating in research which required him to complete surveys stating, “I want to say stuff in my own words.” The remaining four participants (see Table 1) all had a long-standing history of mental illness for over 25 years and were not currently participating in any other group activities through their mental health
service or in their local community. Two out of the four participants chose to be identified throughout the research study by their real name. These participants described this as being “a way to advocate for others like me” (Alexandra) and “I don’t know…I just want to be known as ‘me’” (Phillip). The remaining two participants are referred to by their self-selected pseudonyms. In the interest of staying congruent with the epistemological foundations of mental health recovery theory, participants in this study are represented in a way that values their idiographic knowledge rather than by the use of diagnostic labels (Slade, 2012, p. 79). The authors believe that the way participants in research are represented should remain congruent with the strengths based and consumer focused features present in recovery-oriented mental health care and music therapy practice (Fairchild & Bibb, 2016). Table 2 highlights the similarities between Phillip, Martin and Jazz in regards to their age and gender and all participants’ self identified experiences of recovery.

Table 2. Participant Demographics.

<table>
<thead>
<tr>
<th></th>
<th>Phillip</th>
<th>Martin</th>
<th>Jazz</th>
<th>Alexandra</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>53</td>
<td>51</td>
<td>51</td>
<td>41</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Male</td>
<td>Male</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td><strong>Self-identified experience of recovery</strong></td>
<td>Lives alone and has been coping with mental illness for most of his life</td>
<td>Has been living with serious mental illness for over 20 years</td>
<td>Diagnosed with ‘schizophrenia’</td>
<td>Experiences frequent changes in mood</td>
</tr>
</tbody>
</table>

**Procedure.**

*Community-based therapeutic singing group.* Consenting participants took
part in a 10-week, community-based group singing program. Each weekly session lasted for one hour and was facilitated by a credentialed music therapist (author 1). The group was held in the meeting room of a local community church with an adjoining kitchen. The focus of the group was on offering participants opportunities to connect with others through singing. Humanistic (Abrams, 2015) and resource-oriented (Rolvsjord, 2010) approaches were adopted where participants were invited to collaborate together on the process of the 10-week program. Each session began with time for greetings, tea/coffee and discussion facilitated by the music therapist until all participants had found their seat in the room. After a brief welcome and review of the purpose of the group, the music therapist led vocal ‘warm-ups’ and song singing. In the first session, group members were asked about their preferred structure for the sessions and what they wished to gain from attending the group. Discussion with the participants identified three priorities (in no particular order): 1) singing songs that were familiar to them, 2) learning new musical skills, and 3) meeting new people. A book of lyrics was then distributed that included 50-60 popular songs ranging from the 1950s-1990s. The group members were encouraged to notice each other, listen to one another, and engage in discussion about the song lyrics and what it was like to sing together. Other topics also emerged in discussions within the group, often being related to mental health recovery. Each session ended with a brief reflection on the aims of the group and the invitation to share a meal together that the music therapist had prepared. In the final weeks of the program, participants were encouraged to join a different singing group, a choir linked to the church where the research singing group was located. This choir included both people with mental illness and other members of the local community. In these final sessions, the music therapist discussed participation in the community choir with the participants and the
choir facilitator, a community musician, attended the final 20 minutes of these sessions so that participants could get to know him. Participants were also encouraged to ‘trial’ the choir at the same time as participating in the final weeks of the program in order to facilitate a smooth transition into a larger group setting.

**Qualitative data collection.**

The first author conducted individual semi-structured interviews with each participant after the 10 week program had concluded. Each person was asked about their experience of singing in the group with others. Interviews were audio recorded and transcribed.

**Qualitative data analysis.**

Descriptive phenomenological microanalysis was used to analyse the interview data, a process which aims to “elucidate the experience in a way that captures its essential meaning” to the participant (McFerran & Grocke, 2007, p. 273). This method was chosen in an attempt to generate a descriptive account of each participants experience and identify common features between participant experiences, as in most schools of phenomenological thought (Finlay, 2011). The analysis was a five-step process (see Table 1) informed primarily by Giorgi’s (1975) procedural approach to phenomenological analysis, developed in the school of Psychology at Dusquesne University.

**Table 1. Microanalysis Process.**

<table>
<thead>
<tr>
<th>Step</th>
<th>Label</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Key Statements</td>
<td>Key statements were identified to reduce the data to its essential elements.</td>
</tr>
<tr>
<td>2</td>
<td>Structural Meaning Units (SMUs)</td>
<td>Data was classified into topics/categories.</td>
</tr>
</tbody>
</table>
The data was then reconstructed by the researchers to capture meanings that were felt to be present in the descriptions, following a long period of immersion in the interview transcripts. The titles remained in the participants’ words.

An individual distilled essence was created for each participant in the form of a narrative that captures the essential features of the experience.

Common themes were constructed by examining the individual essences to identify common and distinguishing features across participants.

Quantitative data collection.

Before the group singing program began, participants completed validated outcome measures with assistance from the first author (except for one participant, Jazz who completed the measures six days after the first session, due to arriving late to the first session). After five weeks, participants completed the measures again with assistance from the first author. Finally, at the end of the program (after 10 weeks) participants completed the measures one last time with assistance from the first author.

Two tools designed to measure the sense of belonging were utilised in this study. The Perceived Cohesion in Small Groups (PCiSG) scale (Chin, Salisbury, Pearson & Stollak, 1999) is a six-item self-report measure that aims to capture a person’s perception of cohesion in a small group (range 6-42, higher scores indicating greater perceived cohesion). The scale reflects two dimensions of cohesion (belonging and morale) and has been adapted from Bollen and Hoyle’s (1990) Perceived Cohesion Scale (PCS). The scale has been shown to be reliable in a sample of university students (Cronbach’s alpha coefficient 0.95 for belonging and 0.87 for morale) (Chin et al., 1999) and was chosen for this study due to its specific focus on
capturing belonging within a small group. It has not been validated with adults in the
community or people with mental illness. The Sense of Belonging Instrument (SOBI)
(Hagerty & Patusky, 1995) is a 27-item self report measure that aims to capture sense
of belonging in adults. The measure has two separately scored scales, SOBI-P
psychological state (range 18-72, high scores indicate a person feels valued, needed,
accepted) and SOBI-A antecedents (range 14-56, high scores indicate the person has
antecedents for belonging). Both scales are considered reliable based on a sample of
adults in psychiatric inpatient and outpatient settings (Cronbach’s co-efficient alpha
0.93 for SOBI-P and 0.63 for SOBI-A; Hagerty & Patusky). This scale was chosen as
it is considered reliable in community mental health settings and because the
questions were intended to capture a broader sense of belonging that addressed
participants’ lives outside the group context.

The Clinical Outcomes in Routine Evaluation (CORE) outcome measure
(Gray & Mellor-Clark, 2007) is a 34-item self report tool (range 0-136) which aims to
measure feelings and behaviours related to mental distress and psychological
wellbeing (higher scores indicating higher levels of psychological distress). Items
address subjective wellbeing, psychological problems, daily functioning and risk to
self and others. The measure is widely used to assess change in response to
counseling and psychotherapy interventions and is designed to be suitable across a
variety of therapy types. The measure has been shown to be reliable in clinical and
non-clinical samples (Cronbach’s alpha coefficient ranging 0.75 to 0.95; Gray &
Mellor-Clark, 2007). This measure was chosen due to its wide range of items relating
to a broad sense of wellbeing, which increases the potential of identifying unexpected
outcomes from the intervention with this population. It was also successful in
capturing clinically significant change in a similar study measuring wellbeing in choir
singers in a community mental health setting (Clift & Morrison, 2011).

Quantitative data analysis.

Scores for the CORE and SOBI subscales and PCiSG were computed. Scores were reversed when scales included negatively keyed items. Due to the small number of participants, raw scores for each participant were observed for trends to determine potential outcomes.

Results

Quantitative results.

Although qualitative data is prioritised over quantitative data in this study, the quantitative results are presented first as the authors feel the results from the qualitative data are best presented in combination with the discussion section of this article. The quantitative data are presented below as raw scores for individual outcome measures in a graph for each participant. The data offers an overview of each participant’s progress for the duration of the 10 week program. Unfortunately, little can be concluded due to major limitations of the outcome measures reported by participants during data collection. All four participants reported not being able to understand the questions in the outcome measures they were completing. As a result participants described ‘guessing’ or ‘making up’ answers on the measures and reported feeling disempowered in their attempts to complete the measures.

Participants were given the opportunity to describe their experiences of completing the outcome measures in the interview after the program had finished. This data was analysed separately and reported elsewhere (Bibb & McFerran, under review) in order to further explore and privilege these experiences. It was difficult to draw any
conclusions about the quantitative data from the completed outcome measures knowing this information.

**Phillip.**

Phillip’s quantitative results are displayed in Figure 1 and provide a visual representation of a broadly steady score for all three points of data collection across the SOBI scales and the PCiSG. The scores for the CORE measure were similar for the pre and mid point collection points and then decreased slightly at the post test point. Although all four measures are placed in the same figure, they do not have the same range of scores and are not for comparison against each other. Rather, the value of representing them on the same graph is to allow the reader to compare the three different time points separately.

*Figure 1. Phillip’s quantitative results.*

![Bar chart showing Phillip's quantitative results](chart Phillip)

**Jazz.**

Jazz’s quantitative results are displayed in Figure 2. There was a steady increase in scores for the SOBI-A and the CORE measure from pre, to mid and post
time points. The SOBI-P and PCiSG represented similar scores for the pre and post test points and a slight decrease in score at the mid test point. Again, although each measure is displayed in the same figure, they are not represented for comparison between each other, but rather for each to be compared against itself.

*Figure 2. Jazz’s quantitative results.*

![Graph showing quantitative results](image)

---

**Martin.**

Martin’s quantitative results are displayed in Figure 3. The figure visually depicts large changes between the pre and mid test points and the mid and post test points for the SOBI-A measure. The SOBI-P remained consistent over all three time points and the PCiSG and CORE scores slightly increased from pre to post test and slightly decreased at the mid point.
Alexandra.

Alexandra’s quantitative results can be seen in Figure 4. The figure represents consistency between the SOBI-A scores over time, an increase in both the PCiSG and CORE measures between pre and post test points and a slight decrease overall in the SOBI-P score over time.

Figure 4. Alexandra’s quantitative results.
Qualitative results and discussion

The Structured Meaning Unit themes, Emotional Meaning Unit themes and individual distilled essence from the interview of each participant are presented in Table 3. A number of unique features are apparent in each of the distilled essences, and the tone of each of the participants has been captured through a variety of strategies, including using their own words, reflecting the volume of material, and emphasising the topics they felt were important to raise during the interviews. Each sentence in the distilled essence represents a different Experienced Meaning Unit or ‘theme’ from the participants’ responses.

Table 3. Themes and Distilled Essences.

<table>
<thead>
<tr>
<th></th>
<th>Jazz</th>
<th>Martin</th>
<th>Phillip</th>
<th>Alexandra</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structured Meaning Units (SMU)</strong></td>
<td>Singing</td>
<td>Memories</td>
<td>Being a group member</td>
<td>The facilitator</td>
</tr>
<tr>
<td></td>
<td>Being a group member</td>
<td>Songs</td>
<td>Singing and lyrics</td>
<td>Fluctuating mental health</td>
</tr>
<tr>
<td></td>
<td>Purpose</td>
<td>Location</td>
<td>Group size</td>
<td>Being part of the group</td>
</tr>
<tr>
<td><strong>Emotional Meaning Unit (EMU)</strong></td>
<td>I kept myself quiet</td>
<td>The types of songs were spiritually rewarding</td>
<td>It’s good to anticipate going</td>
<td>Allowing myself to be loud with others</td>
</tr>
<tr>
<td></td>
<td>I was relaxed when we were singing</td>
<td>I was reminded of my youth</td>
<td>It was good it was a small group</td>
<td>Having trust in the therapist</td>
</tr>
<tr>
<td></td>
<td>Being with other people made me feel good</td>
<td>The venue was a peaceful place</td>
<td>It was good to be together with other people</td>
<td>It felt valuable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I could understand the lyrics</td>
<td>It was a safe space</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Singing from experience</td>
<td>To have something</td>
</tr>
<tr>
<td><strong>Distilled Essence</strong></td>
<td>It made me feel good, just being with other</td>
<td>The venue was a very peaceful</td>
<td>It’s good to be together with</td>
<td>That inclusion thing, being part</td>
</tr>
</tbody>
</table>

73
people. I kept myself quiet in the group. I was relaxed when we were singing, rather than sitting and doing nothing.

place and the types of songs we sang to were spiritually rewarding, I was reminded of my youth.

other people. I liked being a member of a group, we all sang from experience. It was also good to have a small number of people in the group and to understand the lyrics in the songs we were singing.

of something is sort of nice. We were there to contribute, to have a go, to be heard and it was a safe space. Allowing myself to be loud with others was a huge thing. The other group members allowed me to be me, for me to be different. It felt valuable and we achieved something.

### Common themes.

Five common topics were mentioned by the four participants in describing their experience of the group program. These topics have been identified as common themes and are discussed below. Participants’ own words are represented by the use of italics throughout the text.

**Being with others.**

Alexandra, Jazz and Phillip described being together as a positive experience. Alexandra and Jazz reported that being with other people and *being part of something* was *nice*, and made them *feel good*. Phillip described feeling *comfortable* with others in the group and enjoying their company. These descriptions support previous research where participants reported feeling a sense of belonging, comfort and connection through group singing participation (Dingle et al., 2013; Eyre, 2011; Pavlakou, 2009). Music therapy research also suggests that in music groups where cohesion is rated high by participants, mental health consumers have more social contact with other group members and consider the group more therapeutic (de l’Etoile, 2002). An important aspect of this theme for Alexandra was the membership
of the group being only for other people who had a lived experience of mental illness. Alexandra felt that she may have been rejected by people if she was in a normal group. She described being less judged by people in the group because everyone had the same challenge in life. Mutual understanding and shared experience are common themes in mental health recovery literature with peer relationships and support being emphasised as a key factor in fostering connectedness and social skills (Mead, Hilton & Curtis, 2001).

Although being together with others in the group was described as a positive experience by these participants, Jazz also illustrated the challenge of this experience and reported feeling more relaxed when the group was singing rather than when they were talking. Jazz also stated that he didn’t like staying around for a chat after the session had finished and left the group promptly after the singing concluded each week. For people with severe mental illness who experience social isolation and exclusion, even just sitting with others can be difficult (Davies & Craig, 2009), while communicating and socialising with others in a group setting can be an added challenge. Feelings of comfort with others and belonging to a group are not unique to participation in group singing, but the addition of singing in a group setting may well be a way for people like Jazz to begin reconnecting with their peers. This has been argued as especially important for people with chronic mental illness since a lack of connection to and communication with others has been linked to relapse (Keltner & Kring, 1998). Singing acted as a useful tool for Jazz, allowing him to participate in a group with others without the need to talk and engage socially. In this way, group singing may be a useful first step to participation in social activities for people with chronic mental illness who experience difficulty in communicating or interacting with others.
**Being heard.**

Two participants referred to their volume in the group, using contrasting words of *quiet* and *loud* when describing their speaking and singing voice. One of Alexandra’s Experienced Meaning Units included a quote where she said, *allowing myself to be loud with others was a huge thing.* The only time that Alexandra allowed herself to sing *unrestrained* was at home with her husband. She spoke of her fear of rejection in response to singing loudly and vocalising her ideas in the group since she had been excluded and bullied in high school. Despite her fears, Alexandra took the risk and *allowed* herself to be loud in the group. She still noted however, that if she had not *felt so safe* in the group she would have *just toned down* her voice. Previous qualitative research into group singing participation has described how people who experience marginalisation and mental illness appreciate opportunities for expression and empowerment (Bailey & Davidson, 2002; Dingle et al., 2013). In Bailey and Davidson (2002)’s choir study, participants reported finding a ‘voice’ through participation in group singing when previously they had struggled to conform to socially accepted roles. In the ‘Transformers’ choir, Dingle and colleagues (2013) found that the group offered participants the opportunity to ‘find their voice’. This was considered an important theme in the study, and was believed to contribute to both the personal and social impact of the choir on participants. Conversely, Jazz described the challenges of being vocal in the singing group and stated, *I kept myself quiet* to describe his participation style. Jazz did not appear to be a confident singer and seemed restrained when singing with others, which may have reflected his conscious decision to ‘keep himself quiet’. Contributing to a group can be challenging for people who have been stigmatised or marginalised due to their mental illness and who have had little opportunity to be heard in society (Bassman, 2001). People who
have been in the mental health system for many years may feel nervous about engaging in community treatment and expressing themselves in a group setting for fear of being involuntarily admitted to hospital (Swartz, Swanson & Hannon, 2003). Bassman describes this experience from a consumer perspective, arguing that once people have experienced involuntary treatment in the mental health system there is a tendency for them to demonstrate a “passive dependency” towards others and have difficulty voicing their opinions (p. 21).

* A sense of purpose.

All four participants described the group as giving them a sense of purpose in their lives. Alexandra spoke in detail of the challenges she had experienced with the mental health service in her local area and her plans to move locations in the future. However, participating in the singing group kept her from moving from the mental health service as she found it *valuable, just to have something* to attend. Similarly Jazz described feeling positive that he had *something to do* each week by attending the group. Martin described his participation as similar to his commitment to attend university many years ago before he became unwell stating, *I would make sure I’m on time for that,* while Phillip described *looking forward* to attending the group. The singing group gave all four of these participants purpose and somewhere to be each week. Although finding a sense of purpose through group participation is not exclusive to singing groups, participation in a singing group may provide motivation for creating structure and routine in one’s life (Eyre, 2011).

* Achieving something.*

Alexandra and Phillip described a sense of achievement by attending the
singing group. Alexandra reported feeling accomplished after completing the program. This was especially important to her, as she described feeling like she had not achieved anything in the last ten years since leaving university and coping with her mental illness. Alexandra described this sense of achievement as being gained through vocal improvement or through discussion with others. Improvement in vocal skills was also reported by Phillip who stated that although it was sometimes difficult to keep track of the lyrics and to sing along with others in the group, he improved over time which made him feel good. Myers and colleagues (2016) argue that one of the most important aspects contributing to ‘a meaningful day’ for someone in recovery is a sense of accomplishment and productivity. Mental health consumers in their study described these features as essential for gaining meaning in each day of their recovery. Sense of achievement is also a common theme in the singing and health literature with participants in Clift and Morrison (2011)’s choir study reporting a great sense of accomplishment from participation in a community choir.

**Group size and setting.**

Alexandra, Martin and Phillip reported that the size and setting of the singing group was an important part of their experience. Alexandra and Martin mentioned the feel of singing in the church and Martin described it as peaceful. The size of the group was also considered important by Phillip and Alexandra. Alexandra stated that the group was better for its small size and that if the group had not been so small she would have toned down the volume of her singing voice. On numerous occasions in his interview Phillip mentioned that he was pleased the group was small. He explained that if there were too many [people in the group], somebody would have to stay out, and that in large groups it was sometimes difficult to be involved and to fit in. Experiences of exclusion are common for people with severe mental illness who can
find it difficult to find a place in society (Shevellar et al., 2014). Thus, community participation and reconnection is particularly important for mental health consumers like Phillip who may have experienced these feelings in the past (Leff & Warner, 2006). Although Alexandra reported appreciating the small size of the group, she also stated later in her interview that if the group happened to be offered again, she would consider risking the dynamics of the small group to drum up some more people.

Indeed, a singing group of four people is not common in community settings and in what little literature there is describing singing groups for people with mental illness, choirs with larger numbers of participants are often described (Dingle et al., 2013; Clift & Morrison, 2011; Lagace et al., 2016). However for people with chronic mental illness who do not often participate in group activities, like the people described in this study, there is great value in participating in a small therapeutic singing group as a way of offering a first step to ‘being with’ and singing with others.

**Final Thoughts**

The aim of this study was to both explore and measure experiences of belonging through a short-term therapeutic singing group for people in recovery. Unfortunately the lack of understanding of the outcome measures that was reported by all four participants meant that little could be concluded from the quantitative data. However, the descriptions of participants’ experiences gained from interview transcripts offered interesting insights into group singing participation. One of the reasons for exploring belonging and connectedness in this study was to offer support for the use of short-term therapeutic singing groups as a way of transitioning consumers into mainstream singing groups and choirs in their wider community. It is apparent through the results of this study that the small size of the group and the use of singing as a way of becoming comfortable with being with others and practicing
‘being heard’, offered participants a first step to safe participation in groups. Upon conclusion of the program, Alexandra and Martin expressed interest in joining the choir linked to the church and decided to attend the choir together the following week. Although it is not known how successful this experience was for Alexandra and Martin, the results from this study offer support for further research into the use of small, short-term therapeutic singing groups as way of transitioning consumers to participate in activities in their wider community. Future studies would benefit from exploring the longer term benefits of such therapeutic singing groups in supporting attendance in a community choir.

Recruitment difficulties and the 50% drop out rate prior to commencement meant that only a small number of people completed this study. Recruitment by a third party (the community mental health organisation) was challenging. The case workers did not have any investment in the program or any incentive to recruit, and although the mental health service promoted participation in the program, the authors were dependent on the case workers to provide information to the consumers themselves. Therefore, recruitment was a challenge, despite attempts to maintain frequent contact with the case managers and conduct education sessions to explain the research project. It has previously been noted that increased communication between researchers requesting recruitment and clinicians conducting the recruitment has not shown to improve recruitment activity of the clinicians (Fletcher, Gheorghe, Moore, Wilson & Damery, 2012). Instead, clearer communication of the potential benefits to both consumers and case managers in providing recruitment may be the most important strategy for future research studies in this area (Bucci, Butcher, Hartley, Neil, Mulligan & Haddock, 2015). Future studies may also benefit from a longer recruitment period.
This study has contributed to the literature about the therapeutic value of singing together in the community for people in mental health recovery. The study aimed to both explore and measure experiences of belonging through a short-term therapeutic singing group for people with chronic mental illness. An embedded, exploratory mixed methods approach was adopted in order to answer the research questions. The qualitative analysis revealed that being with others, being heard, having a sense of purpose, achieving something and group size and setting were important factors in participants’ experiences of the group. These factors may contribute to the first step of participation in community groups for consumers with chronic mental illness who have experienced social exclusion and withdrawal. The study also revealed that each of the four participants struggled to complete the quantitative outcome measures for individual reasons. Further investigation into the appropriateness of using quantitative outcome measures in research with consumers with chronic mental illness is recommended.
References


Bibb, J., & McFerran, K. S. (under review). The challenges of using self-report measures with people with severe mental illness: Four participants’ experiences of the research process.


Eyre, L. (2011). Therapeutic chorale for persons with chronic mental illness: A


Glynn, S. M., & Lui, A. (2007). Enhancing socialization capacities in people with


people away from mental health treatment? Evidence of a survey of persons
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The Law*, 21, 459-472.

The study described in the previous chapter details an embedded exploratory mixed methods design using self-report outcome measures and semi-structured interviews, to understand the role of community-based group singing for four people in recovery. Participants reported that being with others, being heard, having a sense of purpose, achieving something and the group size and setting were important factors in their experience. Due to the lack of understanding of the measures that was reported by all four participants, little could be concluded from the quantitative data. Although the measures used to collect data pre, mid and post the 10 week program were deemed reliable for capturing change in belonging, and many were validated for use with people recovery, they were not understood by participants.

During each data collection point, participants described feeling that the measures were not clear, not well written and were cognitively challenging for them. They required support, clarification and additional time to complete the measures. One participant, Phillip, took 90 minutes to complete three measures that were expected to take ten minutes each (according to the authors of the tools). Alexandra assumed that she did not understand what many of the questions were asking of her because she was “an amateur” and not smart enough to understand them. When I observed the participants completing the measures, and hearing these comments being made, a number of conflicting feelings arose. First, a sense of confusion developed around the ethical nature of the participants’ experiences completing the measures. Was it ethical to ask people to complete measures that took 90 minutes each time? Would this impact their mental state? Second, the disempowering experience described by participants through completing the measures was uncomfortable.
Disempowering people through this research was the opposite of what I had intended and was incongruent with my way of working with consumers in a strengths based and resource-oriented approach.

Last, I began to doubt the validity of the answers participants were providing. Since participants told me they had guessed answers to the questions, it seemed impossible to then somehow ignore this information and still place value on the data. In many objectivist studies, it would be considered unusual for the same person to facilitate the singing program, administer measures and analyse the data due to the potential bias this could create. If I had not been present during quantitative data collection I may have continued on with the research without a reason to believe that people’s responses to the measures were not an accurate representation of their experience. However, watching these adults who had a positive experience of singing together, struggle and appear disempowered by the process of answering these questions made me doubt the validity of the answers.

Although I began to doubt the validity and ethics of administering the measures after the first data collection point, consultation with my supervisory team at the time resulted in the decision to continue with the initial study design. It was only through discussion with participants at the last point of data collection, that it became apparent that further opportunity to share their experience of completing the outcome measures was needed. Privileging and acknowledging these experiences felt necessary despite realising that their responses might challenge my ability to maintain the philosophical stance I had consciously adopted at the beginning of the study. This led to a significant inclusion of an additional question in my interviews with participants asking them to specifically reflect on their experience of completing the
self-report outcome measures. The next chapter details the data collected from these interviews and explores participants’ experiences of this in detail.
Chapter 4

The previous chapter reported on the first study in this thesis, an embedded exploratory mixed methods study, which included interviews with four participants about their experiences of a short-term therapeutic singing group and an aim to measure belonging before, during and after the program. For individual reasons, the participants in this study reported finding the outcome measures difficult to complete.

This chapter comprises a co-authored journal publication (Bibb & McFerran, under review) currently under review with a community mental health journal and is formatted accordingly. It details qualitative data which explores the participants’ experiences of completing the self-report outcome measures as part of the study described in Chapter 3.

Bibb, J., & McFerran, K. S. (under review). The challenges of using self-report measures with people with severe mental illness: Four participants’ experiences of the research process.
The challenges of using self-report measures with people with severe mental illness: Four participants’ experiences of the research process

Abstract

This study aimed to explore four mental health consumers’ experiences of completing self-report outcome measures in a research project. Participants were recruited from a community mental health organisation in Melbourne and were interviewed upon completion of a mixed methods research study where they were asked to complete a series of self-report outcome measures. Descriptive phenomenological micro-analysis was used to analyse interview data and is presented along with the researchers’ observations during the data collection process. Results revealed that participants found the outcome measures cognitively challenging and the language used in the measures did not support the empowering intentions of mental health recovery. The authors suggest that the value of completing surveys for people with severe mental illness needs to be carefully considered so that the research process does not diminish other benefits of participation.

Introduction

“It’s your work, but it’s my life” – Julie Shaw, 1996

These powerful words spoken by Julie Shaw, depict the frustration of a participant in a mental health research study (Shaw & Epstein, 1996). Shaw’s experience as a participant in two different qualitative mental health studies illustrates the subtle differences that contribute to either feeling valued as a participant, or feeling like a rat in a laboratory. In one of the studies, Shaw was interviewed by a researcher who
made her feel comfortable and asked her to select a pseudonym which was later used in published material. The researcher checked interview transcripts with Shaw before publication and valued her contribution as a participant in the research. Shaw believed this study intended to convey consumers as “whole people with distinct personalities” (p. 281). In the “lab-rat inducing” study, the researcher used the interview to ‘pluck’ out material that she felt matched her pre-existing beliefs (p. 282). Shaw was not given the opportunity to contribute to the research study and felt used by the researcher.

Whilst undertaking a mixed methods research study as part of my doctoral research, I became aware of the complexities facing consumers during their participation in research, particularly self-report outcome measures. As a result, I chose to include an additional question in my interviews with participants after the program was complete, where I asked them to specifically reflect on their experience of completing self-report outcome measures in the study. This journal article reports on these reflections.

**The research process and mental health participants.**

Authors have previously highlighted the need for studies which emphasise the unheard voices of mental health participants in research (Dunn, Candilis & Weiss-Roberts, 2006). The psychological risks for research participants not experiencing mental illness include depression and anxiety, altered self-concept, shame, fear and embarrassment (Labott & Johnson, 2004). Added challenges for research participants with a mental illness are feeling stressed from the unknown (Kaminsky, Roberts & Brody, 2003), feeling intruded upon (Boothroyd, 2000), and fearing the need to reveal sensitive information (Carey et al., 2001). It is likely that these risks are amplified for people with severe mental illness (Grant, 2015), since increased symptoms are more
likely to make participants feel anxious when information is asked of them during 
data collection (Boothroyd, 2000).

In two studies seeking mental health consumers’ experiences of participating 
in interview research, the majority of participants (96% Boothroyd, 2000; 86% Grant, 
2015) reported positive experiences. Participants reported being valued and respected 
by researchers who asked questions in a way they could understand (Grant). One 
participant said that the researcher, “treated [them] as an individual…not as just a 
statistical number” (p. 25). However, a small amount of participants in both studies 
experienced the research process as negative. Some participants (6.7%; Boothroyd) 
felt that the questions about their mental health made them feel slightly anxious and 
9% found the entire interview anxiety producing. One participant in Grant’s study, 
described feeling pressured to answer questions that he thought did not apply to him. 
The participant felt he needed to be dishonest with the researcher in order to complete 
his participation in the study. It was noted by Boothroyd that the 9% of participants 
who reported becoming anxious during participation in the research was nearly twice 
the rate of distress reported in studies using ‘well’ community based samples.

The inherent power imbalance that exists between researcher and participant 
(Muhammad et al., 2015), may make it hard for participants to feel they can exit a 
research study, even if they have previously understood that they are ‘allowed’ to, 
during the informed consent process (Grant, 2015). Participants report a desire to 
please the researcher, helping them by participating and answering questions for them 
even if they found the question stressful. One participant in Boothroyd’s (2000) study, 
reported feeling pressured to participate in the research because he could not read the 
consent form and did not want to tell the interviewer. It is important to be aware of
the potential to disempower participants through the research process and to adopt strategies to prevent this from happening.

**Using outcome measures in mental health research.**

Research designs using self-report outcome measures further impact participants’ experiences of the research process. In a study exploring consumers’ experiences of completing a standardised self-report measure of recovery (Hoy, 2014), four out of the 17 participants in the study reported a negative change in feeling state while they were completing and after completing the measure. Another study (Marshall et al., 2001) aimed to understand the subjective experience of participation in long-term outcome research of psychodynamic psychotherapy and psychoanalysis for people with affective disorders. Results revealed that participants reported “minimal negative impact” from participation with a “slight to moderate positive impact” (p. 321). After learning about participants’ positive experiences of the research process, authors presumed that clinicians must have previously underestimated the positive benefits of participation in research for mental health consumers. However, since the study used a questionnaire to assess the impact of questionnaire based research on participants, it is difficult to believe that this is a true representation of the range of experiences resulting from this type of research.

Many researchers emphasise the importance of spending time and energy explaining questions to participants and regularly asking them how they are feeling during the research process (Boothroyd, 2000). This is believed to be especially important for participants with serious mental illness who may require more time and assistance from the researcher when completing interviews or questionnaires (Dworkin, 1992). Yet, opportunities for support are often limited for participants in quantitative studies where research protocols must be adhered to and measures must
be administered in strict conditions. It may be more useful to adapt the design to suit the abilities of participants. For example, in Silverman and Leonard (2012)’s music therapy study of participants with severe mental illness, it was deemed inappropriate to use self-report instruments due to participants’ overt psychotic symptoms. Instead, the researchers chose to use observational measures in order to get the most accurate representation of participants’ music group preferences. Keeping the participant and their capabilities at the centre of our research, ensures a realistic representation of the clinical sample participating in the study.

The study described in this article reports on a small qualitative research project that aimed to understand how consumers with severe mental illness report on their experiences of completing standardised self-report outcome measures. The participants completed outcome measures in a different part of the study, in an attempt to measure social connectedness and wellbeing before, during and after a 10 week music therapy program. During the research process, each of the four participants struggled to understand and complete the standardised outcome measures (the Clinical Outcomes in Routine Evaluation [CORE] questionnaire, the Perceived Cohesion in Small Groups Scale [PCiSG] and the Sense of Belonging Instrument [SOBI]). This led to a change of focus to participants’ experiences of the research process.

**Method**

**Recruitment.**

Consumers receiving community treatment from an adult mental health service in the North-Eastern suburbs of Melbourne, Australia were given information about this study. Mental health workers and case managers were involved in recruiting participants over a two month period by distributing flyers to consumers.
Ethics approval was received for this project by The St. Vincent’s Hospital Melbourne Human Research Ethics Committee A and the University of Melbourne Human Research Ethics Committee. Initially, eight participants agreed to be involved in the study. However, four of the eight participants withdrew from the research due to physical illness (1), work commitments (1) and loss of interest (2). The four participating consumers had a long history of mental illness for over 25 years. Two out of the four participants (Jazz and Martin) chose to be referred to by pseudonyms, while Alexandra and Phillip chose to be referred to by their real name. Phillip (aged 53), Martin (aged 51) and Jazz (aged 51) reported experiencing “mental illness”, “serious mental illness” or a diagnosis of “schizophrenia” (respectively), while Alexandra (aged 41) reported “frequent changes” in her mood. Participants’ own descriptions of their recovery are prioritised over diagnostic labels in an attempt to value their lived experience, defined by Slade (2012) as “self knowledge” (p. 79).

**Data collection.**

Individual semi-structured interviews were conducted with each of the four participants. Participants were asked about their experience of completing the self-report outcome measures during their participation in the music therapy research study. Interviews were audio recorded and transcribed by the first author.

**Data analysis.**

Descriptive phenomenological microanalysis was used to analyse the interview data. This form of qualitative analysis is informed primarily by Giorgi’s (1975) procedural approach to phenomenological analysis. This method was chosen in an attempt to generate a descriptive account of each participants experience, and to prioritise their voice. The analysis was a four step process adapted from McFerran and Grocke’s (2007) microanalysis process, which included: 1) identifying key
statements to reduce the data to its essential elements, 2) classifying data into topics/categories (defined as Structural Meaning Units), 3) reconstructing the data to capture the meaning in the descriptions, following a long time of immersion in the interview transcripts (defined as Emotional Meaning Units), and 4) creating an individual distilled essence for each participant in the form of a narrative that aims to capture the essential features of each participants’ experience.

**Results**

In this section, participants’ individual distilled essences are presented along with reflections written by the primary author in reflexive journal entries. Each distilled essence aims to capture the voice of the participant by using their own words and reflecting the amount of material that was discussed in the interview. Each sentence in the essence represents a different Experienced Meaning Unit or ‘theme’ from the participants’ responses. The primary researcher’s observations are also included in order to provide a sense of the context that was apparent during the research process. Participants’ own words are indicated in the researcher’s reflections through quotation marks.

**Phillip.**

**Researcher’s reflection.**

Phillip completed the questionnaires himself and took 90 minutes in total to complete the questionnaires on all three occasions. There were times when he would sit still for ten minutes or so with the pen in his hand, seemingly thinking about a question. During these times I asked Phillip if he would like assistance or if he was unsure of what the question was asking him. He declined the offer stating, “no, no, I’m ok” and after another few minutes circled an answer on the page. On the second and third occasions it seemed as though Phillip may have memorised some of his
responses from the first time he completed them, as seen by the time he took to think about each question.

*Phillip’s narrative.*

I think they were straightforward, but I think they were searching as well, a lot of points were sometimes unfamiliar. They needed a lot of time, so that I could think about it, but not an excessive amount of time. Sometimes the answers were a little bit different from the last question, but apart from that they were quite succinct and clear.

*Jazz.*

*Researcher’s reflection.*

On all three occasions, Jazz expressed an initial reluctance to complete the questionnaires, stating, “there seems like an awful lot here” and “I’m not good with forms.” With support and reassurance, Jazz was able to complete all measures given to him. He accepted my offer to read the questions out to him so he could just tick the box on the page. Jazz sighed a lot while completing the measures and shuffled in his seat. He seemed to be rushing through the questions and had a tendency to mark the middle option on the page.

*Jazz’s narrative.*

It is hard to remember things in the last week. It was alright. It is just a bit of an effort to remember things. When I could not remember I just sort of made the answer half way between. I understood most of the questions, it made it a bit easier when the researcher read them out.

*Martin.*
Researcher’s reflection.

Martin accepted my offer to read the questions out to him on all three occasions of completing the questionnaires. For many of the questions Martin asked me what they were asking him, stating “I don’t understand.” After I attempted to explain and reframe the question, Martin still did not seem to understand the questions but circled an answer on the page anyway. Martin would often read his answers to the questions out loud to me, seemingly seeking reassurance that his answers were ‘correct’.

Martin’s narrative.

Yeah the questionnaires were a bit difficult actually, especially the first two. The third one, that made sense, the one about the music group. Maybe it was the bigger distribution on the scale, no it was not that. I am not sure. At first I thought the questions weren’t making sense but I might have had more problems completing them by myself.

Alexandra.

Researcher’s reflection.

Alexandra strongly desired to advocate for others with mental illness and believed in the importance of research in this area. Each time Alexandra completed the measures, she spent time marking the questions she did not understand and wrote down suggestions or comments ‘to be considered’ by the researchers. The first and second time she completed the measures, she tried made sure that she understood the questions being asked of her and requested clarification in order to achieve this. The second time she completed them she was more mentally unwell and seemed to get stuck on questions frequently. On this occasion she was very literal about each word written on the page and suggested that the questionnaires be “improved” so they were
“easier to understand.” Alexandra also suggested that perhaps she did not understand the questions in some of the measures because she was an “amateur.” During the interview, Alexandra had a lot to say about her experience of completing the questionnaires. We went through each of her suggestions and the comments she had written down and discussed these along with her general experience of the group.

**Alexandra’s narrative.**

After doing the questionnaires the second or third time, you get more familiar with them. I instantly think of examples and circumstances in my real world to help me when I am answering the questions. I could take forever doing them on my own, it would not necessarily be any better, it would just feel a bit tiring. I am all for having a little list of definitions of terms in the questionnaires. If I was not doing well, I would find that useful. I am less needy of exactness now that I am doing better mentally. I want to make sure that I get it and I am giving reliable information. You know when you want your thoughts and opinions valued? I like to think that what we put down as feedback about the questionnaires will affect future research.

**Discussion**

Jazz, Phillip and Alexandra reported difficulty recalling information and concentrating on the measures they were asked to complete. Jazz found it hard to remember things that he was asked. People with severe mental illness can experience cognition and memory issues which can make it difficult to think back in time (American Psychiatric Association, 2013). Phillip commented on the unfamiliarity of some of the questions and how he needed a lot of time, so that he could think about his responses. All four of the participants took much longer to complete the outcome measures than estimated. Focusing for long periods can be difficult for people with severe mental illness who experience symptoms which can affect their ability to
concentrate. Consumers have previously reported that the more questions they are asked to answer in an outcome measure, the less amount of time and attention they spend on their response (Stasiak et al., 2012).

Alexandra recommended including a list of definitions of terms in the outcome measures so that participants could refer to this in an attempt to better understand the words in each question. Long, complex words and clinical jargon is often difficult for people with mental illness to understand. Language which is “straightforward,” “comprehensible” and “in a form [consumers] can understand” is understandably preferred by participants with mental illness (Stasiak et al., 2012, p. 526). In Hoy (2014)’s study which explored consumers’ experiences of completing a standardised self-report measure of recovery, all 17 participants reported difficulty in understanding the questions asked in the self-report outcome measures. All of the participants reported feeling the need to ask someone for assistance so they could understand what the questions meant. Similarly, Jazz, Martin and Alexandra referred to the support they received during the research as making the data collection process easier. Alexandra and Martin thought they would have more difficulty and feel tired if they had to complete the outcome measures on their own. Jazz referred to the process being easier when the researcher read the questions out to him. In their recommendations regarding the use of standardised self-report measures in a community mental health setting, Greeno and colleagues (2007) suggest conducting outcome measures in an interview style with mental health consumers. These authors argue that reading the questions out to participants reduces literacy burden, so that they are more likely to understand the questions they are being asked.

One of the outcome measures participants were asked to complete in this study, the CORE questionnaire, has been validated for use in psychology and
counseling programs with people experiencing mental illness in the community (Gray & Mellor-Clark, 2007). However, in an earlier study the authors caution future users of the measure stating:

We distinguish clearly between patients seen in out-patient settings within secondary care services (as reported here) and patients deemed to be within a category that has been referred to as ‘serious and enduring mental illness’.

For such patients, the process of understanding and completing a self-report measure might yield results that are not necessarily continuous with those reported here (Barkham, Gilbert, Connell, Marshall & Twigg, 2005, p. 245).

There is no reference in the article as to what is considered a ‘serious and enduring mental illness.’ However, Jazz, Phillip, Alexandra and Martin all had a severe mental illness for more than 25 years, which could explain why they had difficulties completing the measure.

The Perceived Cohesion in Small Groups scale (PCiSG) has only been tested in a non-clinical sample of university students but was used in this study due to the lack of other measures with a small number of items measuring belonging in a small group context. This likely explains why the questions appeared to be cognitively challenging for participants in the current study to understand. The limited number of reliable and validated self-report measures for participants with severe mental illness has serious implications for research in this field. Future creators of such measures may benefit from collaborating with consumers to identify language that is more easily understood by people with severe mental illness.

The authors recently conducted a critical review of the self-report measures most commonly used in Australian mental health research in the last ten years (Bibb, Baker & McFerran, 2016). Results found that only two out of the top seven most
commonly used self-report tools in Australian mental health research in the last ten years were developed from a consumer perspective. This is surprising given the recent emphasis on consumer involvement in contemporary mental health research and the importance placed on lived experience. The perspectives of the participants in this study provide support for the importance of using clear and common language in self-report outcome measures. This is important for both increasing accuracy of the data collected and fostering positive experiences of data collection for participants.

Participants in the current study reported experiences congruent with schizophrenia and bipolar disorder. The Sense of Belonging Instrument (SOBI-A and SOBI-P) was validated with consumers from inpatient and outpatient settings with major depression, and although this can similarly result in reduced mental capacity (American Psychiatric Association, 2013), presents differently to schizophrenia and bipolar disorder. It is also important to note that the measure was created by “experts in the field” (Hagerty & Patusky, 1995, p. 10). This expert involvement may explain why participants had trouble completing the measure and were not able to understand the language used in the items. One participant (Alexandra) was able to explain that she needed to take time, breaking down the questions in this measure in order to understand what was being asked of her. The quality of questions asked of participants in research, influences the quality of data we collect from them (Chase, 2003). The professional and unclear language used in self-report outcome measures can increase the division of power between participants and researchers, potentially disempowering mental health consumers through the research process (Bibb, Baker & McFerran, 2016).

The evaluation of community mental health programs has been traditionally based on measurement of change. However, the difficult experience of outcome
measure completion described by participants in this study highlights a number of challenges in metrically capturing change for people with severe mental illness. Yet these same people were able to describe positive experiences of the music therapy program in interviews by using their own words (Bibb, Baker, Tamplin & McFerran, under review). The small number of participants in this study make it difficult to apply these findings to other contexts, but this study offers interesting insights into four consumers’ experiences of the research process. Future research is needed in this area so that researchers are aware of the potential negative effects the research process can have on participants, and to ensure that consumers experience research participation as a unique opportunity to be heard (Grant, 2015).

Conclusion

This study revealed that completing measures in order to determine change deserves careful consideration. Each of the four participants in this study struggled to complete a number of self-report outcome measures for individual reasons. The language in the measures used in this study was reported as difficult to understand by participants. One participant was even able to articulate the nature of her disempowerment during the data collection process. Watching these consumers who had a positive experience of a music therapy program, struggle and appear disempowered by the data collection process was disappointing and made us doubt the validity of the answers. Future research in this area should consider the congruence between using self-report outcome measures and recovery-based principles in order to ensure that participation in research is not disempowering.
References


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Bridging Material

The study in the previous chapter details the experience of completing self-report outcome measures for the four participants from the study described in Chapter 3. After privileging these participants’ experiences of the research process through the additional interview question in this study, I chose to reposition myself and reconceive subsequent stages of the research. I was not able to continue the project within an objectivist frame after doubting the accuracy and process of using outcome measures in research. This experience of using measures in research led me to perceive the research process as hindering recovery for participants and I was left with questions around the use of measures in mental health research: Was there a place for research using outcome measures in contemporary mental health care if these measures did not foster positive experiences? Are there standardised measures that can promote recovery rather than disempowerment through the research process? I believed there was a need to critically examine the measures most commonly used in this field of research in order to challenge the assumptions surrounding their ‘reliability’. The next chapter details a Critical Interpretive Synthesis of the most commonly used self-report measures in Australian mental health research in the last ten years. This chapter is an extended version of an article published in an Australian mental health journal.
Chapter 5

The previous chapter described the method and findings from interviews with participants about their experiences of completing the self-report outcome measures in the study described in Chapter 3. Chapter 5 reports on the method and findings from a Critical Interpretive Synthesis of the most common outcome measures used in mental health research in the last ten years. It was published in a peer-reviewed mental health journal in January, 2016. An extended version of this paper is presented in Chapter 5, and it is therefore not presented in its original published format.

A critical interpretive synthesis of the most commonly used self-report measures in Australian mental health research

Abstract

Objective: To critically examine the self-report measures most commonly used in Australian mental health research in the last ten years.

Method: A Critical Interpretive Synthesis (CIS) was conducted using seven outcome measures that were identified as most popular in 43 studies from three mental health journals.

Results: Results suggest that the amount, type and cultural appropriateness of the language used in outcome measures is important in both increasing accuracy of the data collected and fostering positive experiences of data collection for participants.

Conclusions: Results indicate that many of the measures most often used in Australian mental health research do not align with the current contemporary philosophy of mental health clinical practice in Australia which emphasises lived experience and consumer input.

Background

Government policy for the service delivery of mental health care in Australia has changed direction in the last ten years and now embeds ‘recovery-oriented’ approaches into all aspects of service design and delivery (Commonwealth of Australia, 2013). Recovery offers a “transformative conceptual framework for practice [and] culture” in Australian mental health care (p. 2). Based on principles of empowerment and collaboration, recovery-oriented care brings lived experience together with the skills and knowledge of mental health practitioners to challenge
conventional philosophies of power and knowledge in health care.

**Mental health research in Australia.**

Research in mental health care has traditionally been based on a positivist worldview. Positivism is associated with experimental research methodology where data is seen as quantifiable and designs focus on objective truth (Lincoln, Lynham & Guba, 2011). Contemporary mental health research is influenced by recovery principles and emphasises the importance of consumers’ perspectives informed by their lived experience (Banfield, Barney, Griffiths & Christenson, 2012). Thus the role of consumers as active participants in mental health research has been increasingly apparent in recent years. In 2002, the National Health and Medical Research Council (NHMRC) released a Statement on consumer and community participation in health and medical research. The Statement for the first time recognised the value of consumer contribution and right to participate in mental health research (Commonwealth of Australia, 2002). Consumers and researchers were encouraged to share the vision of “working in partnerships based on understanding, respect and shared commitment to research that [would] improve the health of humankind” (p. v).

Debate still continues between authors who assume different epistemological understandings of mental illness and the priorities of future research in this area (Rose, Evans, Sweeney & Wykes, 2011). In 2003 and 2013 Griffiths and her colleagues conducted a survey with consumers about their priorities for future mental health research in Australia. In the 2003 study, consumers rated ‘involvement of consumers in research’ as the highest priority, while mental health researchers rated consumer participation as low on their list of research priorities. Both groups in both studies rated psychological and social treatments for mental illness as highest
priorities (Christenson, Batterham, Griffiths, Gosling & Hehir, 2013; Griffiths et al., 2002). In a participatory study within a regional mental health service in Queensland, consumers were also asked to identify future research topics of importance and priority and reported that emotional wellbeing was the most important area for future research (McAllister, Munday, Taikato, Waterhouse & Dunn, 2012). The authors of the study describe emotional wellbeing as “more than the absence of mental illness, or even the achievement of mental health” (p. 274). Like mental health recovery philosophy, emotional wellbeing encompasses feelings of happiness, productiveness, effectiveness and being cared for (Fredrickson & Joiner, 2002). If such outcomes (along with psychological and social treatments as identified as the highest priorities for mental health research in Griffiths and colleagues’ studies) are seen as the highest priority in Australian mental health research, subjective and/or self-report outcome measures are best placed to capture this data.

**Self-report measurement in mental health research.**

‘Self-report’ refers to collecting information and perspectives directly from consumers in a research study (Emerson & Hatton, 2008). Self-report tools aim to measure subjective components of health and wellbeing such as psychosocial wellbeing, happiness or loneliness. According to some researchers, self-report measures can foster experiences of self-efficacy and empowerment in comparison to clinician-reported measures since they emphasise user perspective (Trauer, 2010; Guthrie, McIntosh, Callaly, Trauer & Coombs, 2008).

When asked about their experiences of completing self-report measures, consumers in two studies conferred great value to completing a questionnaire to measure mental health outcomes (Guthrie et al., 2008; Stasiak et al., 2012). In a study interviewing young people and their parents about clinical outcome measures used in
child and adolescent mental health care, parents reported that answering questions on measures enabled them to reflect on their child’s condition (Stasiak et al.). They felt that by being asked to provide their own views and concerns, they were being taken seriously by practitioners. Young people in the same study reported that completing a written measure was “easier” and “less embarrassing” than talking to practitioners about their thoughts and feelings (p. 522). Participants also felt that being able to observe and track their own progress through their responses over time was helpful and empowering.

There is some debate regarding the appropriateness of self-report measures in mental health research. One objection by some consumers in Stasiak and colleagues’ (2012) study was the lack of ability to report on the complexity of mental health and wellbeing or to capture more specific issues. The continuous fluctuation in the acuity of mental illness can make it difficult to accurately track the progress of mental health and functioning. The lack of ability to provide context to the responses given is also described as problematic by some consumers. In contrast to the findings described above, other consumers have reported negative changes in feeling states during completion of self-report outcome measures. Hoy (2014)’s study explored consumers’ experiences of completing a standardised self-report measure of recovery, and four consumers described negative changes to their feeling state after completing the measure. One participant said,

I was feeling crummy to start with, and starting off with how terrible my money is made me feel more down, so I answered the other questions worse than I might have done otherwise. I mean, come on, it’s depressing to think about, you have no friends, no money, it’s all terrible. I felt like a loser (Hoy, 2014, p. 166).
The other main critique of self-report measures has been the potential for participants to be dishonest in their responses or alternatively, misunderstand the questions asked of them. In Stasiak and colleagues’ study (2012), young people reported that it was “easy” and “tempting” to be dishonest when completing self-report measures, particularly if they were being asked about sensitive topics by clinicians they did not trust (p. 527).

One way to minimise these issues is to ‘triangulate’ the way data is collected in research studies and collect multiple perspectives from different sources (Creswell & Plano Clark, 2011). This strategy aims to enhance the rigor and validity of the research by “building evidence for a code or theme from several sources or several individuals” (p. 212). Triangulation through collecting diverse data sources allows the researcher to compare and analyse different forms of data and search for meaning across the data sets. A report from Siggins Miller Consultants (2003) stated that for people with severe and persistent mental illness, “it may not ever be possible to get a valid consumer self-rating of outcome” (p. vii). They argue that consumers themselves believe in the need to validate self-reports by including clinician and carer views. Young people in Stasiak and colleagues’ study (2012) also discussed the value of collecting multiple perspectives. They described the parent’s perspective as “helpful”, acknowledging that they might not be able to judge their own behaviours accurately (p. 528).

In order to determine the effectiveness of treatment outcomes in community mental health settings, it is essential that self-report outcome measures accurately capture consumers’ perspectives (Greeno, Colonma-Pydyn & Shumway, 2007). Currently, it is assumed that self-report measures are understood by consumers and that they are therefore providing an accurate representation of their perceptions.
However, a critical examination of the measures most commonly used in this field of research is needed to challenge the assumptions that underpin our current beliefs around self-report outcome measures. Without this, we are unable to confidently propose a ‘true picture’ of what works in community mental health care in Australia. The intention of the synthesis reported below was to critically examine the self-report measures most commonly used in Australian mental health research in the last ten years.

**Method**

**Critical Interpretive Synthesis.**

A Critical Interpretive Synthesis (CIS) is a specific approach to qualitative literature synthesis. Unlike integrative literature reviews aiming to find ‘truth’ or ‘effects’ (Harden & Thomas, 2010), a CIS is interpretive and focuses on critically examining the literature and challenging the way conclusions have been constructed (Dixon-Woods et al, 2006). The CIS involves an iterative, recursive and reflexive process rather than fixed procedures led by a predetermined hypothesis, often used in traditional systematic literature reviews (McFerran, Hense, Medcalf, Murphy & Fairchild, 2016). Methodology for conducting this CIS was adopted from McFerran and colleagues’ recommendations for ‘doing a CIS’ (see Table 1). This methodology will be adapted to reflect the specific focus of the current CIS which is to examine self-report outcome measures used in community mental health research studies published in the last ten years, rather than to examine the studies themselves.
Approaching the outcome measures and the literature.

The first step in conducting a CIS is describing the intention of the review. Rather than identifying a research question which is fixed from the outset, the study was guided by an intention that provided a ‘compass’ to guide the review journey (Eakin & Mykhalovskiy, 2003). Emerging ideas then influenced the rise of new questions and concepts that were pursued throughout the analysis (Dixon-Woods et al., 2006). The intention of the current CIS was:

*to critically examine the self-report measures most commonly used in Australian mental health research in the last ten years.*

Gathering the outcome measures from the literature.

Literature was first gathered in order to examine the most commonly used outcome measures in published research studies. A systematic process was used to collect studies conducted in Australia between 2005 and 2015 with adult mental health consumers living in the community. Studies needed to have used a standardised self-report outcome measure for pre-post comparison of an intervention to be included. Rather than the first author of this review choosing the tools she assumed were most commonly used in mental health research - derived from her own knowledge and experience of working in the field - a systematic process was developed to test these assumptions.
Initially a broad search was conducted using a number of electronic databases. However, the number of studies identified from the search of just one database (Ovid Medline) was larger than expected (N=688) and the authors decided to limit the search to three individual mental health journals in order to undertake a more in-depth analysis. Based on anecdotal reputation and considering the focus on local research, Australia’s two leading mental health journals were selected - the Australian and New Zealand Journal of Psychiatry (impact factor 3.765) and Australasian Psychiatry (impact factor 0.556). Additionally, since the aim was to specifically find outcome measures used in community based programs the leading international journal in this area was also selected - the Community Mental Health Journal (impact factor 1.146).

Inclusion criteria were research studies conducted in Australia with adults (18-65 years) using standardised pre-post self-report outcome measures in a community mental health context. The final search terms included ‘community’ and ‘Australia’ (for the international journal). All references resulting from the search were imported into an Endnote library (Endnote X5, Thomson Reuters).

Three stages of screening were used to determine the final selection of included studies (seen in Figure 1). During the first stage, publication titles were screened to determine eligibility for inclusion. Where a decision could not be made based on the title, the study was retained for the next stage of review. Abstracts were then reviewed to ascertain whether the studies met the inclusion criteria in the second stage. The final stage involved screening the full text of studies to determine the outcome measures used.
Interrogating the outcome measures.

The names of the outcome measures used in the 43 included studies were extracted. Outcome measures that were tallied three or more times were considered the most ‘popular’ tools used in the three journals between 2005 and 2015. These outcome measures were included in the review and are presented in Table 2. A total of 87 tools were used within the 43 studies, with most studies using more than one.
Table 2. *Most commonly used self-report outcome measures.*

<table>
<thead>
<tr>
<th>Tool</th>
<th>Number of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kessler 10 (K10)</td>
<td>7</td>
</tr>
<tr>
<td>Recovery Assessment Scale (RAS)</td>
<td>4</td>
</tr>
<tr>
<td>Stages of Recovery Inventory (STORI)</td>
<td>4</td>
</tr>
<tr>
<td>World Health Organisation Quality of Life - Brief (WHOQoL-BREF)</td>
<td>4</td>
</tr>
<tr>
<td>Beck Anxiety Inventory (BAI)</td>
<td>3</td>
</tr>
<tr>
<td>Beck Depression Inventory (BDI)</td>
<td>3</td>
</tr>
<tr>
<td>Depression Anxiety and Stress Scales (DASS)</td>
<td>3</td>
</tr>
</tbody>
</table>

Copies of the tools were then sourced and information was extracted from each tool and entered into an excel spreadsheet. The spreadsheet was used as an ‘organising frame’ where the authors compiled the information considered to be most relevant and interesting (McFerran et al., 2016). This often required moving beyond the information found in the tools themselves to a search for information located in the original article which outlined the development of the tool or by searching more broadly. This process was important since the type of data being extracted not only related to the tool itself, but also to how the tool was developed and other contextual factors surrounding its development (i.e. In what country it was developed and the intended purpose of the measure). The aim of analysis was to discover similarities and differences in the data extracted from the outcome measures. Different forms of interrogative analysis occurred within the data set and are described below.

1. **Looking between** the outcome measures: Finding connections or disparities between the tools

2. **Looking into** the outcome measures: Looking deeper into the outcome measures themselves and deriving descriptive statistical data (i.e. Number of items and number of words per item) to compare between the outcome measures
3. Looking outside of the outcome measures: Considering the context of the tools and the background to their development

**Synthesising the Outcome Measures.**

The ‘synthesising argument’ (Dixon-Woods et al., 2006) resulting from the data analysis was built around three main factors that appeared to be influencing the popularity of outcome measures being used by Australian researchers in mental health care.

- **Outcome measure development** including contextual factors such as date of development, location and who developed them
- **Outcome measure aims** including intended purpose and intended audience
- **Outcome measure structure** including time period, number of items, number of words per item and intellectual complexity

These three influencing factors will now be discussed in detail.

**Development.** Three contextual factors around the development of the outcome measures were identified as influential in the popularity of the measures being used: date of development, location and who developed them. The BDI was created in 1972, while four of the tools were developed in the 1990s (K10, DASS and WHOQoL-BREF) and the two recovery scales (RAS and STORI) were developed in the early 2000s. It is not surprising that the outcome measures developed during this later time frame were predominantly focused on recovery-oriented principles. Since the 2000s, recovery philosophy began to gather momentum in Australian mental health services. In 2002 the National Health and Medical Research Council (NHMRC) for the first time released guidelines emphasising the value of consumer contribution and participation in mental health research (Commonwealth of Australia, 2002).
Four of the scales analysed in this study were developed in the USA, two in Australia and one as a cross-cultural tool aimed to be used world-wide (WHOQoL-BREF). The STORI and DASS were the only tools developed in Australia. Stasiek and colleagues (2012) claim that culture is an important consideration when measuring wellbeing and behaviour since the consumers in their study emphasised the importance of knowing the country of origin of the tools they were completing. Participants wanted assurance from the researchers that if measures were developed overseas, they were validated for use in their country. Consumers in Stasiek and colleagues’ study also questioned the usefulness of foreign measures since the way questions were phrased did not seem relevant to them. Other researchers have also highlighted that the language and concepts used in tools developed in one country may not be congruent with different cultural understandings of the same constructs in different countries (Crooke & McFerran, 2014).

The measures identified in the current synthesis all had consumer input into their development. It is important however, to distinguish between tools which were piloted on consumers and collaborative research where consumers were equal partners or co-investigators in the development process (Green et al., 2014). The BDI and the RAS were developed collaboratively with consumers where they had equal input into their development. The BDI was developed by collecting consumers’ own descriptions of their symptoms and using them to develop a scale to reflect the severity of each symptom (Beck, 1972). Similarly, the RAS was created from the analysis of consumers’ ‘recovery stories’ from an initial participatory research study and then piloted with 1,800 community mental health consumers (Corrigan, Salzer, Ralph, Sanger & Keck, 2004). The remaining five tools were piloted with consumers after the questions and structure of the tools had initially been developed by the
researchers, who were mental health clinicians. It is surprising that only two out of the
top seven most commonly used self-report tools in Australian mental health research
were developed from a consumer perspective. Especially given the recent emphasis
on consumer involvement in research and its importance for learning about
contemporary developments in recovery.

Participatory approaches to research are well aligned with recovery theory as
they aim to engage consumers and researchers in an equitable process that is mutually
empowering (Minkler & Wallerstein, 2008). Collaboration with consumers in
constructing knowledge and measuring outcomes of research is fundamental to a
consumer-centred mental health service and to the recovery philosophy (Green et al.,
2014). Collaborating with consumers in the development of tools used in
contemporary mental health research is not only congruent with recovery based
principles, but can offer a way for consumers to engage in the process of recovery
itself (Hense, McFerran & McGorry, 2014). Just as the quality of clinical research is
determined not by social labels, but by a researcher’s expertise and skills, the
knowledge contributed through lived experience should be prioritised over social
labels and power inequality in the conduct of research in mental health care (Green et
al., 2014). We suggest that to create valid measures in line with contemporary
theories of mental health research, researchers need to construct measures derived
from consumers’ lived experiences.

Developments in this area are impeded by the ongoing tension in the field
between differing paradigms in the understanding of mental illness - that of the
traditional positivist worldview and of the more contemporary participatory approach.
These contrasting paradigms lead to the use of different methodologies in research. In
order to address this problem in the process of developing consumer led outcome
measures, Rose and colleagues (2011) recommend a mixed methods approach which has previously been adopted within participatory research and psychometric testing (Rose et al., 2008; Rose, 2009; Greenwood et al., 2010).

**Aims.**

The intended purpose of the outcome measures were identified by sourcing the original articles describing their development by the authors. Two tools (the RAS and STORI) were designed to measure mental health recovery and in one case (RAS) recovery was seen as defined by the consumers constructing the tool. The remaining tools aimed to measure mental health symptoms (4) and quality of life (1) as defined by researchers or clinicians. Outcome measures used in mental health research are traditionally developed by researchers to reflect clinically defined priorities (Kroll, Wyke, Jahagirdar & Ritchie, 2011). As such their content is influenced by what researchers believe to be a ‘good’ outcome. A good outcome according to researchers or professionals may not be congruent with a good outcome for a mental health consumer. I.e. Having close relationships with family members may be a good outcome for professionals but some consumers may report that they maintain their mental health by keeping their family members at a distance (Rose, Evans, Sweeney & Wykes, 2011). The difficulty with using outcome measures from a single perspective is that when they are used in large clinical trials to achieve objective or unbiased results, they become subjective rather than objective. Rose and colleagues argue that outcome measures in research should reflect a balance of conventionally developed measures and measures created from a consumer perspective. A ‘self’ or ‘consumer’ report measure suggests a consumer centred approach and thus gives the impression that outcomes are defined by consumers (Kroll et al., 2011).
Five of the tools were intentionally developed for people with severe mental illness or who may be experiencing symptoms of mental illness such as anxiety or depression. However, two of the tools (WHOQoL-BREF and K10) were originally developed for non-clinical populations, despite being popular for measuring symptoms of mental illness. Greeno and colleagues (2007) suggest that the length and complexity of tools originally developed for non-clinical populations may compromise their validity when used with clinical populations. Many measures are developed and piloted in university based research settings. If the measures are then used with clinical populations, the concern is whether they can accurately be translated into these settings due to potential complexities in language and structure.

**Structure.**

Self-report outcome measures require participants to answer items based on a given time frame. Both of the recovery based scales (RAS and STORI) identified in this review asked participants to rate their feelings in the ‘current moment.’ This reflects the contemporary understanding of mental illness and its unpredictable nature. However, the most commonly used outcome measure in the review (K10) aimed to capture the ‘last four weeks’ in participants’ lives. Due to the day-to-day fluctuations of mental health related symptoms, a period of four weeks could differ immensely making the accurate tracking of change difficult (Stasiak et al., 2012). Additionally, cognition and memory issues can result in the inability to ‘think back’ over long time periods. In the authors’ previous study (Bibb & McFerran, under review) one mental health consumer made reference to the fact that it was “hard to remember things in the last week” when asked what it was like to complete the outcome measures in the research study (p. 14).
All seven outcome measures included in the CIS had a differing number of items. The three tools with the most amount of questions were the STORI (50 items), DASS (42 items) and RAS (41 items). When asked about their experiences of completing outcome measures, consumers report that the number of questions in a tool determines the amount of attention they devote to their response (Stasiak et al., 2012). Although these three measures may be considered concise in research settings, it is likely that participants with a mental illness would find them lengthy. Greeno and colleagues (2007) suggest that after answering a number of similar questions, participants can often respond to subsequent questions by choosing one answer and using it for every item. Optimal accuracy occurs when consumers understand all response options and select the one that best fits them. When the simplest or most convenient option is selected as a result of participant fatigue, the data collected becomes meaningless (Sentell & Ratcliff-Baird, 2003).

The average number of words per item was calculated for each outcome measure by manually counting the words and calculating means. Averages ranged from 2 to 15 words per item/question. The most commonly used tool (K10) had the most amount of words per question (15). The longest question in the K10 had 18 words and asked, ‘during the last 30 days, about how often did you feel so nervous that nothing could calm you down?’ Although 18 words sounds lengthy, the question has been well-structured and is broken down with punctuation marks and uses simple language. The tool with an average of two words per question was the BDI where questions were structured under themes with graded item-response choices. For example, short sentences such as, ‘I do not expect things to work out for me’ were provided under different themes to describe levels of severity for that theme or symptom. This is seemingly helpful for participants who are literate and can scan the
topic, looking through the possible options that suit them. However, a consumer with severe mental illness with limited mental capacity, would need to read and process each response option separately (Greeno, Colonna-Pydyn & Shumway, 2007). Given that the tool has four choice options under each theme, it could take up to four times the amount of time to complete. The 21-item tool then becomes similar to an 84-item questionnaire for someone with a mental illness. During this activity consumers may need to re-read answers if they have forgotten them once finished reading the entire list of options. Instead of going through this lengthy process, research participants completing graded item-response options have previously been noted to just repeat the answer they remember rather than the option that best fits them (Greeno et al.).

Outcome measures often have built-in features that increase their intellectual complexity. Reverse coding and graded item-response options were integrated into three out of the seven outcome measures in this review (BDI, STORI and WHOQoL-BREF). Reverse coded items change the direction of the response. Tool developers use these features in an attempt to strengthen the instruments and ensure that participants read and respond to each question. Greeno and colleagues (2007) suggest however, that these features create additional hurdles for participants in community mental health settings. Reverse coding and graded item-response options are likely to be confusing for people with severe mental illness. Greeno and colleagues recommend changing the reverse-coded items back to the dominant direction of the scale for use in community mental health settings or for researchers to provide a verbal explanation of the items to participants.

There were two outcome measures included in the review (WHOQoL-BREF and DASS) that used jargon or professional language in their questions. The tools had five or more words identified by the first author of this review as professional
terminology, including terms such as ‘physical environment,’ ‘bodily appearance,’ ‘leisure activities’ and ‘perspired.’ Although the average person in the general population may understand the meaning of these phrases, a mental health consumer is likely to become overwhelmed and confused if they do not understand the meaning of such complex words. The WHOQoL-BREF was developed originally with the intention of being used with non-clinical populations, so it is perhaps feasible that the complexity of these words were not initially considered by the developers. The DASS however was created with the intention of being used with participants who may be experiencing emotional disturbance such as anxiety, depression and stress. Despite being reportedly written at a fifth-grade reading level, long and complex words and clinical jargon may be difficult to understand for people experiencing these symptoms which can interfere with cognition and thought processing (DSM-V).

Using simple, culturally appropriate language and avoiding unnecessary clinical terms is likely to increase participant comprehension and in turn obtain meaningful answers to outcome measures (Crooke & McFerran, 2014). Greeno and colleagues (2007) recommend conducting measures as interviews with consumers. This ensures that consumers understand the questions being asked of them and that they answer every question. Reading the questions out loud can reduce some of the literacy burden on participants. Participants are also more likely to ask for clarification from researchers if interaction has already occurred. Australian policy states that contemporary mental health care should “challenge traditional notions of professional power and expertise” (Commonwealth of Australia, 2013, p. 2). Using professional and confusing language in outcome measures increases the division of power between consumers and researchers and potentially disempowers consumers through the research process (Bibb & McFerran, under review). If measures are not
adapted or developed to be accessible to consumers, we risk capturing the perceptions of populations who in fact do not represent the majority of consumers with mental illness in Australia (Kroll et al., 2011).

**Conclusion**

A Critical Interpretive Synthesis was conducted to critically examine the self-report measures most commonly used in Australian mental health research in the last ten years. Seven outcome measures were identified as most popular and included in this review. The strengths and weaknesses of each tool are summarised in Table 3 in an attempt to provide the reader with an easily accessible reference when choosing outcome measurement tools for use in community mental health care research.

Results from the current review suggest that the *amount, type and cultural appropriateness* of the language used in outcome measures is important in both increasing accuracy of the data collected and fostering positive experiences of data collection for participants. Results also indicate that many of the measures most often used in mental health research may not align with the current contemporary philosophy of mental health clinical practice in Australia which emphasises lived experience and consumer input. We recommend that the development of consumer-oriented outcome measures be a prominent goal for researchers in this field.
Table 3. Strengths and weaknesses of the included outcome measures.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
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<tbody>
<tr>
<td>Kessler 10 (K10)</td>
<td>Only 10 items</td>
<td>Developed in USA – may have different cultural understandings of language</td>
</tr>
<tr>
<td></td>
<td>Well structured questions, simple language</td>
<td>Developed by researchers and piloted on consumers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intended use with non-clinical populations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based on ‘last 4 weeks’</td>
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<tr>
<td></td>
<td></td>
<td>Average of 15 words per question – long questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developed in USA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lengthy – 41 items</td>
</tr>
<tr>
<td>Recovery Assessment Scale (RAS)</td>
<td>Developed in 2000s</td>
<td>Developed by researchers and piloted on consumers</td>
</tr>
<tr>
<td></td>
<td>Developed collaboratively with consumers</td>
<td>Intended use with clinical populations</td>
</tr>
<tr>
<td></td>
<td>Outcome of ‘recovery’ defined by consumers</td>
<td>Based on the ‘current moment’</td>
</tr>
<tr>
<td></td>
<td>Minimal use of jargon/professional language</td>
<td>Reverse coding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Graded item-response options</td>
</tr>
<tr>
<td>Stages of Recovery Inventory (STORI)</td>
<td>Developed in 2000s so have incorporated Recovery principles</td>
<td>Developed by researchers and piloted on consumers</td>
</tr>
<tr>
<td></td>
<td>Developed in Australia</td>
<td>Intended use with clinical populations</td>
</tr>
<tr>
<td></td>
<td>Intended use with clinical populations</td>
<td>Based on the ‘current moment’</td>
</tr>
<tr>
<td></td>
<td>Minimal use of jargon/professional language</td>
<td>Reverse coding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Graded item-response options</td>
</tr>
<tr>
<td>World Health Organisation Quality of Life - Brief (WHOQoL-BREF)</td>
<td>Cross-cultural use</td>
<td>Developed by researchers and piloted on consumers</td>
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<td></td>
<td></td>
<td>Intended use with non-clinical populations</td>
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<td></td>
<td></td>
<td>Reverse coding</td>
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<tr>
<td></td>
<td></td>
<td>Graded item-response options</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uses Jargon/professional language</td>
</tr>
<tr>
<td>Beck Anxiety Inventory (BAI)</td>
<td>Intended use with clinical populations</td>
<td>Developed in USA – may have different cultural understandings of language</td>
</tr>
<tr>
<td></td>
<td>Minimal use of jargon/professional language</td>
<td>Developed by researchers and piloted on consumers</td>
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<tr>
<td></td>
<td></td>
<td>Developed in USA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Items structured under themes with graded item-response choices – difficult to understand</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reverse coding</td>
</tr>
<tr>
<td>Beck Depression Inventory (BDI)</td>
<td>Developed collaboratively with consumers</td>
<td>Developed in 1972</td>
</tr>
<tr>
<td></td>
<td>Intended use with clinical populations</td>
<td>Developed in USA</td>
</tr>
<tr>
<td></td>
<td>Only average of 2 words per question – short questions</td>
<td>Items structured under themes with graded item-response choices – difficult to understand</td>
</tr>
<tr>
<td></td>
<td>Minimal use of jargon/professional language</td>
<td>Reverse coding</td>
</tr>
<tr>
<td>Depression Anxiety and Stress Scales (DASS)</td>
<td>Developed in Australia</td>
<td>Developed by researchers and piloted on consumers</td>
</tr>
<tr>
<td></td>
<td>Intended use with clinical populations</td>
<td>Lengthy – 42 items</td>
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<tr>
<td></td>
<td></td>
<td>Uses jargon/professional language</td>
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Services.


Bridging Material

The critical interpretive synthesis detailed in the previous chapter was conducted in an attempt to critically examine the self-report measures most commonly used in Australian mental health research in the last ten years. Results of this synthesis indicated that in fact many of the measures most often used in mental health research do not align with the current contemporary philosophy of mental health clinical practice in Australia which emphasises lived experience and consumer input. Given these results, it may not be surprising that the four participants in study one (detailed in Chapter 3) experienced the outcome measures as challenging and disempowering. The inclusion of outcome measures in objectivist research may not foster experiences that are congruent with recovery-oriented philosophy underpinning government policy. Although I do not discount the need for objectivist research using self-report outcome measures with people in recovery, a strong obligation for researchers to use recovery focused measures should be prioritised in this field, to foster positive experiences of data collection for participants.

After gaining some clarity around the use of outcome measures in mental health research in Australia and addressing my concerns in response to the outcomes of study one, I felt it was still important to understand the role of group singing in mental health contexts. However, after repositioning myself in relation to the overall project I was more interested in a more meaningful way of capturing this. I was interested in a grounded theory approach and the way this would emphasise the conditional and contextual factors involved in understanding the role of group singing during mental health recovery.
The next chapter describes this main study of the thesis which includes 29 interviews with participants from inpatient and community group singing contexts. In each interview, participants were asked about their experience of singing in a group with others, specifically in relation to their mental health recovery. The initial interviews with participants were intentionally kept ‘open’ with an aim to narrow in on people’s experiences of belonging in later interviews. However, when the first few participants I interviewed placed importance on experiencing challenging emotions in response to hearing songs in their singing group, this became the central phenomenon for the grounded theory.
Chapter 6

Triggering Encounters with Music During Participation in Group Singing

In this chapter the methodology and results of the second study of this thesis are presented. First, the aim and choice of research method, description of the participants in the study and the analysis of data are described. In the next section, the findings from 20 interviews are presented as a grounded theory of group singing in mental health recovery. The four main parts that form the theory are presented using statements from participants to offer examples of each theme. Last, an ‘epilogue’ section presents data from an additional nine interviews which were conducted after the theory had been constructed in an attempt to validate and deepen the existing themes in the theory.

Design

Aim.

The aim of this study was to understand the role of group singing in inpatient and community mental health settings in regards to the contextual and conditional factors apparent within these settings which contribute to mental health recovery.

Choice of method.

A grounded theory approach was chosen to allow for a deep exploration of meaning and action in people’s experiences of group singing. The distinct feature of this approach is that the researcher constructs how emerging themes from the data relate to one another and in what process over time they make sense (Stern & Porr, 2011). This process is conducted in an aim to develop a theory from data collected during interviews with participants. Strauss and Corbin (1998) define a ‘theory’ as a way of determining or explaining relationships that exist between concepts or
categories in the data. A theory states possible interactions between the revealing concepts, supporting different understandings of the social world surrounding a phenomenon. Grounded theory encompasses the creation of abstract ideas regarding participants actions in their social world and attempts to continuously seek data to “fill out, refine and check emerging conceptual categories” (Charmaz, 2005, p. 508). The resulting theory from this study was ground in my interpretation of participants social worlds and of the processes involved in their construction.

A brief history of grounded theory.

Grounded theory was developed by social scientists Barney Glaser and Anselm Strauss in the 1960s (Glaser & Strauss, 1967). This was a time when positivist thinking and deductive methods of data analysis dominated the social sciences field (Stern & Porr, 2011). However Glaser and Strauss felt constrained by these “doctrinaire approaches” where they described data as being required to be ‘verified’ and ‘forced’ into pre-existing theory (Glaser & Strauss, 1967, p. 7). They believed that human behaviour could not be explained through a theory that was created outside of the context in which it was studied (i.e. a lab). Instead, Glaser and Strauss saw value in developing relationships with participants and asking them the ‘whats’ and ‘whys’ of a phenomenon, in order to gain a deeper understanding of the research data (Strauss, 1987). Glaser and Strauss developed their own research approach to data analysis, encouraging researchers to generate theory that was closely grounded in and driven by their data.

Initially, a grounded theory approach provided researchers with a template for conducting qualitative research in a way that could be understood by positivists (Charmaz, 2005). Glaser’s work had a strong foundation in positivism that influenced the creation of grounded theory, providing an objectivist slant, emphasising logic and
understanding theory as a ‘discovery’ of knowledge and of the unbiased researcher. Strauss was responsible for incorporating the symbolic interactionism and pragmatic philosophical influence that emphasised meaning, action and process, adopted largely from John Dewey (1920) and George Mead (1913). Symbolic interactionism and pragmatism were key to the development of grounded theory as they allowed for the methodological accountability of human action in the context of problematic situations (Stern & Porr, 2011). In time, Glaser and Strauss began to view grounded theory very differently. In the late nineties Strauss, with his new colleague Juliet Corbin, rejected the positivist and structured approach to grounded theory that Glaser promoted, and moved towards an emphasis on relational coding through analysis (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Strauss and Corbin attempted to incorporate contemporary views about qualitative research whilst still acknowledging and building on the traditional aspects of grounded theory.

More recently, Kathy Charmaz (2005, 2014), a renowned sociologist and researcher also developed a way of using grounded theory that was even less connected to its positivist roots, strengthening the constructivist features of grounded theory. Researchers in this camp, understand participants views as constructs of reality and take individual and social context into account. Both Charmaz and Strauss and Corbin (1998)’s approaches acknowledge the researcher’s influence in analysis. Rather than viewing the researcher as a passive and unbiased observer, these contemporary approaches to grounded theory emphasise self-reflexivity and the importance of the researchers influence on the analytic process (Corbin & Strauss, 2008). The analysis of the current study was heavily influenced by both of these contemporary approaches to grounded theory and used many of the analysis tools suggested by these authors.
Research methodology is constantly evolving. It is likely the grounded theory approach will continue to be adapted and changed as it is used within different disciplines and research genres (Charmaz, 2005). Stern and Porr (2011) argue that each researcher brings a unique theoretical lens to their research. As different professionals explore topics as researchers, their theoretical beliefs and backgrounds are inevitably different. A recent Australian study conducted by Hense and McFerran (2016) utilised an approach the authors labeled as ‘Critical Grounded Theory’ to examine the barriers in access to community based music services for young people with mental illness. From this perspective, it seems that grounded theory is a versatile approach to research methodology and allows the researcher to achieve their own research aims within their own frame of reference.

Data collection and analysis.

Theoretical sampling.

Grounded theory researchers commonly use an iterative approach to data collection and analysis, where analysis begins after the collection of the first piece of data (Strauss & Corbin, 1998). This analysis then informs further data collection, which is analysed and informs subsequent data collection and so on. Where possible participants were selected who could either develop, expand or ‘test’ the emerging theoretical ideas. This is known as a process of theoretical sampling in which the researcher gathers new data depending on the developing theoretical needs of the existing data (Corbin & Strauss, 2008). Each interview provided data which filled out each analytic category and introduced analytic ideas to test the emerging theory. Exploring new perspectives on the phenomenon and expanding the developing theoretical ideas using theoretical sampling resulted in reaching a point where I stopped collecting data and focused on developing the existing emerging ideas into a
theory. This is described in grounded theory literature as ‘saturation’, when no new categories emerge from the data (Charmaz, 2014; Strauss & Corbin, 1998).

**Collaborative and active interviewing.**

The interviews conducted in this study were collaborative and active where both the participant and myself (the interviewer) were active participants in making meaning of the interview data. Active interviewing was termed by social constructivists, Holstein and Gubrium (1995) who articulate interviews as reality-constructing and meaning-making occasions. They argue that active and collaborative interviewing involves understanding participants as experts of everyday life who are always working to interpret their experiences, which are conditioned by daily incidents of interaction. Traditionally, the research interview has been conceived as a research instrument, a tool for investigating ‘truths’ and facts about an experience. However, when the research interview is instead understood as a process of collaboration between the participant and interviewer, it becomes an opportunity for empowerment and participation in social practice (Talmy, 2011). In collaborative and active interviewing, the participant is considered an expert who not only ‘holds facts’, but constructively adds to them and transforms them (Holstein & Gubrium, 1995). Viewing participants as experts and collaborators is congruent with the epistemological foundation of personal recovery in the field of mental health adopted in this study, which sees both consumers and clinicians as ‘experts’ on knowledge development, who engage in a collaborative partnership during clinical interactions (Slade, 2009). Active interviewing is a dialogue between participants and interviewers as they articulate and interpret the participant’s experience through practical reasoning (termed by Garfinkel, 1967). From this perspective, reality is constantly under construction and is interpreted based on the current context.
Thus, in active interviewing, it is the interviewers role to cultivate and encourage active, interpretive and critical thinking in the participant. The interviewer suggests narrative positions, resources, alternate explanations and interpretations to the topic and encourages participants to develop topics in relation to their own experience (DeVault, 1990).

Music therapy researcher Cherry Hense (2015), describes approaching her interviews with young people experiencing mental illness as if they were opportunities for “mutual curiosity and discovery” (p. 26). Hense found that each interview could benefit the participant through gaining insight and awareness of their experience of recovery, rather than purely acting as a source of data for the research. The more participants were aware of how their knowledge of lived experience could impact further knowledge creation, the more empowered they were to understand their experience and create personal change. It could be argued that this type of interviewing invites undesirable ‘bias.’ However, Holstein and Gubrium (1995) argue that bias is only a meaningful concept if the researcher has a restricted view of the participant as possessing a pure and pre-formed vessel of ‘answers’. Instead, all types of interviews rely on the interaction between participant and interviewer, who construct knowledge in collaboration. Further, since socially constructed meaning is in fact collaborative, some researchers posit that it will always be impossible to ‘get rid’ of the effects that come with that collaboration (Garfinkel, 1967; Holstein & Gubrium, 1995; Sacks, Schegloff, & Jefferson, 1974). Each of the 29 interviews with participants in this study were collaborative and I aimed to empower people to express their opinions. Participants were asked about their experience of singing in a group with others, specifically in relation to their mental health recovery. I began the initial interviews broadly, asking participants about their general experience of group
singing. Then, as the central phenomena developed through iterative analysis the focus narrowed in on asking questions about this, if it was not brought up by the participant themselves. Participants were reassured that the researchers were interested in all kinds of narratives about this experience, including both positive and negative experiences.

**Participants.**

Participants were recruited from inpatient and community singing groups. All groups were ‘homogenous singing groups’ meaning that only people with a lived experience of mental illness were invited to participate in the groups. Eighteen participants were recruited from inpatient settings while five participants were recruited from community settings. Although initially it was hoped that a similar numbers of participants could be represented from across the two contexts, developing connections with and getting access to participants from community contexts proved to be much more difficult than initially predicted. All 23 participants were aged between 18 and 72 years. The study received ethics approval from The University of Melbourne Human Research Ethics Committee and from the ethics committees at each private hospital.

**Inpatient sites.**

Participants were recruited from two inpatient music therapy programs in two private psychiatric hospitals in Melbourne. At site one, I was employed as a music therapist and at site two a different music therapist was employed. Both this music therapist and myself facilitated the groups in a similar style, influenced broadly by humanism and resource-oriented music therapy approaches. Participants at the second site were approached several months after the data had been collected and analysed
from the first inpatient site and community sites. Participants were recruited from site two after the initial theory had been constructed in an attempt to validate the theory and to examine and refine the themes further.

Mental health consumers who regularly participated in the singing groups offered during their inpatient admission were invited to participate in interviews. The singing groups were unstructured and ‘open’, held in a group room within each of the hospitals. The groups ran weekly for 60-90 minutes and were supported by medical and nursing staff at the hospital when needed. Each group session had a different membership since the average length of stay at the hospitals was three to four weeks. Books of lyrics were distributed to the group members that included 80-100 popular songs ranging from the 1950s-2016. The group members were encouraged to notice, listen to one another and engage in discussion about the song lyrics and meanings. Other topics also emerged in discussions within the groups, often being related to mental health recovery or their experience in the inpatient setting.

_Recruitment at site one._

I had a pre-existing relationship with consumers in the singing group which I facilitated at site one. In order to minimise any chance of people feeling pressured to participate, their consent was sought by an independent person. A staff member of the therapy team at the hospital distributed information about the research study to potential participants following the group singing session each week (most often the day following the session). People were then advised to approach me if they wished to participate. When people expressed their interest in participating in the research, I emphasised that there was no pressure for them to participate, that participation was entirely voluntary and they could withdraw from the study at any time. If the person was still interested, the consent process was explained to them.
Recruitment at site two.

At this hospital where a different music therapist facilitated the sessions, I attended the final five minutes of each weekly session, explained the study and distributed the Plain Language Statement to consumers. I then arranged a time to visit people who expressed interest in the study while they were in hospital. Prior to each interview the consent process was explained to participants, emphasising that their participation or contributions in the interview would not affect their treatment or their participation in music therapy sessions during their admission.

Community sites.

Participants were also recruited from two community choir groups in Melbourne facilitated by musicians. These participants were approached because I wanted to get a range of perspectives on the different conditions in singing groups including where people were in different stages of illness and in groups which were facilitated by musicians (which is commonplace in community mental health settings). I had an existing professional relationship with the facilitator of one of the choirs, while the other choir was approached as it was identified as being well known in the local community where I lived. Both choirs had been running for approximately two years and invited the same members to attend the group every week if they were able to. Both choirs had 20-30 participants and were supported by mental health workers and volunteers who escorted them to the venue, and offered a meal to members after rehearsal. Both choirs were held weekly in a local church for approximately 90- 120 minutes and were focused on rehearsing popular songs for performance to their local community. I attended the final 20 minutes of each weekly choir rehearsal. In the last five minutes of the session, the facilitator introduced me to the group and I told the group members about the research project and asked them to
approach me after the session if they were interested in participating. I then made a
time to meet with the people who approached me individually at the church venue
later that week. Upon meeting with consumers again, I explained the consent process
and informed them that their participation in the research study would not impact
their participation in the choir. Recruitment was much more difficult in this setting
since many of the people who did express interest in participating in an interview, did
not show up at the arranged meeting time, did not answer follow up phone calls
and/or did not attend several weeks of rehearsals following the arranged meeting
time. This may have been due to the fluctuating nature of chronic mental illness
which can often interfere with people’s ability to remember and get to appointments
by themselves (Fujii, Wylie & Nathan, 2004).

Representing participants.

“Labels get given by the dozen [in hospital] you know and that’s
no judgment on anyone else, that’s just how it is” – John
(participant from inpatient site two)

In the interest of representing the participants in this study in a way that is congruent
with recovery theory, specific individual labels of diagnoses are not provided.
Emphasising group membership (i.e. a diagnostic category) over individual difference
does not value the knowledge that consumers hold about what makes them the person
they are. Mental health recovery is personal and unique (Slade, 2012) and personal
recovery emphasises the mental health consumer as a person rather than a ‘case.’ As
such, instead of using clinical labels of diagnosis, information and labels are used that
participants themselves identified as representing their own personal recovery
experience (seen in Table 1). The information provided in Table 1 was gathered
during my conversations with participants and is reflected by using their own words. There are some descriptions in Table 1 that still include labels of diagnosis to describe recovery experiences. During these discussions with participants regarding how they would like to be represented, it was sometimes difficult for them to articulate their experience of recovery as anything other than the ‘illness label’ they had been given by their psychiatrist. For some consumers who have been in the mental health system for many years, it can be difficult to articulate their own experience of recovery without basing it within their previous experiences (Bassman, 2001). However, it was important to participants that the information they chose to represent their personhood was presented first, before their illness description. Participants also chose the pseudonyms that would be used to refer to their contributions in the research which are represented in Table 1.

Table 1. Details of participants in the grounded theory study.

<table>
<thead>
<tr>
<th>Participant name (pseudonym)</th>
<th>Age</th>
<th>Setting</th>
<th>Identified self-knowledge</th>
<th>No. of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lola</td>
<td>23</td>
<td>Inpatient: Site 1</td>
<td>Student and animal lover with complex physical and mental health problems</td>
<td>2</td>
</tr>
<tr>
<td>Ellie</td>
<td>45</td>
<td>Inpatient: Site 1</td>
<td>Librarian with depression and anxiety</td>
<td>1</td>
</tr>
<tr>
<td>Kate</td>
<td>36</td>
<td>Inpatient: Site 1</td>
<td>Mother with bipolar disorder</td>
<td>1</td>
</tr>
<tr>
<td>Hannah</td>
<td>24</td>
<td>Inpatient: Site 1</td>
<td>Nurse with major depressive disorder</td>
<td>2</td>
</tr>
<tr>
<td>Sam</td>
<td>30</td>
<td>Inpatient: Site 1</td>
<td>Ex-music theatre artist with chronic mental illness</td>
<td>1</td>
</tr>
<tr>
<td>Violet</td>
<td>72</td>
<td>Inpatient: Site 1</td>
<td>Retiree with an “active life” and a mood disorder</td>
<td>2</td>
</tr>
<tr>
<td>Greg</td>
<td>55</td>
<td>Inpatient: Site 1</td>
<td>Teacher and ex-surfer with depression</td>
<td>1</td>
</tr>
<tr>
<td>Hurdler</td>
<td>56</td>
<td>Inpatient: Site 1</td>
<td>Aged care worker and ex-sportsman with a chronic mental illness</td>
<td>1</td>
</tr>
<tr>
<td>Milly</td>
<td>22</td>
<td>Inpatient: Site 1</td>
<td>Creative arts student with bipolar disorder</td>
<td>2</td>
</tr>
<tr>
<td>Kay</td>
<td>59</td>
<td>Inpatient: Site 2</td>
<td>Single, retiree with long term depression</td>
<td>1</td>
</tr>
<tr>
<td>Bridgit</td>
<td>48</td>
<td>Inpatient: Site 2</td>
<td>Mother of two, horse rider with depression and suicidal tendencies</td>
<td>1</td>
</tr>
<tr>
<td>Sally</td>
<td>18</td>
<td>Inpatient: Site 2</td>
<td>Carer, animal lover with bipolar disorder</td>
<td>1</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Location</td>
<td>Description</td>
<td>Code</td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>John</td>
<td>27</td>
<td>Inpatient: Site 2</td>
<td>Sports lover with has anxiety and depression</td>
<td>1</td>
</tr>
<tr>
<td>Tara</td>
<td>21</td>
<td>Inpatient: Site 2</td>
<td>Peer support worker, guitarist/singer with complex post-traumatic stress disorder</td>
<td>1</td>
</tr>
<tr>
<td>Hugh</td>
<td>20</td>
<td>Inpatient: Site 2</td>
<td>Psychology student, TV show buff experiencing depression and anxiety</td>
<td>1</td>
</tr>
<tr>
<td>Katherine</td>
<td>43</td>
<td>Inpatient: Site 2</td>
<td>Mother, yoga lover, experiencing anxiety and depression</td>
<td>1</td>
</tr>
<tr>
<td>Des</td>
<td>55</td>
<td>Inpatient: Site 2</td>
<td>Paramedic from rural Victoria with PTSD, suicidal ideation and drug addiction</td>
<td>1</td>
</tr>
<tr>
<td>Collins</td>
<td>26</td>
<td>Inpatient: Site 2</td>
<td>Red-head, cat-lover, music festival lover, with bipolar</td>
<td>1</td>
</tr>
<tr>
<td>Margaret</td>
<td>41</td>
<td>Community</td>
<td>Sales assistant with a mental health disability</td>
<td>2</td>
</tr>
<tr>
<td>Dan</td>
<td>46</td>
<td>Community</td>
<td>Drug dependent person with OCD</td>
<td>1</td>
</tr>
<tr>
<td>James</td>
<td>44</td>
<td>Community</td>
<td>“Bloke in a wheelchair” with depression</td>
<td>1</td>
</tr>
<tr>
<td>Lindy</td>
<td>38</td>
<td>Community</td>
<td>Singer with mental illness on a disability support pension</td>
<td>2</td>
</tr>
<tr>
<td>Sarah</td>
<td>40</td>
<td>Community</td>
<td>Person with depression who had a stroke</td>
<td>1</td>
</tr>
</tbody>
</table>

**Data analysis process.**

Analysis was an ongoing and iterative process in which the procedures were not prescribed and many of the steps were repeated throughout the analysis of one interview. The analysis process was primarily influenced by my own interpretation of the data and how it could be framed as a way of understanding people’s journey through mental health recovery by singing together. Each interview was treated to a number of these procedures, including:

1) Transcription

2) Memo Writing

3) Initial Coding

4) Focused Coding

An illustrative example of how the method was used in each of these stages of the analysis process is noted in this section, using an excerpt from Lola’s interview (seen
in Figure 1). Each example demonstrates how the grounded theory method was applied to the data for each part of the analysis.

| J: There can be times where someone will choose a song and it kind of brings up stuff... |
| L: Yeah it does. |
| J: Yeah? |
| L: Like a lot of the songs, a couple of the songs bring up emotion for me but being able to sing those songs and have that release it feels like I’m...I dunno just kind of letting go and feel almost empowered of being able to sing it out rather than just screaming it out and to let go of those emotions through singing...it just feels incredible like it, I really enjoy it. |
| J: Yeah. That’s great, ok. So even though they bring up the strong emotions, it’s being able to sing and.... |
| L: Yeah and so have that release. |
| J: Yeah yeah. So if you listen to some of those songs that bring up a strong emotion on your iPod or something in your room, would that be the same as if you... |
| L: No because it makes me just feel sad listening to them. But when I sing them it makes me feel like I’m releasing it. |

*(J=interviewer, L=participant Lola)*

**Figure 1.** Excerpt from Lola’s interview.

*Transcription.*

Each interview was transcribed by listening back to the recording as soon as possible and writing down what was said. The original recording of each interview was replayed several times during the analysis process, since it was important to also consider what was not said by the participant in certain moments and reflect on the intention of the language used. There were occasions when I considered what the participant’s mental state was like at the time, whether statements were made tentatively or definitely, or if the interview was interrupted by staff at times when certain comments were made. Reflexivity is an essential element in qualitative research which provides insight into how knowledge is developed (Pillow, 2003). In
this study reflexivity offered some clarity around the links between the data, analysis and findings. For example, the initial question in my interview with Lola seen in Figure 1 is offered in response to a statement Lola had made earlier in the interview. Without reflecting on the context surrounding this excerpt, Lola’s response to the question may have been interpreted differently during analysis due to the leading nature of the question I asked her. Practicing reflexivity also included considering how I felt when certain statements were made and how I responded to these comments in the moment. This is defined by Finlay (2005) as “reflexive embodied empathy”, which involves a process of engaging reflexively with the participant’s lived body, your own body and the inter-subjective relationship between the two (p. 272). These reflections were important for understanding and interpreting the interview data.

**Memo writing.**

Memo writing is crucial to grounded theory, and in this study offered a way to begin analysing the data iteratively and early in the research process (Charmaz, 2014). Memo writing was used throughout the data collection and data analysis process of the study and was a useful way to become actively engaged in the data and to develop and reflect on ideas as they arose. Memo-writing was especially helpful in encouraging reflection on thoughts about the codes and data in any way that occurred to me in the moment (Charmaz, 2014). Memos were dated, labeled and represented “informal analytic notes” (p.162) which detailed thoughts about the data and analysis process as they occurred. One memo I wrote after transcribing Lola’s interview depicted my reflection on her description of releasing emotion through singing (which she described in the excerpt in Figure 1) as well as ideas for exploring this concept with the next participant. The memo is offered below as an example.
Lola discusses this idea of letting out or letting go of emotions through the physical act of singing and ‘singing out’ the anger or hurt. This relates to the physical act of singing as being a release of emotion, which has not been mentioned explicitly so far. It may be useful to further explore the role of singing for coping with difficult emotions with future participants.

**Initial coding.**

The coding process involved labeling segments of data with titles that categorised and accounted for each piece. In the grounded theory coding process there is an increased focus on moving beyond participants’ concrete reports of the phenomenon to interpreting and making sense of stories and statements. During initial coding of the interview transcripts, fragments of data were studied line-by-line in an attempt to remain open and ‘close’ to the data (Charmaz, 2011). The use of gerunds (Glaser, 1978) during this process helped to maintain a strong sense of action in the data, detecting processes and actions (Charmaz, 2014). Using coding words that reflected action maintained the fluidity of participants experiences. The initial codes were provisional and constantly changed throughout the whole analysis process. The initial coding of Lola’s excerpt is illustrated in Figure 2.
During the second phase of analysis, similar codes were grouped together and labeled with in-vivo headings. Using each participant’s own language was a useful way of preserving their unique contribution (Charmaz, 2014). It was also important to examine the hidden assumptions of people’s language in the interview data to consider what values and views may be reflected in their language. In many cases, focused coding followed initial coding, but the analysis process was not linear and there were times when I experienced what Charmaz describes as an, “aha! Now I understand” moment (p. 141). This occurred when a new participant explained something in a certain way which made previous participants statements much more explicit. This experience instigated a return to the earlier interview data to view the codes differently. During the focused coding process the most useful and relevant initial codes were built on and tested against the rest of the emerging data. I was constantly asking questions of the data during this process, attempting to engage reflexively with it in order to avoid as many pre-conceptions or assumptions I had as possible (Corbin & Strauss, 2008). This was especially important in the third and
fourth iteration of focused coding, since these codes were the most likely to advance the theoretical direction of the analysis. The software package NVivo (QSR International Pty Ltd. Version 10, 2014), was helpful in this process to highlight certain phrases and words and group similar ideas together.

**Combining themes across participants.**

The most essential part of developing a theory is the interconnection of categories and themes to form an overarching theoretical scheme (Corbin & Strauss, 2008). This step in the analysis process involved integrating the themes and deciding on a core category. The core category is described by Corbin and Strauss as “the concept that all other concepts will be related to” (p. 104). After interview number eight, it became clear that ‘triggering encounters’ was the category with the most relevance and potential for connecting all of the other categories together. At this stage, similar themes were grouped together from each participants’ data, and themes that were most relevant to the central phenomenon were identified. The integration of themes were mapped using diagrams in an attempt to represent the ‘bigger picture’. Supervisory support was important during this time to assist in developing confidence in my own analytic ability and to discuss doubts and concerns while integrating the data (Corbin & Strauss, 2008, p.106).

Writing storylines (Strauss & Corbin, 1998) or narratives also helped to conceptualise the central phenomenon. A series of sentences including the participants own words formed the structure of a story line for each participant which described the process of experiencing triggering encounters in response to music. The storyline developed from Lola’s data is presented as an example below. Lola’s own words are represented in quotation marks.
For Lola, being in a group with people “who are hurting too” is important. Lola can feel “sad” in response to being triggered by “emotional songs” but by “letting go of the emotion” through singing, she is able to “turn the negative to a positive” experience. Lola also “carries a lot of anger” but by singing in the group she can “release” some of it and “change the intensity” of her experience. This can make Lola “feel so much better” after her participation in the group. By attending the group during her hospital admission Lola has “been able to let go of some of the hurt through the singing” that she has “carried for years”.

The conditional matrix.

One feature of grounded theory that was introduced by Strauss and Corbin (1998) is labeled the conditional matrix. This tool has been particularly useful in the analysis of data in this study. The conditional matrix uses ‘conditions’, ‘actions/interactions’ and ‘consequences’ to assist in gathering and ordering the data and to map and trace the pathways taken for each participant. Strauss and Corbin emphasise the role of the researcher in making distinctions between the different elements of their data as they code. The analysis process in this study was not overly structured or directive in response to using the conditional matrix tool. Rather, the matrix was used as a way of enriching the analysis and for gaining an understanding of the circumstances and context surrounding each category or code and positioning these processes in relation to one another (Corbin & Strauss, 2008). The conditions and subsequent actions/interactions and consequences related to the central phenomenon were grouped together across cases. Raw data examples were inserted underneath each theme so that each category could be filled out. Figure 3 symbolises the initial contributions to the theme ‘let it out through singing’ which was
represented in Lola’s interview excerpt in Figure 1. This theme is depicted as an ‘action’ (a way of coping) related to the central phenomenon. Lola’s comments from the original interview excerpt have been combined with her other comments related to this theme and are represented in pink text in the figure.

**How to cope with triggering experience**

1. Let it out through singing

   I just sing it and it goes away [VIOLET]

   I’m bringing in a lot of the happiness from the group and being able to let go through my voice, even when I’m really sad and having a really bad day, just to go in there and be able to sing it out is...makes me feel so much better. When I sing, I am able to let go of some of the hurt through such a positive way instead of screaming or yelling, it’s a real release for me, being able to sing those songs and have that release. It feels like I’m just kind of letting go. I feel empowered, being able to sing it out rather than just screaming it out and to let go of those emotions through singing, it just feels incredible. It changes the intensity down to a much lower level. It changes and I’m singing and I’m able to let it go, so it changes that intensity down. It makes me just feel sad listening to them but when I sing them it makes me feel like I’m releasing it. To let them go in a powerful way, turns that negative to a positive. It makes me feel like I’m letting out all of my feelings...and I can sing and it makes me feel like I’m letting go of a lot of emotion. It just makes me feel like I’m releasing something through just singing. I feel like I’m letting it go [LOLA]

   expressing my feelings and emotions through a different medium [SAM]

   it’s a different sort of expression, like expressing your feelings through music, it’s different [HANNAH]

**Figure 3.** Example of ‘action’ theme using the conditional matrix.

Next, a series of tables were created in an excel spreadsheet containing the codes and categories related to the conditions, actions and consequences for each participant (Strauss & Corbin, 1998). Figure 4 presents an example of the ‘actions’ spreadsheet where each of the themes under the category ‘actions’ are represented for each participant. The ‘let it out through singing’ theme is combined across cases with other ‘action’ themes that were relevant for each participant.
Seeking different perspectives.

Throughout the data analysis process it was useful to seek out different perspectives on my analysis. Using supervisors and graduate research colleagues was helpful. Conducting multiple interviews with some participants was also helpful to gain further understanding of their experiences (Laslett & Rapoport, 1975). As opportunities arose, I returned back to the participants in an attempt to both verify my analysis and clarify meaning and context with participants, gaining a deeper understanding of the phenomenon. In many cases, specific questions and enquiries about certain themes were taken into second interviews with participants and the emerging theory was mapped out and discussed. It was not feasible to interview all participants a second time, but the few who were able to, offered valuable feedback and comments on which parts of the theory represented their own experience. It did not seem necessary to conduct multiple interviews with participants from the second inpatient site as these interviews were already being conducted to validate and refine the theory after the initial data analysis had occurred. Some changes to the themes were made following discussions with participants and the raw data from subsequent
The central phenomenon: Triggering encounters with music.

The central phenomenon which emerged from the data was the theme ‘triggering encounters with music’. The first time this emerging category was mentioned was in the first interview with Hannah. I started the interview by asking some broad questions such as, what has it been like coming to the group? Why did you keep attending? Hannah initially spoke about the group ethos, how the singing group was a safe place and evoked positive feelings for her. I followed these leads initially, pursuing the concept of what it was like to experience positive feelings through group singing. I asked Hannah what it was about the group that she found positive, and Hannah said:

*There have been some songs that have been hard for me as in my own sort of issues. But I’ve actually felt that if I hear these certain songs on the radio or whatever, it really effects me and I’ll have to turn the radio off or I’ll ask someone to turn whatever they’re listening to off. But I’ve felt that in music therapy with these certain songs I felt really anxious at the start when I saw that they were in there but nah I dunno it’s really helped me. Like I’ve been able to join in and listen to the songs in music therapy and I dunno it’s made me be able to sort of hear those songs again.*

I was initially surprised that Hannah’s statement included an element of negativity about her experience, an honest report of feeling anxious in music therapy when she saw that there were songs in the book which she associated as evoking negative emotions. I appreciated her honesty in this moment and probed further into her experience. During the analysis of the interview, I considered including a question...
about this category in the next interview. To develop a diverse and multi-faceted grounded theory, I felt that it was important to actively seek to contradict previous participants’ descriptions. I made sure I asked very carefully and openly about each participant’s experience, remaining conscious not to put existing ideas in people’s minds. I began the next few interviews broadly and led into the triggering phenomena if it was not brought up by the participant themselves. For the first three participants (Hannah, Kate and Lola), triggering experiences were mentioned initially by the participants themselves without prompting. Participants’ experiences of triggering encounters were congruent with my own clinical experiences of working with people with mental illness in singing groups. It was no surprise to me that this process of regaining healthy relationships with previously ‘triggering’ music was occurring in these groups. It is likely a part of the reason this phenomenon formed part of the current research project. As such, the theory developed from the data, represents my experiences and my interpretations of the participants’ experiences of triggering encounters with music.

Results

The following section describes the results of the main study in this thesis derived from the analysis depicted in the previous section. A grounded theory approach was used to respond to the research aim, to understand the role of group singing in different mental health settings and the contextual and conditional factors apparent within these settings which contribute to mental health recovery. Data was collected through 20 interviews with 14 people with mental illness participating in community or inpatient singing groups. Findings from a later nine interviews which were conducted to validate and deepen the theory are presented in the ‘epilogue’ section of this chapter. Findings of the initial 20 interviews are presented as a
grounded theory of group singing which is described as a resource for regaining healthy relationships with music in response to triggering encounters with music. This interpretation of the data demonstrates the way consumers experience triggering encounters with music in their singing group and use the group conditions as coping resources to regain musical, emotional and social health (presented in Figure 5). The four main parts that form the theory will be discussed in this section: triggering encounters with music, conditional factors to triggering encounters, coping strategies, and regaining health. These four main parts of the grounded theory are represented in bold text in Table 2 and are followed by their corresponding categories for each section. Words spoken directly by participants are italicised throughout the chapter and act as examples of the raw data relating to each category. Raw data corresponding to each category is also presented in tables throughout the chapter when there are more than four participants contributions in an attempt to provide clear examples of each category and which statements were contributed by which participant. Examples of reflexive embodiment (Finlay, 2005) are also presented as personal reflective statements in response to participants’ contributions throughout the presentation of the results. These statements are provided in an attempt to offer clarity around how the theory was constructed and the relationship between my analysis and the results.
Figure 5. The conceptual framework for the grounded theory.

Table 2. Themes and categories in the grounded theory.

<table>
<thead>
<tr>
<th>Triggering Encounters With Music</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause of the triggering encounter:</strong></td>
</tr>
<tr>
<td>Encounters with Memories</td>
</tr>
<tr>
<td>Encounters with Emotions</td>
</tr>
<tr>
<td><strong>Anticipating triggering encounters:</strong></td>
</tr>
<tr>
<td><strong>Perception of triggering encounters:</strong></td>
</tr>
<tr>
<td>Challenging</td>
</tr>
<tr>
<td>Challenging but ok</td>
</tr>
<tr>
<td>Positive or neutral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conditional Factors to Triggering Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Existing music use habits:</strong></td>
</tr>
<tr>
<td>Being conscious of the influence music can have</td>
</tr>
<tr>
<td>Using music to reinforce pathology</td>
</tr>
<tr>
<td>Avoiding music when you are unwell</td>
</tr>
<tr>
<td>A passionate relationship</td>
</tr>
</tbody>
</table>
with music

<table>
<thead>
<tr>
<th>The role of the group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling connected with others</td>
</tr>
<tr>
<td>Feeling supported and accepted</td>
</tr>
<tr>
<td>Feeling understood in the company of others with lived experience</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The role of the facilitator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating a relaxed and flexible environment</td>
</tr>
<tr>
<td>Musical and leadership skills</td>
</tr>
<tr>
<td>Focusing on music skills</td>
</tr>
<tr>
<td>Focusing off music skills</td>
</tr>
<tr>
<td>The facilitators attitude:</td>
</tr>
<tr>
<td>Unconditional positive regard</td>
</tr>
<tr>
<td>Authenticity</td>
</tr>
<tr>
<td>Empathy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The role of the consumer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committing to the group</td>
</tr>
<tr>
<td>Fluctuating mental health</td>
</tr>
</tbody>
</table>

**Coping Strategies**

**Relational coping:**
- Seek support
- Share your feelings

**Internal coping:**
- Positive thinking
- Distraction
- Acceptance
- Avoidance

**Practical coping:**
- Let it out through singing
- Take positive risks
- Don’t sing it

**Regaining Health**

- Regaining social health
- Regaining emotional health
- Regaining musical health

**Triggering Encounters with Music**

Many of the participants in this study described experiencing intense memories or emotions in response to hearing certain songs in the singing group.

These experiences were termed ‘triggering encounters’ in an attempt to highlight the often unexpected nature of the event. There were different elements to participants’
triggering encounters including the cause of the encounter, anticipation of the encounter and the participants’ perception of the encounter.

**Cause of the triggering encounter.**

There were two obvious ways of being triggered by songs heard in the group. For the majority of participants (n=11), familiar songs with memories or emotions associated with a song ‘re-triggered’ an emotional response. For other participants songs they had not heard before triggered emotions that reminded them of their current situation or mental state (n=3). For two participants occasions of both these types of triggering were experienced. The next section describes the two different types of triggering experiences.

**Encounters with memories.**

Thirteen participants described how familiar songs triggered memories, which caused them to experience an intense emotional response during the singing group (see Table 3). Participants were reminded of certain events, people and places when a meaningful song was played. The nature of these memories were diverse and included positive, negative and neutral responses to the memories. For example, Hurdler described his experience of these encounters with memories by saying, *the songs take me back to exactly where I first heard them*, while Milly was reminded of what she termed, her *dark place* when she heard a particular song.

Table 3. *Contributions to the category ‘Triggered by Memories’.*

| Memories especially [are brought up]. Mostly happy, mum liked to dance and sing. My father was a drinker, he was a manic depressive…he used to smash up our house (Sarah) |
| Some of the songs actually have meaning to me (Sam) |
| It reminds me of those times when I’ve been quite bad (Milly) |
| I am triggered to think about things that have happened (Ellie) |
| Some songs bring up difficult memories (Kate) |
| I am taken back to the vinyl records that my brother used to keep (Hurdler) |
| If it [the memory] makes me happy, that’s good (James) |
| I like Bob Dylan songs so if his songs come up I enjoy those and they bring back fond memories (Greg) |
| It triggers off all the happy memories, or if it was a song you remember when it was very sad (Margaret) |
| There is one song that reminds me of my father. Whenever I sing it I get the emotion. Sometimes even tears come up and I know that I’m still mourning for my dad (Lindy) |
| I have songs that have an emotion for me. There is a lot of emotion attached to those songs (Lola) |
| There have been some songs that were sung at [my boyfriend’s] funeral (Hannah) |
| It [the song] brings back a photo of that person (Violet) |

**Encounters with emotions.**

Three participants described their triggering experience as being caused by a song directly evoking an emotional reaction rather than a memory. Although in many cases they had not heard the song before, the music triggered an emotional response that they related to their current situation or mental state. Dan described a strong emotional response to some songs he had heard for the first time in his singing group. The songs allowed him to connect with an emotional place and with feelings that he hadn’t felt before in his life. Violet had certain music that she knew could trigger memories for her, but she also described a triggering reaction in response to love songs. These love songs were the type Violet described as, making you think of your
love that you’ve broken up with and you’ve got to move on and evoked thoughts of her current situation. Similarly, Ellie related to the words of the songs she did not know which triggered an emotional response for her. Some songs had words that would just ring so true to Ellie, words that were about a new beginning or a sad thing happening to somebody.

**Anticipating triggering encounters.**

Eight participants described their experience of anticipating the songs they expected to trigger memories or emotions for them during the group (see Table 4). For Hannah and Kate, this anticipation occurred once they had seen certain songs in the folder given to them in the group session. Just seeing or knowing there was a few [songs] in there (Kate) evoked a feeling of anxiety and panic (Hannah) for them. Kate also experienced anticipation when the song began to play in the group. She felt a sense of doubt, describing herself as thinking, ‘oh my god I can’t do this’, while anticipating her reaction to the song. The other six participants anticipated triggering encounters by just knowing that there were some songs that might trigger a reaction in them. This may have been from previous experiences of being triggered by these songs (i.e. there are a couple of songs that bring up emotion for me - Lola), or knowing that there were themes of lyrics that triggered emotions or memories for them based on their current situation or mental state (i.e. the ones where it makes you think of your love that you’ve broken up with and you’ve got to move on - Violet).

Table 4. Contributions to the category ‘Anticipating Triggering Encounters’.

<table>
<thead>
<tr>
<th>When I saw them in the folder I felt super anxious and sort of wanted to walk out. When I saw that they were in there it was super uncomfortable at the beginning. You feel really anxious and panicky. It’s like a red flag in your head (Hannah)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was a few in there and I just went ‘oh shit, how is my reaction going to be?’ When those songs came on I was like ‘oh my god I can’t do this’ (Kate)</td>
</tr>
</tbody>
</table>

166
A couple of songs bring up emotion for me (Lola)

When I’m really bad that’s the song I want at my funeral. When I’m kind of feeling quite suicidal and stuff, I find that song quite hard to sing, even though it’s one of my favourite songs (Milly)

The songs are emotional, they can bring back emotions. They can bring back very happy ones, but they can bring back sad ones (Margaret)

I’ve got one song I don’t like to particularly hear (Violet)

There is one song that reminds me of my father. I’m a bit nervous about singing it. I haven’t actually sung yet (Lindy)

Yeah there’s some songs where the words are just like ‘wow’ you know? I definitely can relate to some of the words in a good and bad way (Ellie)

Perception of triggering encounters.

Each participant had a different way of describing and perceiving the impact of their triggering encounter. Through the analysis of all 20 interviews, three main categories of the way triggering experiences were perceived emerged:

- Challenging,
- Intense but ok,
- Positive or neutral.

The majority of participants described a triggering encounter occurring, but it was the way they perceived the experience that differed.

Triggering encounters with music are challenging.

Eight participants described challenging emotional experiences in response to certain songs (see Table 5). The types of challenging emotions that were evoked for participants during this triggering encounter were described using phases like: it hits you (Hannah), it brings up negative emotions (Hannah), you feel more anxious and you feel sad (Hannah), it makes me want to cry (Lindy), it brings me back into the
dark place (Milly), I feel teary inside, and upset (Lola). Words like hard, difficult, challenging (Hannah) and too much (Kate) were used to describe what it was like for participants feeling the challenging emotions during this time.

Table 5. Contributions to the category ‘Triggering encounters with music are challenging’.

<table>
<thead>
<tr>
<th><em>[I feel]</em> anger, angry yeah… and it brings back a photo of that person (Violet)</th>
</tr>
</thead>
<tbody>
<tr>
<td>So many emotions come up. The first time those two songs were sung in the group, yeah that was super hard. That was definitely really hard, it was really challenging for me. It sort of like hits you and you’re like ‘oh this song actually like hits home’. It brings up negative emotions or sadness or whatever. You’ll feel more anxious and you’ll feel sad and negative emotions will come up for you with certain songs. Right in that moment was when I wanted to walk out (Hannah)</td>
</tr>
<tr>
<td>It makes me want to cry. Whenever I sing it I get the emotion. Sometimes even tears come up and I know that I’m still mourning for my dad (Lindy)</td>
</tr>
<tr>
<td>I guess it brings up kind of a lot of sadness and kind of brings me a little bit back into the dark places I’ve been in. It kind of brings me back there and reminds me of those times when I’ve been quite bad (Milly)</td>
</tr>
<tr>
<td>There was maybe some negative emotions that were brought up (Sam)</td>
</tr>
<tr>
<td>I’m upset and I’m singing those songs and they make me feel teary inside (Lola)</td>
</tr>
<tr>
<td>I think there was a couple a times where I missed a couple of lines cos it was just too much (Kate)</td>
</tr>
<tr>
<td>There are memories especially…my father was a drinker, he was a manic depressive, he used to smash up our house (Sarah)</td>
</tr>
</tbody>
</table>

*Triggering encounters with music are intense, but ok.*

Songs also evoked intense emotions or memories for Ellie and Margaret, but they perceived them as ‘ok’. Ellie described her encounter as only momentary and that was manageable, because there can also be happy feelings as well. Both Ellie and Margaret reported mixed experiences with triggering songs that reminded [them] of
all sorts of emotions (Ellie), bad moments but also times where you can sort of have a laugh (Margaret). Margaret described how listening to songs that made her feel sad could sometimes resolve those sad feelings if [she] listened to that song when [she] needed to be sad and when [she] needed to grieve.

**Triggering encounters with music are positive or neutral.**

Four participants noted that songs did evoke emotions or memories for them, but the way they perceived them were not sad or upsetting. The emotions or memories triggered were either happy memories or neutral memories for these four participants. Greg described the memories associated with songs written by Bob Dylan as *fond memories*. James reported feeling happy after singing a familiar song associated with positive memories, stating, *if it makes me happy, that’s good.* Hurdler and Dan’s experience was not upsetting, which was evident by the visible smile on their face while they recalled their encounter with music. Hurdler said, *some of these songs I’ve heard as a child or seen on a black and white TV and the songs take me back to exactly where I first heard them. Songs take me back to the vinyl records that my brother used to keep. I still remember the clip that went with that song, when it’s sung.* Dan said, *my heart opened and I didn’t know that feeling. A lot of the songs allowed me to connect with that place.*

**Conditional Factors to Triggering Encounters**

Ten categories were derived as conditional factors to the triggering encounters and were categorised into four themes: the role of existing music use habits, the role of the group, the role of the facilitator and the role of the consumer. These themes were the foundations of the central phenomenon, conditions that influenced the way the phenomenon was experienced by participants. During the de-constructing and re-constructing phase of analysis (conducted while mapping themes using the
conditional matrix), I returned to the data and reconstructed themes that were ‘fractured’ during the open coding process (Strauss & Corbin, 1998). Although themes like ‘feeling connected’ and ‘gaining skills’ emerged in the initial line-by-line coding, it was not clear how the themes related to one another until the central phenomenon was confirmed. It then became apparent that these themes were the foundations of the central phenomenon, conditions that influenced the way the phenomenon was experienced by participants. Not all the conditions needed to be present for the phenomenon to occur, but each participant had numerous different types of conditions that played a role for them in their own experience.

**Existing music use habits.**

The role of existing music use habits relates to participants’ relationships with music outside of attending their singing group. Existing music use habits include the way participants listened to music in isolation prior to attending the group, in between sessions (while in their room in hospital or at home) and after attending the group. Sometimes participants described their existing music use habits in detail and found it helpful to compare their isolated music listening experiences with how they engaged with music in their singing group. There were four types of existing music use conditions: being conscious of the influence music can have, using music to reinforce pathology, avoiding certain music when you are unwell and an affectionate relationship with music.

**Being conscious of the influence music can have.**

Four participants were aware of the way music could make them feel when they listened to it alone. Milly was aware that listening to certain music by herself could evoke an upsetting response. She said that listening to certain music in her room could take her back to what she called her *dark place*, stating, *it just makes me feel*
even worse. When I’m getting all these negative thoughts and urges and stuff, sometimes I’ll listen to it and it will make me just want to die. Similarly, Lola knew that she did not feel safe listening to certain songs at home by herself, while both Lola and Margaret knew that listening to certain songs could impact them negatively or make them feel sad. Ellie was aware that hearing new songs on the radio would trigger more sad feelings for her than the golden oldies as she felt that the new songs were more emotional and depicted sad stories that she could relate to.

**Using music to reinforce pathology.**

Sam, the only contributor to this category, knew that a certain song could evoke negative emotions when he listened to it alone, but would listen to it anyway when he was feeling mentally unwell. Sam reflected honestly on this experience during the interview stating, *I would actually make myself more depressed on purpose. It’s not the best medicine in the slightest but that was something that I was renowned to do.*

**Avoiding certain music when you are unwell.**

Three participants reported actively avoiding certain music when they were unwell. Hannah and Violet described being with friends in a café or at their home when certain songs would come on the radio. Hannah said,

*I’ll have to turn the radio off or I’ll ask someone to turn whatever they’re listening to off. I just couldn’t listen to them, because as soon as I’d listen to them it would take me right back there and I didn’t want to go back there.*

Kate also described occasions when she would avoid particular songs on the radio or when she was listening to her iPod at home stating,
Sometimes when it comes on the radio or something, I just change the channel or I just go ‘nah I can’t do it.’ Listening on your iPod, it’s just too hard. I suppose sometimes I do just press fast forward.

**A passionate relationship with music.**

Four participants described a passionate existing relationship with music (seen in Table 6). Participants used words like love (Ellie and Sam), amazing, passion (Lindy) and powerful (Milly) to describe their relationship with music. Milly described a passion for music despite the intense and negative emotional reaction she experienced sometimes when she listened to music in isolation (presented above). For Milly, music was someone who [was] not judgmental and who [was] just there for her. She described her relationship with music as being a big part of [her] journey with bipolar. Ellie made reference to a previous active relationship with music and her love for playing her violin in orchestras and at home, stating I love music and I play music.

<table>
<thead>
<tr>
<th>Singing is my passion, it gives you a boost and helps you get through the day. It’s amazing (Lindy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’ve always enjoyed singing in the shower and stuff. Music is one of the most powerful things, especially when you’re unwell, I think it makes such a difference. I felt like sometimes it [a song] was written for me, yeah it’s weird. Music is someone who’s not judgmental and who’s just there. When I was really unwell there was certain music I would listen to. I think it’s been a big part of my journey with bipolar (Milly)</td>
</tr>
<tr>
<td>I’ve always loved music (Sam)</td>
</tr>
<tr>
<td>I love music and I play music (Ellie)</td>
</tr>
</tbody>
</table>
This strong connection made with music was evident in the interviews with these participants. They described music as having power in itself and often having power over them. Not only were the words participants used to describe their relationship with music suggestive of this passion, the tone in their voice and the way they described music was also prominent. It was as though they were talking about a friend, affectionately describing what the friend offered them in their friendship and tentatively speaking about the complexities of the relationship or the negative ways their friend could make them feel. Margaret was one of many participants who spoke in an excited and animated way about her relationship with music. After my interview with Margaret I wrote a memo reflecting on my embodied reactions to Margaret’s comments (Finlay, 2005):

She was just so passionate about music and singing. The way she was emphasising some words and pausing in between phrases. It made me feel really passionate about what she was saying too. I felt myself matching her energy.

During this part of the interview, I seemed to be mirroring Margaret’s energy and excitement. Prominent scholars in the field of phenomenology and reflexivity have written extensively on the way the researcher can act as a ‘mirror’ during interviews, reflecting the participant through their stance, gesture and expression (Churchill, 2000; Finlay, 2005, 2006). Researchers can gain more insight into participants lived experiences by attending to their bodily movements and behaviour during interviews (Finlay, 2005). In this instance, reflecting on my embodied reaction to Margaret’s comments helped me to realise that a new category was emerging in the data. The strength of each participants connection with music and the passion involved in this
relationship was most prominent. This led to the naming of the category, ‘a passionate relationship with music’.

The role of the group.

The role of the group refers to the relational aspects of group singing which was initially the primary focus of the study. However, after the initial stage of analysis, it became clear that although the relational aspect of singing was important, it was not central. It was a part of the larger phenomenon of triggering encounters with music. All 14 participants described something positive about the relational aspect of their group and reported some form of feeling connected with or supported by others in their group. Three categories were created to capture the different aspects of this theme: feeling connected with others, feeling supported and accepted and feeling understood in the company of others with lived experience.

Feeling connected with others.

Eight participants described feeling a sense of connectedness with other people in their singing group (see Table 7). This sense of connection was described as occurring through friendships (James and Lola) and caring (Margaret) for others. These connections were seen as powerful (Hurdler) and positive (Lola) by participants who spoke fondly of the relationships they had formed with others in their group. Lola and Milly described the importance of being physically together with people in their group. For Lola, being together and feeling connected with others resulted in not feeling alone. Milly noted that singing together had the ability to bring everyone together in the group, connecting on a common goal.

Table 7. Contributions to the category ‘Feeling Connected with Others’.

| It’s a really nice way to get the community in here together. It’s like a team exercise, |  |
you interact with people you wouldn’t usually interact with on a day-to-day basis, even in here (Sam)

I’ve got friends, there is something in common there (James)

Everyone’s singing together and singing kind of brings everyone together (Milly)

It’s a team effort, the singing so I feel part of a team (Sarah)

I haven’t had friends before I’ve come here. To have friendship is positive and I feel like I’ve made friendships through the singing group (Lola)

Several people that I have met have been lovely people. They’re just amazing, and they help you go through life if there’s a struggle (Lindy)

I feel like these people are my friends. We’ve built up a friendship between us all, we all care about each other (Margaret)

I mean the connection, the dynamics and connecting with other people without actually asking questions, it’s quite remarkable. It’s a sense of unity which is really powerful. It’s kind of like synergy, there’s this strengthening, there’s this bonding and it cuts across all demographics and all singing styles (Hurdler)

**Feeling supported and accepted.**

Nine participants reported feeling supported and accepted by their group members (see Table 8). Although similar and related to the previous category, feeling connected and feeling supported were separate. In the previous category, participants reported joining together with others, connecting and making friends. However, descriptions were categorised together in the current category, when they communicated more of a subjective feeling of respect and safety. This related to the environmental group culture rather than definable social connections and friendships between group members. Participants described a feeling of acceptance in their group. Six out of the nine participants described this as not feeling *judged* by the other members in their group (Sam, Margaret, Hurdler, Violet, Dan and Ellie). Words like *trust* (Hurdler) and *respect* (Kate) were used by participants to describe their group
culture, and four participants called their group a *safe space or place* (Hurdler, Lola, Hannah and Ellie).

Table 8. *Contributions to the category ‘Feeling Supported and Accepted’.*

<table>
<thead>
<tr>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel accepted. We are never dismissed for what might be wrong for us or the fact that we haven’t got a job or we need to live in supported accommodation. That is never judged upon us in that choir, never (Margaret)</td>
</tr>
<tr>
<td>The people there aren’t the type to judge. I felt comfortable when I walked in for the first time. I was in safe hands (Sam)</td>
</tr>
<tr>
<td>There’s definitely respect in that space (Kate)</td>
</tr>
<tr>
<td>You need to be able to trust, you need to be able to feel safe and not be judgmental (Hurdler)</td>
</tr>
<tr>
<td>I know that nobody’s being judged (Violet)</td>
</tr>
<tr>
<td>People will accept you. It was mutually supportive, no one was in a position to judge anyone (Dan)</td>
</tr>
<tr>
<td>I’m in a supported group. I feel like here is like a safe place (Lola)</td>
</tr>
<tr>
<td>It’s sort of like a safe place where people are understanding and have empathy and everyone listens to each other. A powerful and positive and safe sort of environment (Hannah)</td>
</tr>
<tr>
<td>It’s just a safe space to be for an hour. A very safe and warm place to be, a very comforting place to be. It’s sort of very inviting, very warm, very safe. It’s ok to have a few tears in here and if you did everyone understands, no one is going to judge you (Ellie)</td>
</tr>
</tbody>
</table>

*Feeling understood in the company of others with lived experience.*

Six participants described a shared understanding by being with others who were, or had been experiencing mental illness (see Table 9). Participants used *we* (Hannah) and *everyone* (Kate, Ellie and Milly) to illustrate this shared experience, collectively describing their experience of mental health recovery. Hannah used the word *we* on many occasions when describing others in her singing group, *we’re all*
going through hard times, we’re all in a psych ward, we’re all going through our own sort of things. Participants described the shared understanding with others as being comforting (Ellie) and not so scary (Kate).

Table 9. Contributions to the category ‘Feeling Understood in the Company of Others with Lived Experience’.

<table>
<thead>
<tr>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is something in common there (James)</td>
</tr>
<tr>
<td>We’re all going through hard times. We’re all in a psych ward. We’re all going through our own sort of things. We are in a mental health unit and we’re all struggling (Hannah)</td>
</tr>
<tr>
<td>You just feel like you’re in a group of people that get it. You know that other people have got stuff they’ve been through too so it’s not so scary I suppose. It is just being in a group with people that you know have been through tough stuff in their life. Being in a group like that meant that everyone had been through something and everyone’s got baggage and I thought ‘yep I’m sure there are other people that are thinking about this too’ (Kate)</td>
</tr>
<tr>
<td>It’s a different feeling, coming here and singing with people that are hurting too (Lola)</td>
</tr>
<tr>
<td>The fact that everyone’s going through the same thing at this point in life is comforting (Ellie)</td>
</tr>
<tr>
<td>It’s kind of different because it’s people who are suffering as well who are singing and they know what it’s like to suffer and be in pain when they’re singing the song. It’s just important that everyone is experiencing the same thing (Milly)</td>
</tr>
</tbody>
</table>

The role of the facilitator.

This theme includes conditions that relate to the role of the facilitator and their fundamental workings of the group. Categories in this topic are: creating a relaxed and flexible environment, the facilitator’s attitude, musical and leadership skills and focusing on or off music skills.
Creating a relaxed and flexible environment.

Five participants commented on the flexibility of their singing group environment or ethos (see Table 10). All five participants who contributed to this category were from an inpatient setting. This was first described during the first interview with Hannah. Hannah noted the difference between other therapy groups she attended during her hospital admission and the music therapy singing group stating, *in general group, it’s sort of just like all the negative type stuff comes up, whereas in music therapy you don’t have to delve into that.* This comment illustrated how the existence of flexibility and choice in the group influenced Hannah’s experience of the triggering phenomenon. The words that stood out to me from this statement were *you don’t have to,* meaning that she felt she had a choice as to whether she would *delve into her negative stuff* with the group or not. This was paradoxical at the time, since Hannah later went on to describe how she managed to cope with the triggering experience in the group by delving into all the *negative stuff* that came up and sharing her feelings with the group. However, with further analysis and reflection it seemed critical that she had the choice to delve into this, or not. I wrote a memo after the interview:

This is interesting. Here she says that negative stuff comes up in general therapy and this is seen as a bad thing, but also goes on to say that although the negative stuff may come up in music therapy, having the option of delving in or not is important. Again the importance of the sense of having freedom and choice in the 'safe place' she describes.

Although Hannah experienced the *negative stuff* in both groups, the presence of flexibility and choice in the singing group changed the experience and the outcome of the experience for her. This flexibility was both described by participants as the ethos
of the group – informal (Ellie), relaxed (Milly), calm and casual (Sam) - as well as the flexibility to come and go from the group when they wanted. Participants appreciated the flexibility and option (Kate) to attend the group in an inpatient environment where much of the therapy program was mandatory. The fact that the group was voluntary made Kate especially want to go. She described her attendance in the group as participation [she had] chosen to do rather than something you have to pick because you have to go to two groups a day.

Table 10. Contributions to the category ‘Creating a Relaxed and Flexible Environment’.

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no pressure. It’s not something that you have to pick because you have to go to two groups a day, it’s optional, which makes you want to go. I’m not locked in and it’s participation I’ve chosen to do. It’s non-confrontational, you don’t go into it thinking ‘oh I don’t really want to do this’, you go in thinking ‘it’s just singing it’s ok’ (Kate)</td>
</tr>
<tr>
<td>The beauty about some of the emotions that come with some of the songs is people have a choice. You’ll never get the same feeling, the dynamics change and spontaneity is a very hard thing to obtain when you’re not very well mentally (Hurdler)</td>
</tr>
<tr>
<td>It was such a very casual, very calm environment (Sam)</td>
</tr>
<tr>
<td>It’s very informal, people come and go. There’s no sense that you have to stay in that space if you don’t want to. Or you can come late, it’s not like a class where you feel bad if you’re late. So I think that’s nice, that people can come and go (Ellie)</td>
</tr>
<tr>
<td>It’s just really relaxed (Milly)</td>
</tr>
</tbody>
</table>

Musical and leadership skills.

Sam, Greg and James commented on the skills that I or their facilitator brought to the group, not only in voice and guitar or piano but also in their ability to lead musically (as seen in Table 11). Greg stated, you play the music and the tunes
very well and then it’s easy to sing. Sam commented on the way I played the songs stating, the way that you perform them, they’re not in the depressing funeral type of way, they’re actually still uplifting and upbeat. James commented on his facilitator’s ability to lead the group stating, she’s good at leading us.

Table 11. Contributions to the category ‘Musical and Leadership Skills’.

<table>
<thead>
<tr>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>The boss, she’s very good. She’s good at leading us and she’s got a good voice (James)</td>
</tr>
<tr>
<td>The way that you actually perform them also, they’re not actually in the depressing mourningful (sic) funeral type of way they’re actually still quite uplifting still quite upbeat (Sam)</td>
</tr>
<tr>
<td>You’re good on the guitar, really good. You play the music and the tunes very well and then it’s easy to sing to (Greg)</td>
</tr>
</tbody>
</table>

Focusing on music skills.

Margaret, Lindy and Dan (all community participants) placed importance on learning and/or improving vocal skills through their participation in group singing. Margaret described how participating in the group had influenced her ability to sing properly. Margaret felt that participation in the group taught her she could improve in [her] voice, and if [she] concentrated better and treated [her] body like an instrument then [she] would be so much better. Dan illustrated his willingness to learn skills through his participation in the group stating, I’ve got a good voice and I want to learn to use it. While Lindy proudly described her group as singing in tune and singing together.

Focusing off music skills.

Four participants, who were all from an inpatient setting, placed importance on being part of a group, which did not emphasise vocal skills (see Table 12). Vocal
skills were not a focus of the group they were a part of and *it didn’t matter if you [could] sing well or not sing well* (Lola). Sam and Lola even commented on their perceived lack of vocal ability stating, *I know I don’t have a good voice* (Sam) but emphasised that, *it’s not about how talented you are* (Sam) because everyone’s just *enjoying themselves* (Lola). Kate and Ellie commented on the difference between their singing group and their perception of the required skills to participate in an ‘actual choir.’ Ellie stated, *it’s not like an actual choir practice where you’d have to be perfect in your tone or you’d have to get the intervals exactly right. It doesn’t matter what your voice is, you just sing.*

Table 12. *Contributions to the category ‘Focusing Off Music Skills’.*

<table>
<thead>
<tr>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s a group to come along and sing, it’s not a group to be a choir which produces lovely music. You can produce lovely music through singing with multiple people but that’s not what this is about. Being in a group where no one is a good singer helps because I think singing could be beneficial but I would get a barrier to going and joining a choir or something like that. It’s been good to sing with a bunch of people that can’t sing as well (Kate)</td>
</tr>
<tr>
<td>It sort of doesn’t matter because everyone else is encouraging each other and it doesn’t matter if you have a terrible voice. I’ve noticed that there’s times when I’m louder than other people but I’m just enjoying it. It doesn’t matter if you can sing well or you can’t sing well, everyone’s just enjoying themselves (Lola)</td>
</tr>
<tr>
<td>I know I don’t have a good voice [but] it’s not about how talented you are in those classes (Sam)</td>
</tr>
<tr>
<td>No one is being judged about how they sing. It’s not like an actual choir practice where you’d have to be perfect in your tone or you’d have to get the intervals exactly right. It doesn’t matter what your voice is, you just sing (Ellie)</td>
</tr>
</tbody>
</table>

*The facilitator’s attitude.*

Eleven participants made reference to their group facilitator’s attitude, including their style and approach (see Table 13). It is important to note that seven of
the participants who contributed to this category, were members of the group I facilitated as a music therapist in an inpatient setting. The other four participants were members of different community choirs facilitated by two different community musicians. I felt a sense of discomfort in the interview when participants spoke about my own facilitation skills and style. The below excerpt from my reflexive journal illustrates this discomfort after my interview with Ellie.

I felt really uncomfortable when Ellie used words like ‘talent’ and ‘warm’ to describe me as the facilitator of her group. I did not feel these reactions when participants from other groups described their facilitator, I embraced their comments. I thanked Ellie for her comments about my skills in this moment but I felt like I wanted to change the topic and brush her comments aside.

It was only upon listening back to the interview that the awkwardness in my voice when thanking Ellie for her kind words became apparent. I recalled observing Ellie sense my discomfort around this topic as she moved on quickly to another topic without any verbal prompting. It is possible that Ellie experienced her own embodied reactions in response to seeing and hearing my discomfort at this time, and reacted by moving on to the next topic. This reflection process influenced the analysis at this stage. It seemed important to go back and listen again to the interviews with the inpatient participants and acknowledge their comments about their experience of my presence in the group and value their description of how this influenced their triggering encounter. Importance was placed on three different areas within this category: unconditional positive regard, empathy and authenticity.

Table 13. \textit{Contributions to the category ‘The Facilitator’s Attitude’}.

| He has got a heart full of compassion for people. He is so dramatic and he is amazing. He just comes up to you and you just get up there and you sing for him and |
then he just tells you where you can go with your voice and if you have a voice, if you have a career (Lindy)

He’s got an amazing ability to make everyone feel special. Feeling that you are dismissed as someone with a disability, we’re never treated like that by him. He has incredible patience, he makes it fun. He was giving us incredible opportunities to find hope, not only within ourselves but as a group. He gives you such hope that no matter who you are you can sing (Margaret)

I do like how you go around and even when someone comes in late, you kind of go around in the circle but then you go [to] that person and then you go back around. I like that that person still gets to pick however many songs that everyone else does even though they came in late or sat somewhere that wasn’t quite right. It’s really nice that you do [that] because it makes you feel included even if you just came in for the last 15 minutes (Kate)

[Facilitator’s name] does well with us singing. She is patient. I like her (Sarah)

It’s not just what the participants bring, it’s also what the facilitator brings. YOU [emphasis added] shared something and people took that away (Hurdler)

You’re really good at picking out when a certain song is…you know people can be quite sensitive to a song, you’re really good at picking that up. When the song ends, you always check in and just see how the person is. But you don’t push for them to express what the song means for them. You check in with people and then they feel comfortable enough to tell you, or tell the group how that song’s made them feel (Hannah)

I appreciate that someone has got a talent such as yourself and bringing their skills to an institution like this where people are trying to get well. And you’re a very accepting person, I’ve found you very warm and friendly and you just welcomed everyone and you knew everyone’s name and it was just a very pleasant place to be (Ellie)

When I met you, you were really lovely. I guess it’s nice how you go round the circle and everyone can pick a song cos I guess it reflects what everyone’s feeling at that moment (Milly)

_Unconditional positive regard._

Five participants described me or the other group facilitators as demonstrating a positive regard for group members. This was portrayed through words describing their facilitator as _welcoming, warm, accepting_ and _friendly_ (Ellie). Participants told stories about their facilitator’s inclusive nature and actions. Margaret described her
group facilitator as having *an amazing ability to make everyone feel special.* While Kate and Milly placed importance on the way I would ask everyone to choose a song for the group to sing, making them *feel included even if [they] just came in for the last 15 minutes.* Similarly, Ellie felt it was important that I knew everyone’s name in the group stating, *you just welcomed everyone and you knew everyone’s name and it was just a very pleasant place to be.* Margaret described her facilitator as, *giv[ing] you such hope that no matter who you are you can sing.* This meant a lot to Margaret who had previously been *dismissed as someone with a disability* within her local community.

*Authenticity.*

Hurdler, the only contributor to this sub-category, noted that what the facilitator *brings* or contributes to sessions is important. During the interview Hurdler reflected on one of the sessions he attended where I shared something about myself with the group. Hurdler was impressed that I *shared something,* and he noted that this authentic gesture was important to him and the other participants in his group.

*Empathy.*

Hannah, the only contributor to this sub-category, noticed my ability to *pick up* on songs that affected participants’ feelings and *check in* with the participant, while not *pushing them* to express their feelings. It was important to Hannah that her facilitator was empathic toward her needs in the group and allowed her to contribute what she was able to at that time.

**The role of the consumer.**

The final theme of conditions relates to the role of the consumer, their individual circumstances and events that influenced how the central phenomenon was
experienced. This theme includes two categories: committing to the group and fluctuating mental health.

**Committing to the group.**

Four participants described a personal commitment to attending their singing group and the many challenges they faced while maintaining this commitment (see Table 14). Participants described *making an effort* to get there (Greg), being *serious about it* and *coming back every week* (Margaret) despite challenges and *blockages* (Lindy). Challenges were described as being: *no energy* (James), disagreements with co-members (Lindy), disapproval from family members (Lindy) and doctors appointments (Greg). Some of these participants shared detailed accounts of these challenges and were proud to have still committed to the group despite them.

<table>
<thead>
<tr>
<th>Table 14. Contributions to the category ‘Committing to the Group’.</th>
</tr>
</thead>
<tbody>
<tr>
<td>My family have been not so warm to me cos I’m doing this and they don’t like it. I also had a bit of a disagreement with [“Anglea”] - she also comes to this choir. It hasn’t stopped me coming but it’s a wall and a blockage (Lindy)</td>
</tr>
<tr>
<td>I make an effort to get there. My doctor was coming and I didn’t want to leave so I asked him to wait (Greg)</td>
</tr>
<tr>
<td>We’re all there voluntary, off our own steam every week coming back. We’re all serious about it, we all want to be there. We’re all standing strong and we all keep coming back, that says everything (Margaret)</td>
</tr>
<tr>
<td>Sometimes I’ve got no energy but I keep going (James)</td>
</tr>
</tbody>
</table>

**Fluctuating mental health.**

Sam and Ellie (who were both inpatient participants) described how their fluctuating mental health influenced their experience of triggering encounters with music. During the interviews (which were both in the days leading up to their
discharge from hospital), Sam and Ellie reported that their ability to cope with the emotional nature of the group singing experience had improved along with their improved mental health. Ellie said,

*I'm back to being myself now. I can do it now, like last night when we sang it (a challenging song for her) I wasn’t struggling with my emotions but if it was two weeks ago I might have found myself having difficulty with some of the words because I would have been triggered to think about things that have happened.*

Ellie also described the emotions that were evoked with certain songs as if they were preconscious, explaining that *if there is sadness, it might come up.* If Ellie’s mental state was fragile at the time she participated in the group, this sadness would more easily move to consciousness. Sam also felt that his response to certain songs *change[d] depending on [his] mental health.*

**Coping Strategies**

There were ten different ways that participants described coping with triggering encounters. These ways of coping were often viewed by participants as positive strategies or resources that the music or the group could do for them during this critical moment. Some participants had numerous ways of coping at this time, which can be seen by their inclusion into a number of the ten categories. Participants described themselves as active in this process, using their own resources, or resources they took from the relational or structural conditions of the group that allowed them to cope with this challenging time. These coping strategies were divided into three different types of resources: relational coping, internal coping and practical coping.

**Relational coping.**
Relational resources refer to the coping strategies participants used, which involved other group members (see Table 15). This category is divided into two different categories: a) seek support, and b) share your feelings. Both categories refer to participants’ use of the group environment to help them cope with their own challenging experience.

Table 15. Contributions to the category ‘Relational Coping’.

<table>
<thead>
<tr>
<th>Contribution</th>
<th>Seek Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>The support that I got back or the acknowledgment I got back completely calmed me down and I was like ‘I can do this’, ‘this is a good thing’ ‘this isn’t a negative thing’. There’s a sense of protection or something in the group, it’s sort of safe. I could have easily just shut down and walked out and not have stayed in the group when things got hard for me with certain songs, but it’s that safe place. How to cope is easier because you’re around people and it’s kind of like a safe environment. You’re surrounded by people and it’s a safe environment and you’re able to sort of cope with it better (Hannah)</td>
<td></td>
</tr>
<tr>
<td>My reaction was, I was able to contain…not contain the emotions but I was able to cope with the song and I think I processed it a little bit. But if I listened to it on my ipad or iphone or whatever it would have been different. Because it was in a group situation I sort of thought ‘no I really don’t want to cry here’. I think it was partially being around people that I knew just got it. Initially was like ‘oh god’ and Hannah heard me and she said ‘yeah I know this one’s really hard for me too’ but she’d been going [to the group] a few weeks and I think she found a similar kind of thing (Kate)</td>
<td></td>
</tr>
<tr>
<td>I guess everyone’s singing together and I guess singing brings everyone together. It was nice to be supported. Everyone’s having constant things being brought up by the songs and I think everyone kind of feels that in the group. And it’s kind of nice that everyone can share that experience (Milly)</td>
<td></td>
</tr>
<tr>
<td>The fact that we’re all a group and we’re united when we’re singing, there’s a feeling of togetherness (Margaret)</td>
<td></td>
</tr>
<tr>
<td>I feel like here is a safe place to listen to that music and because I’m in a supportive circle of supportive people, a supportive therapist, I’m in a supportive place (Lola)</td>
<td></td>
</tr>
</tbody>
</table>
Seek support.

Five participants were able to seek emotional support from others in their singing group during their triggering encounter. Hannah and Lola described a sense of support (Lola) and protection (Hannah) from being surrounded by people in a safe environment and thus being able to cope with it better (Hannah). Kate described the difference between being able to cope with the triggering experience in a group situation compared to being alone in her room. Milly felt that it was nice to be supported during this time and knowing everyone can share that experience of being triggered was important. Both Milly and Kate described comfort in knowing that others were experiencing similar encounters and this helped them to cope with their own experience. Kate described talking with Hannah about her feelings during the triggering encounter and knowing Hannah was going through a similar thing helped her to cope in this moment. Similarly, for Milly just knowing everyone was having constant things being brought up by the songs and that everyone kind of [felt] that in the group was comforting.

Share your feelings.

Hannah, the only contributor to this category, reported being able to cope with the triggering experience by expressing what the song meant to her, [making] it easier and [getting] her through. Hearing other people express their emotions in
relation to a ‘triggering song’ was helpful for Hannah and encouraged her to do the same.

Internal coping.

Many participants used their own internal resources to cope with the triggering experience. This included using distraction, positive thinking, acceptance and avoidance. These four categories were interpreted as internal coping resources since they were resources that the participant used alone, internally, without others necessarily knowing they were experiencing a challenging emotional reaction to a song.

Distraction.

Ellie, the only contributor of this category, described trying to focus on the actual ‘singing’ of the song rather than focusing on the feelings or thoughts in her mind during her triggering encounter. Ellie was able to become distracted from thoughts about the song by participating in and focusing on the activity. Ellie viewed this as an opportunity to practice being mindful during her triggering experience rather than sitting there and being distracted by her thoughts.

Positive thinking.

Seven participants described coping by thinking positively about their triggering encounter (see Table 16). This primarily involved the belief that the benefits of participating in the singing group were worth experiencing a challenging triggering encounter (Ellie). Violet described this as not letting the one song that upset her outdo the other twenty that she really enjoyed. For Hannah, receiving positive outcomes from participation in the group and knowing she would feel better afterwards was helpful. While the determination to continue singing was Ellie’s
motivation to keep going and get past that moment. Ellie described this by saying, if there’s one tear, it’s worth the experience of being in the group. Further, Violet, Sarah and Kate described using positive self talk or internal dialogue to help them cope with the triggering encounter. This dialogue offered a sense of comfort to them. These participants used phrases such as keep going, it’s ok (Kate) and offered themselves a sense of hope and reflection using affirmations such as serenity now, it’s all in the past, and tomorrow’s another day (Sarah).

Table 16. Contributions to the category ‘Positive Thinking’.

<table>
<thead>
<tr>
<th>I think it [the beauty] just comes when I’m singing it and I just remember all those times but they’re not there right now they’re not as real and raw as they have been in the past (Milly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If there’s one tear, it’s worth the experience of being in the group and having mindfulness. You want to keep singing, it’s that motivation to get past that moment, you want to keep going (Ellie)</td>
</tr>
<tr>
<td>You know that you’ll get that benefit and you’ll know that you’re going to feel better after it (Hannah)</td>
</tr>
<tr>
<td>One song that upsets you, you don’t let outdo the other twenty that you’ve really enjoyed. I think I said a couple of things like ‘oh we’ve probably all been there at one stage or another’ and maybe I’ve made a few internal comments to myself (Violet)</td>
</tr>
<tr>
<td>You also know that a lot of other people will enjoy it. The people in the audience will enjoy it and your friends in the choir will enjoy it (Margaret)</td>
</tr>
<tr>
<td>I just say to myself, ‘tomorrow’s another day…serenity now’ I say to myself (Sarah)</td>
</tr>
<tr>
<td>But all I did was miss a few lines and then I kept on going and I was like ‘no keep going, it’s ok, you’ve done it before’ especially after that first week (Kate)</td>
</tr>
</tbody>
</table>

Acceptance.

Five participants described accepting challenging thoughts and feelings to cope with the triggering encounter (see Table 17). There were different ways of
accepting these emotions and feelings for different contributors to the category.

Participants used phrases such as bottle it up (Lindy), it’s only a three minute song (Sam), it will pass (Ellie), there is beauty in suffering (Milly) and you’ve got to go along with it (Violet) to describe the way they tolerated and accepted these challenging feelings. Ellie likened her experience of a triggering encounter with her experience of depression, stating,

\[
\text{Life is about emotions, it’s just good and bad, that’s life. It doesn’t matter if sad feelings come up, it will pass, you pass through it, which is really what depression is. It’s a very low feeling for some people, and for some people it’s less intense and for some people it’s more intense.}
\]

Table 17. Contributions to the category ‘Acceptance’.

| It’s like, well it’s only a 3 minute song and then boom there’s something different (Sam) |
| Bottle it up and swallow your pride and it will help you get over it. Yeah so [I wrestle with it and put it in my heart (Lindy) |
| Life is about emotions it’s just good and bad, that’s life. Even if there is the odd word that triggers something, that’s not important to me. It doesn’t matter if sad feelings come up, it will pass, you pass through it (Ellie) |
| I also think it’s one of the most beautiful songs, there is kind of a beauty in suffering. As horrible as suffering is, I think there is a beauty in it (Milly) |
| They are also other peoples favorites so you’ve got to go along with it (Violet) |

\textit{Avoidance.}

Three participants were able to cope by avoiding the triggering experience. They described different reasons for coping in this way. Margaret and Lindy referred to the professional nature of their role in the choir, feeling that they needed to pull back and really prepare to make sure (Margaret) that they did not waiver or cry
(Lindy). Lindy described this as hard, but felt that she had to be strong and close off the emotion. For Milly, just being in a group environment was a way to separate from or avoid the triggering encounter. She compared this to listening to the same song while alone in her room, stating, normally if I listen to it by myself I’d probably start crying and it will be a lot more emotional.

Practical coping.

The next theme includes descriptions of practical coping strategies taken by participants during their triggering encounter. These coping strategies involved a conscious decision by the participant to do something practical to help them manage the experience. There were three main categories within this theme: let it out through singing, take positive risks and don’t sing it.

Let it out through singing.

Four participants described actively releasing emotions through singing during their triggering encounter (see Table 18). Singing was understood by participants as a powerful (Lola) and different (Sam and Hannah) way to express and release challenging feelings and thoughts. Lola was one participant who described the experience of letting go through [her] voice in great detail. The feeling of letting go of emotions was an important release for Lola. Lola described feeling empowered from letting go of emotions through singing. Letting go of emotion through singing, changed the intensity of Lola’s emotions down to a low level. She reported feeling strong emotions such as anger and sadness in response to hearing certain songs in the group. However, instead of screaming and yelling it out, Lola changed these feelings into a positive experience by singing [them] out.
Table 18. Contributions to the category ‘Let it Out Through Singing’.

<table>
<thead>
<tr>
<th>I just sing it and it goes away (Violet)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m bringing in a lot of the happiness from the group and being able to let go through my voice. Even when I’m really sad and having a really bad day, just to go in there and be able to sing it out makes me feel so much better. When I sing, I am able to let go of some of the hurt through such a positive way instead of screaming or yelling, it’s a real release for me. I feel almost empowered, being able to sing it out rather than just screaming it out and to let go of those emotions through singing, it just feels incredible. It changes the intensity down to quite a low level. It makes me just feel sad listening to them but when I sing them it makes me feel like I’m releasing it. To let them go in a powerful way, turns that negative to a positive. It makes me feel like I’m letting out all of my feelings. It just makes me feel like I’m releasing something through just singing, I feel like I’m letting it go. All my emotions sit in my gut and whenever I sing anything it all just comes out and it feels like a massive release. Instead of screaming it out, I’m singing it out and everything is just coming out because otherwise I’ll scream it out and that’s a negative way, but this is a positive way of releasing that emotion. So I sing it and it all comes out and I’ve had that same release from my anger but with singing it out it will feel better than if I had of yelled it out. So it’s the same sort of release so if I scream, it’s releasing everything and if I sing it’s releasing everything as well. But with the singing it’s more a positive and I feel better from that, I feel more positive afterwards. Whereas later even though I’ve screamed it out, I’ll feel more negative about that (Lola)</td>
</tr>
<tr>
<td>I’m expressing my feelings and emotions through a different medium (Sam)</td>
</tr>
<tr>
<td>It’s a different sort of expression, expressing your feelings through music, it’s different (Hannah)</td>
</tr>
</tbody>
</table>

*Take positive risks.*

Sam, Kate and Lola reported testing themselves during the group in response to their triggering encounter. Gaining control over their song choices meant that they could cope more easily with the intense emotions or thoughts the songs evoked. Lola described consciously choosing songs that had *an emotion* for her. She chose them so she could *deliberately sing them* and release the feelings they brought up. This made her feel *more positive* about the songs. For Kate, after coping with the triggering experience in previous group sessions, she tested herself by saying, ‘*ok I coped with it*
once, let’s try and do it a second time’ in order to know that she could really do it and it wasn’t just a once off. Despite knowing that the songs they chose would be potentially triggering, Sam and Kate tested themselves during the group in order to be in control of the way certain music could make them feel. When I asked Sam to describe his reasons for doing this he said,

*It’s about taking chances. If I don’t push myself in here, how am I going to go when I go home. I thought if I tried it here and it worked here, well I’ll have no qualms about it happening when I leave and I go into the real world.*

**Don’t sing it.**

Margaret and Violet described how the intensity of the triggering encounter influenced their desire to sing the song or not. By purposefully choosing not to sing the song that triggered an emotional response, they could cope better. Violet described this by saying, *I might not even sing it to be quite honest, I might just listen. It just upsets me too much.* And Margaret said, *a song that makes me feel sad, I’d probably just want to listen to it, I wouldn’t want to sing it.*

**Regaining Health**

A number of different outcomes were experienced by participants after the triggering encounter occurred. During the initial analysis process, consequences or outcomes of experiences were grouped together. After returning to the interviews during the later stages of analysis it became clear that participants’ descriptions of these outcomes alluded to a sense of ‘regaining’ something, through their triggering encounter. The word ‘regain’ is commonly used in mental health recovery literature to describe consumers’ ambition to live a meaningful life despite the presence of symptoms (Anthony, 1993; Lewis, 2012; Slade, 2009). Rather than focusing on
ambitions to ‘return’ to a life prior to a mental illness diagnosis and being ‘cured’ of symptoms, recovery experts emphasise the importance of ‘regaining’ a new and meaningful life in the presence of mental illness. Similarly, participants who contributed to this theme described the presence of memories or feelings still evoked in response to certain songs after regaining a healthy relationship with them, but they were able to cope better with the feelings or memories evoked. Participants were able to have a meaningful relationship with music, their emotions and others despite the presence of triggering encounters. There were three different categories describing three ways of regaining health: regaining social health, regaining emotional health and regaining musical health.

**Regaining social health.**

Three participants reported feeling a sense of social belonging after the triggering encounter. Milly and Ellie described this as leaving the group feeling not so alone (Milly). Hannah and Ellie reported being understood (Hannah) in their singing group. Being in a group environment during a triggering encounter allowed Ellie to realise that everybody goes through hard times and you’re not alone if you’ve had difficulties. During the analysis process, feeling understood and not alone were considered important elements that contributed to belonging in a group context.

**Regaining emotional health.**

Four participants reported feeling better after the triggering experience in response to expressing emotion (see Table 19). This sense of feeling ‘better’ was described using phrases such as a weight’s been lifted off your shoulders (Hannah), a positive release (Lola), I’ve released everything that’s sitting in my gut (Lola) and it’s like an emotional release (Margaret), it’s like I’m at peace (Margaret). Hannah was very explicit about this in the interview stating, it’s not like you finish the group and
we’re left feeling sad. It’s never like that. It’s more like we feel better for opening up.

For Violet, Sarah and Hannah the sense of feeling better came in response to the triggering experience ending. Sarah and Hannah described feeling more positive (Sarah) once the triggering song had finished and a sense of feeling proud of yourself for getting through it (Hannah).

Table 19. Contributions to the category ‘Regaining Emotional Health’.

<table>
<thead>
<tr>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s sort of like I’m at peace. It’s sort of like I’ve literally let out a whole lot of mixed feeling in myself and I’ve found a peacefulness afterwards. It’s like a release. Sometimes after choir practice or a choir performance I’ll actually feel very tired, because the words, they’re coming from the heart. I feel that it’s resolving something as I go home. There’s something about music for me that lets out a lot of stuff in the singing and the performing. It’s like an emotional release. It’s almost like you’ve done a lot of physical exercise and your whole body’s tired (Margaret)</td>
</tr>
<tr>
<td>It’s not like you finish the group and we’re left feeling sad, it’s never like that. It’s more like we feel better for opening up, because we feel comfortable enough and we feel like we’re able to open up so therefore it makes us feel like a weight’s been lifted off your shoulders. You’ve been able to express how certain songs make you feel, and when it’s over it’s not like we go on and on about our emotions at all, we sort of let them out during the group. You can get upset and there’s a lot of empathy shown, but it doesn’t end negative like it might in the general program. This one[group] ends positive not in a negative way so it’s sort of a safe space where you can express, but you know that you’re not going to fall in a heap (Hannah)</td>
</tr>
<tr>
<td>I’ve had a positive release and I’ve released everything that’s sitting in my gut (Lola)</td>
</tr>
<tr>
<td>I feel better [after the song has finished], more positive (Sarah)</td>
</tr>
</tbody>
</table>

Regaining musical health.

Five participants described feeling differently about the songs that had initially triggered challenging emotions or memories after participation in their singing group (see Table 20). The five participants described both changed feelings in response to hearing the song after listening/singing to it in the group, and also an ability to listen to it again in a different context. Participants reported being able to
hear those songs again (Hannah), connecting with them again in a positive way (Hannah), choosing and enjoying (Kate) those songs again and adding them back into their playlist (Kate). Participants described feeling stronger and better (Hannah) in response to being able to connect with those songs again, because of the important meaning to them. Hannah and Kate described how singing [the songs] in the group sort of normalised them (Kate) and Lola described how she had been able to turn ‘that’ song into a release song through singing it in the group each week.

The five participants described what it was like to hear the triggering songs again after regaining a healthy relationship with them. Hannah explained how the feelings and memories being triggered by certain songs do not consume you anymore. Although Hannah acknowledged that the song is still attached to a memory, she now felt that she could control how she felt in response to the memory, which [was] good. Now on each occasion she heard this song, most times [she] thinks about the memories, but most times it’s ok. For Sam, now that song can be playing but [he] won’t look upon it as a negative thing, it’s just a thing. Sam described a sense of accomplishment in response to the songs having a different meaning, stating, I feel quite proud. It’s sounds silly but it was something I accomplished and something I achieved by myself. There was a strong sense of power and control from the participants when they described what it was like to listen to these certain songs again. Sam’s body posture changed at this stage of the interview, sitting taller and using his hands to gesture. The volume of Sam’s voice increased and he spoke faster. I noticed myself feeling this renewed sense of power also, mirroring him, growing taller in my chair and smiling in response to Sam’s regained sense of control (Finlay, 2005, 2006).
It’s really helped me. I’ve been able to join in and listen to the songs and it’s made me be able to sort of hear those songs again. The song has a whole new meaning, than what it does when you just hear it on the radio. Actually, it made me feel stronger and it made me feel better that I could connect with those songs again, because they meant so much to me. I feel like I’m connecting with them again and in a positive way. It just makes me feel like I’ve been able to go back there without it having such a negative impact, now it’s more of a positive impact. It sort of makes you feel stronger because it doesn’t consume you anymore. It’s attached to a memory but you can sort of control how you feel and stuff, which is good. It sort of makes you feel stronger and you think about the memories but most times you can just listen to another song and it’s ok (Hannah)

The other thing that I’ve found it’s done is normalise a lot of songs which I find difficult. Singing them in the group has sort of normalised them a little bit, which means that now I’ve heard them and not been so emotionally attached to them, which has been really good. Now I can actually enjoy them again instead of thinking ‘I don’t want to listen to that’. Over the weeks doing it a number of times has really normalised that stuff, I’ve kind of added them back into my playlist. Sometimes they pop up and I just think ‘yep, this is ok now I can do this’ (Kate)

Being able to turn that song into a release song (Lola)

Now it’s like, that can be playing but I won’t look upon it as a negative thing, it’s just a thing. So now I have those songs in my head that have a different meaning to what they originally used to mean. I felt quite proud. It’s sounds quite silly but it was something I accomplished. That’s why I think I’ve kept coming again and again and again, because it’s something I achieved by myself and I felt quite accomplished (Sam)

It gets easier as you go along I think. Every time you sing the song, it gets easier (Lindy)

Validating the Theory (Epilogue)

The following section describes the analysis of data collected from a further nine interviews with nine new participants. These interviews were conducted in an attempt to validate the existing theory presented above. Although a point of saturation had been reached after the 20 interviews in the previous phase, I chose to interview
more participants to examine and refine the themes further. It remained important to value the previous 14 participants voices, and acknowledge that the existing theory was formed in a particular and unique context. Validating the theory was conducted not in an attempt to seek the ‘truth’ or ‘correctness’ of the theory. Rather, it was about gaining further support for the theory by adding depth to the themes and talking with new participants in a different program about their experiences of group singing.

The majority of participants in the second phase of data collection reported triggering encounters during their group singing experience. Two participants, Katherine and Tara, did not report triggering encounters with music while attending the group. Although, Tara did describe her experience of listening to certain songs on her iPod and reported how they could evoke certain memories and emotions for her. Similarly, Katherine did not report experiencing a triggering encounter in the group, but spoke about her observations of other participants’ triggering encounters and commented on their responses. Katherine also described conditional factors to her group experience and her existing music use, which contributed to these categories in the existing theory.

Three different aspects of the new data will be discussed in the following section: data that confirmed the theory, data that influenced changes to the existing theory and new data that deepened the theory. The themes derived from the new interviews were largely comparable with the existing theory. The entirety of the data from the nine new interviews is displayed in tables under each theme in Appendix A. The existing theory represented in Table 2 earlier in this chapter, is displayed again below in Table 21 with the addition of the nine new participants’ contributions. Contributions to the table are annotated with grey highlighted text to represent changes made to categories in the theory after contributions from new participants,
non-highlighted text to represent themes that stayed the same after contributions from new participants and dark grey highlighted text to represent new categories added as a result of contributions from new participants. Again, participants’ own words are reflected throughout this section through the use of italics.

Table 21. *The existing theory with contributions from new participants.*

<table>
<thead>
<tr>
<th>Triggering Encounters with Music</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause of the triggering encounter</td>
</tr>
<tr>
<td>Encounters with memories</td>
</tr>
<tr>
<td>Encounters with emotions</td>
</tr>
<tr>
<td>Anticipating triggering encounters</td>
</tr>
<tr>
<td>Perception of triggering encounters</td>
</tr>
<tr>
<td>Challenging</td>
</tr>
<tr>
<td>Challenging, but ok</td>
</tr>
<tr>
<td>Positive or neutral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conditional Factors to Triggering Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing music use habits (Pre-conditions)</td>
</tr>
<tr>
<td>When negative emotions are intensified through listening to music in isolation</td>
</tr>
<tr>
<td>a) Being conscious of the influence music can have</td>
</tr>
<tr>
<td>b) Using music to reinforce pathology</td>
</tr>
<tr>
<td>c) Avoiding music when you are unwell</td>
</tr>
<tr>
<td>When music doesn’t help</td>
</tr>
<tr>
<td>Using music to feel better</td>
</tr>
<tr>
<td>Mental health influences music use</td>
</tr>
<tr>
<td>A passionate relationship with music</td>
</tr>
</tbody>
</table>

| The role of the group                       |
| Feeling connected with others               | Sally, John, Kay, Hugh |
| Feeling supported and accepted              | Collins, John, Katherine |
| Feeling understood in the company of others with lived experience | - |

| The role of the facilitator                |
| Creating a relaxed and flexible environment | Kay |
Musical and leadership skills (Recognising the facilitators' skills)
Focusing on music skills
Focusing off music skills

The Facilitator’s attitude:
- Unconditional positive regard
- Authenticity
- Empathy

Kay, Katherine, Sally, John, Bridgit

Katherine

John, Kay

The role of the consumer
Committing to the group -
Fluctuating mental health Bridgit, Collins, Sally
Influencing outcome through song choice Des, Hugh, Collins

Coping Strategies
Relational coping
Seek support Sally, Bridgit, Kay
Share your feelings John

Internal coping
Distraction -
Positive thinking Bridgit
Acceptance Bridgit, John
Avoidance -

Practical coping (Taking action)
Let it out through singing Sally
Take positive risks -
Don’t sing it Des

Regaining Health
Regaining social health -
Regaining emotional health Des, Sally, John, Collins
Regaining musical health Collins, Sally

Confirming the theory.

Many of the existing themes and categories in the theory did not change after contributions from the nine new participants. In viewing the data, I had a strong sense that much of it fitted in to the pre-existing categories and themes, but felt it was important to be sure that my own pre-existing assumptions were not being placed on the new data. A process of reflexive consideration and testing of concepts was
required by comparing the actual words used by participants as well as by noting my instincts about what participants had really been talking about. This process took place over a number of days of working with this particular material. After engaging in this process, I still had a sense that much of it fitted into the existing categories and themes, particularly when it related to similar processes or concepts already represented in the theory. For example, in the ‘triggering encounters with music’ category ‘cause of the triggering encounter’, six out of the nine new participants described certain songs that were associated with memories evoking emotions, or emotional responses to songs due to their current mental state. These reports were similar to previous participants’ contributions categorised under the themes ‘encounters with memories’ and ‘encounters with emotions’ which offered further support to the existing theory. John was one of three contributors to the sub-theme ‘encounters with memories’ and reported that if he had related [a certain song] to something in the past and then [heard] that song [in the group] it might bring up emotions that are difficult. In the previous phase, thirteen participants described how familiar songs evoked memories which caused them to experience intense emotions.

Kay was one of three other participants from the later phase of data collection who contributed to the theme, ‘encounters with emotions’. These three participants related a song to their current feelings and mental state. When the song ‘The Rose’ was played in the group, Kay reported feeling upset because she believed the song [was] about loneliness and this reminded her of her own situation and how she currently felt lonely. While listening to the song in the group, Kay wasn’t remembering a specific event, or somebody [she] had lost, like John described in the previous theme, she was thinking of emptiness. Similarly, in the previous phase, three
participants also described an intense emotional reaction in response to certain songs, that in some cases they had never heard before.

**Changes to the existing theory.**

With additional participants contributing to many of the themes, I believed it was important to go back to the original data and reassess categories and labels. Returning to the existing theory with new data required reflexivity and transparency to ensure that all 23 participants voices across the two phases were represented and labels accurately portrayed both new and existing data. Table 22 displays the original themes that were altered after contributions from new participants, changes made and the reason for the change.

Table 22. Changes to the existing theory.

<table>
<thead>
<tr>
<th>Theme title</th>
<th>Original title</th>
<th>Reason for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing music use habits</td>
<td>Pre-conditions</td>
<td>This theme was initially labeled ‘pre-conditions’, meaning that the categories underneath this theme had to occur before the other types of conditions. The pre-condition category related to participants relationships with music prior to attending their singing group. The first group of participants primarily referred to their music use prior to their attendance in the singing group. However, when participants in the later phase described their music use, they referred to it as being an existing relationship with music that occurred not just prior to attending the group, but during their admission to hospital and after attending the group. After returning to the original data with the new data, I thought that participants in both phases were relating to their ‘existing music use’ that although did influence their experience of the triggering phenomenon, did not have to occur prior to the other conditions.</td>
</tr>
</tbody>
</table>
| Being conscious of the influence | When negative emotions are intensified through listening to music in isolation | This category was divided into three categories after contributions from new participants. Participants from the later phase discussed their existing music use in detail. This deepened the existing category and warranted the creation of more specific categories under the theme ‘existing music use habits’.

**Being conscious of the influence music can have**

Going back through the data in light of the experiences from new participants made me realise that there was a
<table>
<thead>
<tr>
<th>music can have</th>
<th>consciousness to the influence music could have on participants.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding certain music when you are unwell</td>
<td><em>Avoiding certain music when you are unwell</em> - This idea was not fully developed in the first phase so it did not warrant its own category, but it was still mentioned by a few participants. Participants from this later phase spoke specifically about how they had deleted particular songs from their iPod, or would deliberately avoid listening to music when they were unwell.</td>
</tr>
<tr>
<td>Using music to reinforce pathology</td>
<td><em>Using music to reinforce pathology</em> - This category was briefly mentioned by one participant in the first phase of data collection but in the new phase it was described more explicitly.</td>
</tr>
</tbody>
</table>

| The role of the facilitator | Recognising the facilitators skills | There were five new contributions to this category which meant I needed to use the original and new data to reflect on the most appropriate title for this category. Upon reflection, the facilitator’s skills were not emphasised in the participants descriptions, it was their presence and then within that were their skills. John and Kay noticed that their facilitator would notice certain emotional responses from participants in the group. One participant from the previous group, Hannah also noted that as the facilitator of her group I had an ability to ‘pick up’ on how songs affected people in the group. |

| Practical Coping | Taking Action | With new contributions from participants and getting space from the original data, I came to realise that this category was much more practical than the other resources themes and needed re-wording. Although participants were taking action to cope, this category did not seem different from the others in its theme. Being practical was a much better description of the way participants coped with the triggering encounter. |

**New additions to the theory.**

**Existing music use habits.**

A number of new themes were developed within the existing category, ‘existing music use habits’. Music listening and the many factors which influence music use were described in depth by the second group of participants. Initially, I identified four existing types of music use conditions. However, after the most recent
phase of data collection, another six categories within this theme were developed: a) using music to reinforce pathology, b) being conscious of the influence music can have, c) using music to feel better, d) when music does not help, e) mental health influences music use, and f) avoiding music when you are unwell. Once these new themes were developed, it was important to go back to the original data from the first group of participants and, where appropriate, integrate data in cases where these topics had been mentioned before but not as explicitly. Each new theme will now be described in detail, with contributions from new participants only.

*Being conscious of the influence music can have.*

Four of the nine new participants made reference to a consciousness of the influence certain music could have on their emotions (see Table 23). Some participants in the previous phase did describe the different ways music could make them feel. However, the four new participants spoke about this in more detail and their awareness around the emotions music could evoke in them was much more apparent. For example, Tara was able to identify the type of music that she knew would make her feel upset or sad. When Tara was 15 and *first got sick, [it] was the worst year of [her] life.* She recalled listening to a lot of John Mayer during this time, and now, those same songs could be *really triggering* and Tara could not listen to them. Tara and her friends have *all told each other what [their] triggers are.* She described knowing that ‘Karla’ can’t listen to Pink Floyd, and ‘Jacqui’ can’t listen to Bright Eyes and her friends *know what’s triggering* for her too. Similarly, John was aware of how certain music could make him feel and reported using music to deliberately influence his mood. John reported listening to music to lift [his] mood [and] sometimes just to transition, if [he was] feeling down or sad. John found this process useful to *identify [with] and actually feel emotions.* Whenever John was
having difficult experiences with emotions he would put some hip hop on which he knew would be uplifting for him. John would also save some types of music for certain occasions when [he] want[ed] to feel sad, knowing it would make him feel sad when he heard it.

Table 23. Contributions to the category ‘Being Conscious of the Influence Music can Have’.

<table>
<thead>
<tr>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I was 15 and I first got quite sick and I was really sick and I was like suicidal and all of that, I remember listening to songs that were quite…I just remember listening to a lot of John Mayer and it was really kind of…those songs can be really triggering and like I can’t listen to them now at all. I can’t ever listen to like 99% of John Mayer’s songs because I just connect it to that time and that was like the worst year of my life so yeah it’s really triggering like I can’t listen to any John Mayer. We’ve all told each other what our triggers are, and I know that [Karla] can’t listen to um Pink Floyd, and yeah and like [Jacqui] can’t listen to Bright Eyes and all of this stuff, so my friends know what’s triggering (Tara)</td>
</tr>
<tr>
<td>I feel calm and relaxed when I’m listening to jazz or when I’m listening to music that I enjoy. Whereas the sad songs and songs that have been at funerals and things like that, that can drag me down a little bit (Collins)</td>
</tr>
<tr>
<td>There’s two types of sadness. I will be deeply saddened where I’ll just play sad music and then there is a little sadness where I will play a bit of sad music and then end it off with some kind of happy music and I will go on about my day. It’s a way of expressing it without having to speak it out, to validate my sadness. I play 3 or 4 songs and then I dunno I run out of sadness. I think it’s a way to just put all my sadness into the song and then leave it there and come back to it (Hugh)</td>
</tr>
<tr>
<td>If I’m having difficult experiences with emotions, I will generally put some hip hop on that I relate to and lyrics that are meaningful to me. That’s usually nice uplifting music. I’ll listen to music to lift my mood, and I have definitely still listened to music when I’m going through difficult times, in order to, sometimes just to transition, I’ll use that time if I’m feeling down or sad and identify and attach to that too, just to actually feel that emotion and not suppress it or resist that feeling (John)</td>
</tr>
</tbody>
</table>

Using music to feel better.

Four participants described using music to make them feel better (see Table 24). Although this topic had been briefly mentioned by participants in the previous phase, these four new participants described how they could use music to positively
influence their mood in much more depth. When Tara listened to certain songs that reminded her of a time when [she] was well, it was consoling for her. Tara described a particular album by the artist Laura Marling that reminded her of an important time in [her] life, a time that she described as, the start of wellness. Tara described listening to this album if she is trying to get [her]self in a place where [she] is feeling free and great or just OK. Similarly, Collins described listening to heavy metal music when she is not in a good place mentally. Heavy metal music is a bit of a release for Collins and it gets the anger out. Collins reported that if she listens to this type of music, she can have her emotions mirrored back to her, which makes her feel not so alone. Des described music as being a part of [his] life all the time. Even when [he is] sad, there’s music [he will] listen to to feel better. Further, Hugh described how listening to certain music has saved a lot of anguish for him. If Hugh can put all of his sadness into a song then it can prevent [him] from further sadness and doing irrational things like hurting [him]self.

Table 24. Contributions to the category ‘Using Music to Feel Better’.

<table>
<thead>
<tr>
<th>Songs that I sometimes listen to are from a time when I was well. Like there’s this particular Laura Marling album, ‘A Creature I Don’t Know’ that I listen to if I’m trying to get myself in a place where I’m feeling free and great or to you know to feel ok. I was 19 but it was the first time I was well enough to go on cute dates and just enjoy myself. And I felt really free and it was a really nice summer. It was such an important time in my life in terms of being the start of wellness for me. I just remember feeling ‘wow I’m well enough to do this stuff now’ and that whole album was I just listened to it so much (Tara)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I was not in a good place mentally I usually listened to heavy metal. I think it’s a bit of a release like…it gets the anger out…like…maybe to have it mirrored back to me kind of thing…it makes me feel not so alone if that makes sense (Collins)</td>
</tr>
<tr>
<td>I reckon it’s saved a lot of anguish, further anguish. It may prevent me from further sadness. Like I said, putting all my sadness into a song rather than continuing feeling sad and doing irrational things like hurting myself or just burying myself in the sand…and feeling super depressed (Hugh)</td>
</tr>
<tr>
<td>Music has been part of my life all the time. And even when I’m sad, there’s music I</td>
</tr>
</tbody>
</table>
When music does not help.

Tara and Hugh identified the very complex nature of their relationship with music. Although music could be *consoling* for Tara, she described that it could also *be the opposite*. Similarly, Hugh felt that music could make him *very sad but then at the same time very happy*. Hugh said, *I love it but hate it at the same time*. When Hugh said this in the interview, he had a longing tone in his voice, which had a rawness to it. In this moment I felt a new sense of rawness and openness present in me too and what I represented in that room, music. I wrote a memo after the interview describing this embodied reaction (Finlay, 2005).

The way Hugh said this, ‘I love it but hate it at the same time’, there was almost a whininess or an anguish in his voice and in his face. It was raw and exposed. The words felt meaningful, real and honest. I noticed myself feeling exposed in that moment too. As if music’s negative side had suddenly been revealed and I was representing it in this moment.

This reflection initially helped me to realise that a new category was emerging. This was the first time a participant had blatantly described a negative impact from music listening. In the previous data set, participants had only hinted towards the negative impact music listening could have on them. Furthermore, when presenting the theory at research seminars, many colleagues queried whether or not this notion of the ‘negative impact of music use’ was falsified or exaggerated. Thus, it seemed extremely significant and powerful to me in this moment, that a participant, whom I had never met before, was naming it very clearly when I gave him opportunity to.
Hugh also shared his experience of the times that music was *not an option* for him. *If he was* really sad and really anxious, *listening to music would* do nothing. When this happens, Hugh described being unable to *concentrate on the music* because he would be just *focusing on [his] thoughts.*

*Mental health influences music use.*

Four participants described the influence their fluctuating mental health could have on the way they use music (see Table 25). This topic had come up before in the previous dataset, but only in the context of participants’ experience of their fluctuating mental health impacting their experience of the triggering encounter in their singing group, rather than in relation to their isolated music use. I purposefully aimed to delve deeper into the new participants’ experiences of music listening, which may be why this topic was often raised by participants in the second phase. It is also possible that I had an increased sensitivity for hearing this after hearing the previous participants describe how their mental health influenced their experience in a group setting. The four new participants’ contributions to the theme are presented in Table 25.

Table 25. *Contributions to the category ‘Mental Health Influences Music Use’.***

<table>
<thead>
<tr>
<th>Yeah basically, when I’m depressed I dunno like I feel very empathetic, I do hear the lyrics and I hear the stories and it does sort of trigger me sometimes. But I’m not in that space anymore and now I listen to…lately I’ve been listening to jazz on the TV, which has been nice and soothing and calming. Jazz really chills me out, cos I don’t have to think about words…which could be triggering words. [When I’m unwell, I would listen to] sometimes hip hop, like Aussie hip hop, cos I can relate to that a lot. They’re Australian people that sing about their trials and tribulations and so I listen to that (Collins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yeah I’m just enjoying music again, That kind of dropped off…when I’m unwell yeah, the first thing. Yeah I will still listen to my music, but it’s more the Pink Floyd, rather than the lighter rock and roll. When I’m not feeling well, yeah more of the reflective stuff. [But now] instead of just picking one album on the Ipod, I’ll let it shuffle through (Des)</td>
</tr>
<tr>
<td>When I’m sick I don’t [listen to music]. I don’t have the energy to go and put a CD on (Katherine)</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>I think right now I have a really positive relationship with music but it used to be really not good. But I think it’s also because when I was 15 and I first got unwell, I was only in my first couple of admissions or whatever…and I think I’ve spent like a year and a half minimum in and out of psychiatric wards since then. So you know I’ve built up, I’ve had to build up like my resilience and all of that kind of stuff. So I think I’ve got myself to a place where my relationship with music is good. But I think then it wasn’t. I think I definitely listened to songs that I could relate to in negative ways. But I think that also went hand in hand with creating a better relationship with myself in general. Yeah I think that my emotional development and recovery from many different mental illnesses [laughs] went hand in hand with…with how I listened to music and how I related to music and how I approached listening to or creating music (Tara)</td>
</tr>
</tbody>
</table>

### The role of the consumer.

‘The role of the consumer’ theme describes conditional factors to triggering experiences which relate to the contributions to the group from the participant that influenced the way they experienced the phenomenon. Categories in the theme initially were: feeling relaxed in a flexible environment, the facilitator’s attitude, musical skills and focusing on or off musical skills. One new category within this theme was developed after the latest phase of data collection titled ‘influencing outcome through song choice’.

#### Influencing outcome through song choice.

Three participants described purposefully choosing certain songs for the group to sing in an attempt to control the outcome of the session for them or for others. This topic had not been raised in the previous data collection phase. This may have been because participants did not choose to discuss it in the interviews or it may not have been relevant for them. As such this theme has contributions from only new participants and there was no need to integrate parts of the original data into this
theme. Collins was one participant who described deliberately choosing upbeat songs rather than the really down ones [or] the triggering ones in one of the sessions she attended. Choosing upbeat songs influenced Collins’ experience of the group and she reported a very different experience to the other sessions when she did not do this. Hugh described forcing [him]self to pick a happier song while he was in the group. Hugh knew [that other] people were going to be doing sad songs, and [he didn’t] want to relate sadness to that type of group, cos it was positive. Choosing a ‘happier song’ left a positive memory for him. Similarly, Des described choosing songs that he knew were going to enlighten [him and] lift the experience for the rest of the group.

**Conclusion.**

This chapter described the aim, method and findings of a grounded theory study, including data from 20 interviews and an additional nine interviews with participants from a new inpatient mental health context. A grounded theory approach was used to respond to the research aim, to understand the role of group singing in different mental health settings and the contextual and conditional factors apparent within these settings which contribute to mental health recovery. Findings were presented as a grounded theory of group singing which was described as the way consumers can experience triggering encounters with music in their singing group and use the group conditions as coping resources to regain musical, emotional and social health. Data from the additional nine interviews validated and deepened the existing theory by confirming, changing and adding new data to each of the themes. The next chapter will discuss the entire theory within the context of relevant literature.
References


professionals. Cambridge: Cambridge University Press.


Chapter 7

Discussion

In this discussion chapter I respond to the research aim by articulating how group singing contributed to participants’ experience of mental health recovery. The term ‘musical recovery’ is used as a way to frame the results and reflects the understanding that has emerged through the analysis of the study. This chapter is divided into four sections that illustrate the different factors in musical recovery for people with mental illness using examples from the results of this study. First, musical recovery is introduced as a process of regaining healthy relationships with music, which promote mental health recovery. Second, the factors which may interfere with musical recovery are discussed including triggering encounters and existing music use habits. Third, factors which promote musical recovery through group singing are presented, including contributions from the consumer themselves, the facilitator of the group, and the consumers’ peers. Last, the chapter concludes by offering a suggestion for musical recovery in music therapy practice.

The aim of the research study described in the previous chapter was to explore the role of group singing within inpatient and community mental health contexts and the conditional factors which contribute to mental health recovery. To address this aim I conducted a grounded theory study with 23 people experiencing mental illness who participated in singing groups within inpatient music therapy contexts or community choir contexts. Findings were presented in Chapter 6 as a grounded theory of group singing which was described as a resource for regaining healthy relationships with music during mental health recovery. A framework of ‘musical recovery’ will now be described as a way of interpreting the results from this study and relating them back to the relevant literature.
Introducing Musical Recovery

People with mental illness can lose touch with the resources that help them to cope during different stages of their recovery (Ansdell & Meehan, 2010). Many participants in this study reported existing music use habits and triggering encounters in their singing group and at home which interfered with their use of music as a health resource. These participants also reported that attending group singing was helpful to support regaining a healthy relationship with music after disconnecting with it. Rather than returning to the relationship they had with music prior to this experience, participants described developing a new and changed relationship with music, which was shaped by their experience in the group. Reconnecting with music in a positive way after interferences, offered participants a sense of control over their music use and their ongoing relationship with music. Factors promoting this process within the singing group contributed to participants’ renewed positive relationship with music. I propose that this process is ‘musical recovery’, what I define as: a process of regaining healthy relationships with music which promote mental health recovery.

The remainder of this chapter describes in detail the process of musical recovery, its relationship to mental health recovery, and how participation in group singing promoted the process for participants in this study. It must be noted however, that just like mental health recovery, musical recovery is an individual process and this chapter does not intend to depict a rigid model of what musical recovery ‘is’ in every case. Rather, it offers examples of musical recovery to inform future research and clinical practice of this process developed through the findings of this study.

The word ‘regain’ which is used in this definition of musical recovery, depicts a repossession of something after losing it. The term was chosen in an attempt to purposefully reflect the language commonly used in the mental health recovery
literature. Recovery theorists argue for the importance of consumers regaining a meaningful life in the presence of symptoms, rather than focusing on ambitions to return to a life prior to illness (Anthony, 1993; Deegan, 1996; Slade, 2009). Participants who contributed to the theme ‘regaining musical health’ in my study described memories or feelings still evoked in response to hearing certain songs, after regaining a healthy relationship with them, but they were able to cope better with their responses. These participants regained a healthy relationship with music through the supported group environment.

A connection between supported music use offered during group music making and people’s ongoing relationship with music during recovery has previously been explored by music therapy scholars. Ansdell and Meehan (2010) published a seminal article on this topic arguing that people in recovery can reconnect with music as a health resource by engaging with it in a supportive context. Instead of using the term ‘musical recovery’ as I have done in this study, the authors use the phrase “music-health-illness narratives” to depict a person’s pre-illness relationship to music, a disconnection with music due to illness and then a re-establishment of a healthy relationship with music with the support of a music therapist (p. 35). In a later publication with Tia DeNora, Ansdell (2015) describes how participation in music therapy helps to “mid-wife” consumers back to a healthy relationship with music during times of acute illness (p. 221). Both Ansdell’s studies and the findings of my study, illustrate that supported music engagement promotes the regaining of music as a pathway away from illness and towards healthy recovery. This is a process of musical recovery, a term which was constructed through this study and influenced by Ansdell’s previous work in this area.

Reconnecting with music through participation in group music therapy was
also identified as a main theme in Hense, McFerran and McGorry (2014)’s study which specifically relates to young people’s musical identities. These authors state that consumers can experience changes in their musical identity that correspond with changes in their mental health, during acute illness through to planning for recovery in the broader community. Subsequently, Hense (2015) proposed a theory of recovery of musical identity in her doctoral study by offering an understanding of the relevance of ‘music therapy processes’ to ‘processes of recovery’. The complex relationships that consumers describe with music during their recovery in Hense’s study, bare similarity to descriptions of the musical recovery process from participants in this study and further support the role of group music therapy in the promotion of regaining healthy relationships with music. The studies described above provide examples of the emerging discussion within music therapy literature of the relationship between music therapy practice and recovery. Grocke, Bloch and Castle (2008) describe the congruence between resource-oriented and community music therapy approaches to aspects of recovery philosophy that focus on strengths and social connection. McCaffrey, Edwards and Fannon (2011) argue this is particularly apparent in many of the core principles of recovery philosophy which they describe as being precursors to music therapy practice. They call for music therapists internationally to consider the potentials recovery can offer music therapy practice, noting that music therapy is able to support contemporary mental health services to reorient towards a recovery-oriented approach by focusing on people’s strengths and resources. Solli offers another description of the similarities between music therapy and recovery from the perspective of people in recovery themselves. Solli describes how service users can experience “freedom”, “contact”, “wellbeing” and “symptom relief” during music therapy in an inpatient setting, highlighting the ways these
themes relate to the belief that recovery does not look to reduce symptoms, but focuses on building capacities and experiences of wellbeing (Slade, 2010; Solli & Rolvsjord, 2014, p. 7). Solli (Solli, Rolvsjord & Borg, 2013) also argues in a qualitative meta-analysis of consumers’ experiences of music therapy, that music therapy can offer a space for promoting resources within recovery. These authors have offered valuable perspectives on the relationship between music therapy and recovery philosophy, and illustrate the potential role music therapy can have in supporting recovery-oriented practice. The theory of the process of musical recovery as occurring through supported music engagement, I argue, contributes to this literature base by offering a framework depicting the ‘regaining of music’ as a process of recovery in itself.

Musical recovery as a process not an outcome.

Just as mental health recovery is a process, musical recovery is also a process, not an outcome. The participants in my study described occasions of healthy connection with music, an avoidance or an absence of music, as well as other changing relationships with music during their recovery. Many participants identified this relationship with music as changing in response to fluctuations in their mental health. Therefore, regaining healthy relationships with music for the promotion of recovery is not an outcome that can be achieved through the application of music interventions or practices. Rather, musical recovery is an ongoing process of regaining and developing one’s relationship with music while in mental health recovery. This description differs from a biomedical understanding of ‘clinical recovery’ from ‘illness’ which depicts recovery as an outcome (Davidson, 2012). From a biomedical perspective, musical recovery could be seen as being an outcome of supported engagement with music. Through this lens, musical recovery would
depict a sense of being ‘recovered’ musically with the eradication of unhealthy uses of music and triggering associations. Instead, the results of this study illustrate that mental health consumers who engage with music are constantly ‘in’ a process of musical recovery, which involves a negotiation of music use in relation to fluctuating mental health and other factors related to their mental health recovery.

When terming musical recovery as ‘a process’, it instantly makes it difficult to define, achieve and measure. There is a risk that depicting musical recovery as a process will result in it encapsulating every example of one’s engagement with music during recovery and in turn become meaningless. The conceptualisation of mental health recovery as a process has received similar critique. Roe and colleagues (2007) and Lester and Gask (2006) argue that if recovery is understood as a process rather than an achievable outcome and incorporates all experiences of mental illness, it is no different to the process of everyday life. However, from the perspective of musical recovery, I argue that just as a happy life does not always have to be in the absence of symptoms, musical engagement does not always have to be about achieving a state of optimal ‘musical health’, where music always promotes positive experiences and emotions. It is helpful to draw on the work of Larry Davidson (2006, 2012) here who strongly advocates for recovery as a process. He suggests that to truly understand recovery as a process without it needing to lead to ‘recovery’ or being recovered from mental illness, as an outcome, the two must be viewed as completely separate from each other. To separate them, we must ‘bracket’ our understanding of recovery as an outcome and accept that for some people, serious mental illness may mean a long-term enduring of symptoms. For these people, traditional clinical measures of outcome that measure symptoms may not change much over time. However, this does not mean that their life as a whole cannot change substantially in other ways which
are important to them. For example, we do not expect a person who uses a wheelchair to reclaim use of their legs, but they can still have an improved quality of life by using the handrails and ramps that make public spaces in their community accessible to them. This may also be the case for someone with a mental illness, who can be supported to attend a choir in their local community, go out for dinner with friends or see a movie, all without any considerable change in their symptoms of mental illness (Davidson et al., 2001; Davidson & Roe, 2007). Being ‘in’ recovery in this sense, means engaging in a meaningful life within the limitations of illness, rather than waiting until all symptoms have depleted to begin one’s life again. In this way, being ‘in’ musical recovery also means that experiences of triggering or unhealthy music use habits will still occur as mental health fluctuates. However, by constantly regaining and negotiating healthy relationships with music, these experiences occur in addition to and within the context of positive experiences of coping and supported music use.

If mental health recovery was considered an outcome, there is also an implication that any admission to hospital, or any episode of symptom increase is a relapse or a set back to a consumer. In this case, they would not be considered as being in recovery as they are seemingly regressing (Davidson, 2012). However, people can experience increased symptoms when they perform positive aspects in other areas of their life which involve change or apprehension, like moving out on their own or attending social events. Within a biomedical approach to recovery, these people would not be considered as being in recovery. Within the context of musical recovery, experiencing a triggering encounter in group, or listening to a song which reinforces one’s pathology at home (like some participants in this study described) would be considered set backs to musical recovery and perhaps the person
experiencing this would not even be considered to be in musical recovery at all. But as illustrated in this study, consumers can still experience challenging experiences or engage in unhelpful music use habits and be in a process of musical recovery. These aspects may interfere somewhat and create some challenges along the way, but are normal and common experiences. If consumers were expected to wait until they only used music in healthy ways all the time or had no pre-existing associations with music which might trigger memories or emotions before ‘achieving’ musical recovery or ‘being in’ musical recovery, this would mean that for many people, they would never be in musical recovery. Thus, musical recovery is not an outcome or an earlier stage on the path to a ‘full recovery’ without negative or challenging experiences with music engagement. Rather, it is a process of negotiation with interferences and fluctuating mental health, of regaining healthy relationships with music that promote recovery.

Conceptualising musical recovery as a process could also mean adopting a stage model to describe different phases of progress in this process. However, I have intentionally steered away from this, due to the limitations these models have on personal experiences of recovery (Davidson, Rakfeldt & Strauss, 2010). The negative aspect of stage models is that they are linear and each stage progresses to the next. However, participants in my study did not describe a neat and linear progression in their descriptions of the musical recovery process. Instead they described a complex, multi-dimensional process which was different for each person. Many of the stages of recovery models within mental health literature imply that once regaining a ‘positive sense of self’ for example, one could then return to school or work, progressing to the next stage in the process (Andreson, Oades & Caputi, 2003). The problem with this is that for different people the journey to regaining a positive sense of self may be
different. When using this example to illustrate the musical recovery process, it could be thought that the first stage in the process of musical recovery is learning healthy habits to music use at home which then leads to a later stage of attending a music group in the community. However, for some consumers, attending a community music group may be the key aspect to assisting them to learn ways of engaging in healthy music use habits at home.

These examples from the mental health recovery literature offer some insights into a way of understanding musical recovery as a process. We must accept that some music habits or some triggering reactions to songs may not resolve, ever, or at least for a certain period of time for some people, just like some symptoms of mental illness may never resolve. But the consumer can still pursue and be ‘in’ musical recovery regardless of this. The results from this study suggest that musical recovery is an ongoing process which is non-linear, a process such as the diagram depicted in Figure 1. A musical recovery process involves many occasions of back and forth, and up and down with interferences and challenges in music use. It is a constant negotiation of gaining and regaining healthy relationships with music to promote mental health recovery rather than an attempt to achieve an arguably illusionary clinical outcome.

Figure 1. An example process of musical recovery inspired by Davidson, 2012.
Factors Which Interfere with Musical Recovery

Triggering experiences with music.

Music has a unique power to express inner states and feelings…and there is, finally, a deep mysterious paradox here, for while music makes one experience pain and grief more intensely, it brings solace and consolation at the same time (Sacks, 2007, pp. 300-301).

This quote from the late neurologist Oliver Sacks depicts the complex experience of triggering encounters with music that participants described in this study. Hearing songs in the group evoked intense emotions and memories for the majority of participants, but this experience was not considered negative or regressing. Rather, triggering experiences offered an opportunity for deep reflection and relief for people who had in some cases previously been avoiding these songs or using them in unhelpful ways at home. This experience also highlighted participants’ unique strengths and resources which they were able to utilise to cope with these intense experiences. Thus, although triggering experiences with music may interfere with the musical recovery process, this does not imply a set back or an interruption to the musical recovery process. Rather, these interferences contribute to the musical recovery journey and offer pathways to health promotion by engaging with music in a supportive setting.

Triggering has traditionally been associated with the field of substance abuse and misuse with Hatterer (1982) suggesting that it was a reoccurrence of memories or flashbacks. Over time it appears that this term came to be associated with any return to addictive or unhelpful behaviour in response to having tried to cope with emotional issues or intense situations (Bernheim & Rangel, 2004). For example, if a therapist tried to address repressed memories with a consumer and the consumer resisted, but
subsequently went home and used heroin, this would be described as the therapy triggering a relapse into the use of substances to manage their difficult emotions associated with the illness. In this more recent use of the term instead of memories or emotions being re-triggered, the emphasis is on the triggering of symptoms in response to external stimuli like watching a movie about someone who commits suicide or hearing a song which reminds a person of their ex-partner.

In this study, the term triggering is not used to suggest a recurser, or regressing to particular patterns of behavior that are used to self soothe. Instead, it is used to describe what happens within the therapy and community-based sessions when songs are heard. Similarly to the traditional notion of triggering described in the substance abuse literature, triggering in this context depicts how people described their emotions as raised and intensified within the context of a singing group and how repeated descriptions from these participants suggested that this was not necessarily associated with a return to particular behaviours in the group, but was associated with the kinds of emotions that could be thought to possibility lead to those behaviours.

For many of the participants in this study, a connection was formed between a particular song and the specific memories with which it was associated. When that song was played again in their singing group, the memories were re-triggered, evoking an emotional reaction for the participant (like the example of hearing a song which reminds someone of their ex-partner). Music has previously been identified as ‘triggering’ when it becomes associated with an event in one’s life and upon hearing that piece of music again, people report the evoking of emotions and memories of people or places that were associated with that original event (Baumgartner, 1992). For other participants, emotional responses were triggered when hearing a certain song that reminded them of their own current situation or mental state (like the
example of watching a movie about someone who commits suicide). These two types of triggering experiences were gathered together under the heading ‘cause of the triggering encounter’ in my results chapter where I illustrated how people like Lindy described familiar songs with memories or emotions associated with them ‘re-triggered’ an emotional response. For Lindy, a certain song reminded her of her late father and each time the song was sung in the group she described feeling the associated emotions or memories related to this.

In much of the mental health and psychotherapeutic literature, triggering experiences are understood as ‘normal’, but negative signals for relapse because of the coping responses that consumers often engage in when these feelings or memories arise (Bernheim & Rangel, 2004). However, participants in the current study reported being able to process the negative thoughts and feelings evoked from these experiences through their participation in the singing group. The use of group music making as a way of evoking, processing and exploring negative emotions or memories is illustrated in the music therapy literature with Baker, Gleadhill and Dingle (2007) arguing that participation in group music therapy is helpful for people with substance addiction as they can practice the exploration of intense emotions in a healthy way without substance use. Encouraging tolerance of distressing emotions for people with mental illness in an inpatient setting was also a prominent theme in Bibb, Castle and Newton (2016)’s study where participants described using group music therapy as a way of tolerating and coping with intense feelings of anxiety. Robertson (2015) argues that this experience is particularly prominent within therapeutic singing settings due to the unique capacity of group singing to facilitate emotions through sharing songs and the memories and emotions associated with them.

The use of songs as a form of evoking and processing negative emotions or
memories is also a key theme in psychodynamic music therapy literature. Ken Bruscia (1998) describes songs as a way to help consumers experience, express, and explore the emotions contained within them (p. 10). Within a psychodynamic approach, songs can be purposefully or un-expectantly recalled by the therapist or consumer in response to issues discussed during therapy. Participants are then able to experience and process these feelings within the context of the supportive therapeutic environment. Hakvoort (2002) provides an example of intentionally evoking responses in participants through using improvisation in individual music therapy sessions. In her description of a music therapy program within a forensic setting, experiences of improvisation within music therapy were reported as effective in treating people’s anger issues. The music therapist described using music to purposefully trigger anger responses in people during sessions to allow the underlying problems provoking their anger to be resolved.

By examining past experiences and unconscious emotions, psychodynamic music therapy aims to enable consumers to gain a deeper understanding of their internal world (Kim, 2016). Within these approaches songs can be used to work through the issues consumers bring to therapy (Hadley, 2003). Psychoanalytic theory and practice are used in the understanding of the music therapy process, along with a focus on the exploration of past experiences in the person’s development of new relationships. In their article describing music therapists’ perspectives of pivotal moments of music therapy, Gavrielidou and Odell-Miller (2016) provide an example of psychodynamic work within a mental health setting that illustrates the way it is used to explore consumers’ past experiences. They describe ‘pivotal moments’ as powerful and meaningful experiences for the consumer which provoke change in their understanding about their current situation. In the article, a case study describes one
participant, ‘Peter’’s pivotal moment as being the most challenging session he had had in music therapy, but also the most helpful in that he was able to share meaningful and deep emotions through the session. Like the experiences described by participants in my study, this illustrates that negative emotions can be experienced within music therapy sessions and positive outcomes can still be achieved. Further, it was also considered important by the authors of this study to provide a safe and containing place, in which Peter’s ‘depressive’ feelings could be understood and ‘dealt with’. This example depicts similarities to the findings from my study in that music therapy offered Peter a space to process intense emotions just as group singing provided participants in my study a safe space to process challenging emotions and memories in response to music. However, rather than understanding experiences within music therapy as a way to process preexisting issues like these examples of psychodynamic approaches illustrate, the focus was on using these experiences as resources for health.

Negative or challenging emotions can be seen to reflect consumers immediate, preexisting problems as illustrated in Gavrielidou and Odell-Miller’s study and are often the focus of more traditional psychological approaches like psychotherapy. However, triggering experiences reported in my study have purposefully been framed from a perspective where the focus is on identifying the positive aspects of such experiences. By viewing previous experiences as issues or problems which should be ‘fixed’, a risk of unnecessarily pathologising or placing negative associations on normal and healthy experiences arises. Within a recovery framework, there is a strong emphasis on seeing beyond problems and limitations of illness, and encouraging consumers to live alongside normal illness experiences (Anthony, 1993; Slade, 2009). Supporting recovery requires a focus on health and strengths, not issues and
challenges (Fairchild & Bibb, 2016). Similarly, within the process of musical recovery, associations with songs and emotional responses that arise in response to engaging with music, are important aspects of musical recovery.

**Existing music habits.**

Most consumers have previous experiences of engaging with music before they attend a singing group. Participants from the current study brought with them previous knowledge and resources of the way certain songs could make them feel when they listened to them in their lives outside of their singing group. Some participants also compared what it was like to listen to the same songs which they knew were upsetting or ‘triggered’ emotions or memories when they were alone in their room in the hospital or at home. These descriptions were grouped together as existing music use habits. Participants not only described bringing songs from their lives outside into the singing group (which was often how the triggering encounter occurred) but they also described bringing songs they had sung in the group to their home lives. Group singing is not an isolated activity and participants’ descriptions of their music use and knowledge illustrates that they use music in their everyday life before, after and often at the same time as their participation in group singing, even while in hospital. Rolsvjord (2015) advocates for the significance of this process for people in recovery since the songs people choose in the group, or bring with them to music therapy are often associated with important people or occasions in their lives outside of the music therapy context. In this way, participation in group singing contributes to part of a life long engagement with music for people during their mental health recovery.

Participants also brought a knowledge of their previous responses to music and an awareness that their responses were often dependent on their fluctuating
Tara gave a particularly detailed description of the way her relationship with music changed over time and how her music listening habits were strongly associated with her recovery from mental illness. The relationship between music use and mental state has previously been discussed in the music, emotions and wellbeing literature. McFerran’s (2016) recent meta-analysis examining two sets of this literature (music therapy studies and music psychology studies) concluded that the way people with mental illness use music is dependent on their mental state. She suggests that music use during mental health recovery is a continuum which represents changes to music use along with consumers’ fluctuating mental health. The continuum construct suggests that increased awareness of the different uses of music may be helpful at different times.

There were also times that participants described using music at home or in hospital to intentionally improve their mood. One participant, Hugh, provided a vivid description of times that his music use could prevent him from engaging in self-harming behavior when he was alone and acutely unwell. He described ‘transferring’ his sadness into the songs he listened to, which allowed him to feel lighter. Similar examples in the music therapy literature illustrate that people like Hugh do use music in ways that promote their health when confronted with life challenges. Schwantes and colleagues (2011) report that music listening during acute periods of depression can allow people to place sad feelings into songs and leave them there (Schwantes, Wigram, McKinney, Lipscomb & Richards, 2011), while Cheong-Clinch and McFerran (2016) found that this is particularly important when people with mental illness experience urges to self-harm. These authors describe one young person’s experience of how listening to a preferred song would remove their desire to self-injure for an extra three minutes.
In this study, participants described times when music was not helpful. Hugh reported that during moments when he was very anxious, listening to music was not an option for him. Hugh was aware that in this state, his previous coping strategies of using music would not be helpful. The often unhelpful nature of music use was also a theme in Cheong-Clinch and McFerran (2016)’s study where young people with mental illness found that occasionally music did not help them to cope despite previous successful experiences with music. Cheong-Clinch and McFerran argue that for people with mental illness, ‘happy music’ does not necessarily make ‘sad’ people feel ‘happy’, rather music tends to reflect the listener’s current mental state. Some participants in my study engaged in listening to music which reflected their mental state, but in some cases it reinforced their pathology, making them feel worse. Collins was one participant who reported a time when she deliberately listened to a particular Coldplay song which served to intensify her depressed mood while attempting to commit suicide. The use of music to intensify or ruminate existing thoughts and feelings has been previously explored in music psychology contexts, with prominent Australian authors Garrido and Schubert (2013) arguing that people who are already unable to regulate their mood due to mental illness, listen to sad music even when benefits are not gained. They report that people with depression are more likely to ruminate with music, listening to the same song repeatedly while thinking constantly of the same associated thoughts and memories since they have difficulty disengaging from negative emotional experiences. Thus for Collins, mood congruent music had the potential to exacerbate her already depressed state.

Although some participants reported using music to intentionally intensify their mood, others reported avoiding the songs that intensified their mood, passing over them on their iPod or asking friends to turn songs off from the radio. The
avoidance of distressing songs has been previously reported in the grief and loss literature with Flynn (2014) most recently reporting that actively avoiding particular songs written in music therapy was helpful for grieving parents to cope with the ‘triggering’ experience which reminded them of their grief (p. 190). However, avoiding challenging or intense songs is not necessarily considered a healthy coping strategy within a mental health context. Rather than avoiding the emotional experiences that were associated with these songs, facilitating an awareness of the participants’ negative emotions or feelings and experiencing these in a supported environment, has been identified as preventing alternative coping strategies to current patterns of coping which may involve alcohol, drugs, or self-harm behaviours (Otto, Safren & Pollack, 2004).

Factors Which Promote Musical Recovery Through Group Singing

The consumer.

One of the most prominent findings from this study was the active role that participants played in coping with triggering encounters with music. Participants described coping with the triggering experience themselves in group sessions by using the internal, relational and practical resources available to them. These results illustrate the importance of acknowledging the consumers resources and what they bring to music therapy and group singing sessions, rather than believing entirely in the power of music therapy interventions and the expertise of therapists. Emphasis on the strengths and resources of consumers is found in the theoretical tenets of humanism. Historically, Carl Rogers (1951) and Abraham Maslow (1962) advocated for the free will of the consumer and the democratic relationship between the consumer and therapist within therapy. This was one of their most important contributions to therapy as it called for a reconsideration of the dynamics of the
therapeutic relationship. As a result, for the first time, therapeutic approaches prioritised the choices made by the consumer and their inner resources for change over the techniques of the therapist. In response, Bohart and Tallman’s (1999) model of the consumer as active-self-healer further challenges the traditional psychotherapeutic model by advocating for the consumer’s resources and ability to solve their own problems. They argue that naturally occurring healing processes transpire in everyday life when people confront their problems, and use proactivity and generative thinking. Therefore it is expected that this would also occur when people attend therapy.

The theoretical principles of humanism have influenced user-led approaches to music therapy theory and practice. Most prominently, resource-oriented music therapy emphasises consumers as active agents in their own experiences with music. The consumer is viewed as a “resource-person” (Rolvsjord, 2006, p. 7) with the ability to appropriate music in response to their own health needs. Rolvsjord (2010) particularly advocates for the “client’s craft” (p. 191) in her articulation of resource-oriented music therapy and illustrates the many contributions that mental health participants bring to the music therapy context in her article titled ‘What Clients do to Make Music Therapy Work’ (2014). Bolger (2013) also highlights the strengths and resources of people when describing contributions of the marginalised young people in her research which explored collaborative processes in three different community music projects in Victoria. Bolger argues that people contribute to the collaborative music group process in three phases of investment by “buying in to the project”, negotiating and “playing through” the project, and making conscious choices when “sounding out” the collaborations (p. 237). However, O’Grady, Rolvsjord, and McFerran (2014) argue that although skills and resources represent potential, people
must be able to access these resources and use them in relationship with, and in the context of group music participation. Participants in my study provide an example of the way consumers are able to access and use their inner resources within a group music setting when they are faced with a challenging situation.

It is also the way consumers use and access the potential resources in music which contributes to their participation in group singing. The consumers’ role in their music use and engagement is emphasised by music sociologist Tia DeNora (2000) who states that music’s outcomes or potentials derive from the way in which a person appropriates that music, the pre-existing associations they bring to it and the context in which it is heard or used (p. 42). Based on in-depth interviews with women of different ages in the UK and US, De Nora believes that music has an “interpretive flexibility”, illustrating that its meanings are constituted in and through different circumstances of use (p. 44). De Nora’s theory considers music as a resource, which provides affordances or potentials dependent on the way and context in which they are appropriated. This perspective offers a sound argument for recognising the consumers own role in their music use and their responsibility to appropriate music for their own health.

A number of participants across both inpatient and community settings described coping with the intensity of their triggering experience by using their own skills and resources. For some participants this involved using positive self-talk or internal dialogue, which offered a sense of comfort. Positive thinking is considered a helpful form of coping in the mental health literature with Alexander and colleagues (2009) highlighting positive thinking as one of the most frequently used strategies for coping with intrusive thoughts. Drawing on their inner resources allowed the participants in my study to gain confidence and for some participants, this renewed
confidence resulted in a desire to take risks in the group sessions. This was apparent for Sam and Kate, who despite knowing that the songs they chose would potentially trigger intense emotions or memories, still chose the songs and tested themselves in an attempt to be in control of the way they responded to them. This process is understood within the mental health literature as ‘positive risk-taking’ and is described by Morgan (2004) as the weighing up of potential benefits and harms of exercising one choice of action over another. Positive risk-taking is an important step in the process of recovery as it requires the consumer to take responsibility for, rather than to conform to treatment (Stickley & Felton, 2006). In this case, Sam and Kate identified the risks involved in choosing a song which they thought may affect their mental state and still chose it, using their own resources and support from the group to achieve positive experiences.

Some participants in this study also described purposefully choosing certain songs during sessions in an attempt to control the outcome for them or for others. Collins was particularly articulate in describing her deliberate choice of ‘upbeat songs’ to try to change her experience of the inpatient group singing sessions. Making choices to exert control in sessions was also a theme in Rolvsjord’s (2015) music therapy study describing mental health participants’ contributions to the music therapy process. A common way of taking control in sessions in this study was described as choosing songs in an attempt to regulate emotions. Like Collins, participants in Rolvsjord’s study described choosing songs to feel a certain way or choosing a new song to change the intensity of the emotion they were experiencing in the music therapy session.

Another more practical coping strategy was described by a small number of participants as using singing to express and release feelings in response to hearing
challenging songs in their group. Lola described on many occasions a sense of empowerment and reduced intensity of emotions by releasing angry and painful emotions through singing. Historically, existentialist theorists like Rollo May (1972) have emphasised creativity as a way of feeling and expressing emotions. According to May, embodying our emotions allows us to express them creatively and use them in a way that is helpful for our mental health. In therapeutic group singing contexts, creative expression remains an important part of the role of group singing with Solli and Rolsvjord (2014) particularly describing the release of intense emotions through singing in a mental health context. In their study exploring the experience of music therapy with people in an inpatient mental health setting, they present one participant who, like Lola, described releasing anger through singing in the music therapy group. Similarly, Eyre (2011) argues that the expression of difficult emotions through singing for people with mental illness encourages them to not only recognise negative and stressful emotions, but to express and cope with these emotions as well. These descriptions of the coping strategies used during triggering encounters in group singing sessions demonstrate that mental health consumers who participate in these groups, already use their many resources to facilitate coping with triggering encounters. Consumers are active in their own therapy and group singing experiences and make use of the resources that music affords to process and cope with their own emotional experiences. Therefore, it is clear that one of our many roles as singing group facilitators and music therapists is to recognise and allow space for what consumers already do in our sessions to make them ‘work’.

The facilitator.

The role of the group singing facilitator in this study represents the largest group of conditions influencing participants’ experiences of being triggered by songs
in a group singing context. The group facilitator enters a collaborative relationship with participants with their own ideas, theories and “a tool kit of techniques and methods” (Rolvsjord, 2010, p. 202). In Rolvsjord’s conclusions and recommendations for future music therapy practice she emphasises a variety of characteristics of the music therapist’s role in mental health settings that also emerged from the analysis of data in my study. It is clear through the findings of my study that the facilitator’s role in a group singing context, includes not only their contribution in terms of the techniques they used (their ‘doings’) but also how they contributed to the collaboration with the consumer, their way of ‘being’ or their ‘beings’. The facilitator’s ‘doings’ and ‘beings’ are interrelated and are of equal importance in the group singing process.

**The facilitator’s attitude/ ‘beings’:**

According to Carl Rogers’ (1959) theory of client-centred therapy there are three core conditions or attitudes which are essential for fostering an environment conducive of personality change and growth within therapy. If the therapist is congruent, empathic and offers unconditional positive regard toward the consumer, an environment is fostered where the consumer can begin to make therapeutic change. Similarly within a resource-oriented music therapy framework, a therapist’s set of attitudes are considered their way of ‘being’. The therapist’s ‘beings’ are understood as strengths which enrich the therapeutic process and relate to the therapist’s personhood, adding a style, cultural attitude and relational quality to sessions (Rolvsjord, 2010, p. 202). The three core attitudes identified in Rogers’ theory of client-centred therapy (congruence, empathy and unconditional positive regard) can be appropriated to the group singing facilitator’s role or ‘beings’ within the context of this study.
**Authenticity/congruence.**

Hurdler noted that I as the facilitator brought something to the group, recalling a time that I had shared something about myself and that this was appreciated by the participants. Sharing something personal (also known as self disclosure) is a way of the therapist being authentic in their interactions with the consumer and can involve the disclosure of facts, feelings and insights (Hill & Knox, 2002). Authenticity or congruence is defined by Rogers (1959) as the willingness to relate transparently to people without hiding behind a professional façade. Within the music therapy context, congruence is known as authenticity. Music therapy scholar Ken Bruscia (1989) defines authenticity as “being who I am…an at-oneness between consciousness, intention, experience and action” (p. 105). In this case, I shared my musical background with the group and my experience of participation in choirs during my schooling years. Sharing of the therapist’s identity and music with consumers is emphasised as important in maintaining authenticity within a music therapy context (Rickson, 2009). Therapy is a collaboration where the therapist brings authenticity and genuineness and their personhood influences the therapeutic process. When the therapist shares their personhood this can equalise power in the therapeutic relationship and allow the facilitator to become more of a person to the participants so they can easily identify with them (Rachman, 1990).

**Empathy.**

Participants described appreciating their group facilitator’s ability to ‘pick up’ on and ‘check in’ with their feelings, while being sensitive not to push them to express their feelings when they were not ready. These descriptions are congruent with the theoretical understanding of the therapist’s role in creating an empathic environment in which the consumer can then decide themselves what they need from
the therapy (Joseph, 2010). Empathy is considered the second of the three essential conditions to therapy within a client-centred model (Rogers, 1986) and is defined as “the feeling or thinking of one personality into another until some state of identification is achieved” (May, 1989, p. 63). The client-centred therapist has an empathic appreciation of the consumer’s experience and communicates their desire to understand them. When participants feel a sense of empathic understanding from their facilitator, they are more likely to continue sharing and exploring their thoughts and feelings because they feel understood and accepted (Kleinberg, 1991).

*Unconditional positive regard.*

Unconditional positive regard was depicted through participants’ descriptions of their facilitators, using words such as warm, accepting and friendly. Participants reported a sense of being included and un-judged by their facilitator. By fostering unconditional positive regard, a non-judgmental, accepting attitude toward the consumer and their experiences was developed (Joseph, 2010). Unconditional positive regard is the final core condition described in Rogers’ (1951) model of client-centred therapy which involves accepting the consumer for who they are and listening to them without judgement. This condition stemmed from Rogers’ rejection of the expert-driven therapy models, believing they fostered a lack of respect for consumers. Instead, a therapist’s positive regard involves ‘prizing’ the consumer and their opinions and feelings.

A number of participants in the current study also described feeling like their facilitator believed in their ability to sing. Margaret was one participant who articularly described feeling like her facilitator gave her hope that she could be a singer. This was important to Margaret who had previously experienced being dismissed as someone with a disability within her local community with limited
resources and skills. Within a resource-oriented music therapy approach, unconditional positive regard is understood as the therapist’s belief in the consumer’s competence, resources and potential for therapeutic change. The music therapist believes in the consumer even more than their music therapy techniques or methods (Rolvsjord, 2010, p. 202). For people like Margaret who may have been previously excluded from society and stigmatised due to their mental illness, this is an important part of the role of their group singing facilitator.

_The facilitator’s ‘doings’._

What the facilitator ‘does’ in the context of group singing with people who have mental illness relates to the practical work that they contribute to the singing group. It is noteworthy that the participants from inpatient settings were the ones who particularly described the importance of having a relaxed and flexible environment in their singing group. Hannah provided an example of this when describing the importance of choice and freedom and how this differed from her experiences in other groups in the hospital. She spoke about having the option to ‘delve in to’ her feelings, or not, both negative and positive. In the other therapy groups, she felt this was simply expected of her. Further, feeling that expressing her feelings was optional made her more inclined to share with others in the group, not less. Freedom and control is also a theme in the music therapy literature, with McFerran and Sheridan (2004) highlighting how experiences of control in music therapy can contribute to quality of life and self esteem and can be fostered through opportunities for choice, promoting control and mastery. Dalton and colleagues argue that this is particularly important in inpatient mental health contexts, since there is little opportunity for self-determination (Dalton, Elias & Wandersman, 2001). In my work with Hannah, I intentionally provided empowering opportunities such as song choice and freedom to
take an active or passive role in discussion. This is similar to another Australian case study by van der Walt and Baron (2006) who highlight the importance of how a music therapist sets up the conditions for this to occur. Their study with a young person with mental illness, describes how the music therapist purposefully promoted opportunities for choice and control through sessions with the young person in hospital. Through the provision of such opportunities in inpatient group music therapy, people like Hannah have the choice to participate in the session or not, participate in music making or not, determine the degree of their participation, select songs and influence the progression of each session. This facilitates active decision making, which can enhance a person’s sense of control.

A different aspect of choice and control was noted by some participants in the inpatient context which was the freedom to come and go from the group. These participants appreciated the choice to attend the group in an inpatient environment where much of the therapy program was mandatory. Even though a number of participants contributed to this category, Kate described a particular facet of voluntary group participation explaining that she was more inclined to attend the singing group as it was something she had chosen to do herself, rather than being told to attend by staff. The difference between mandatory and voluntary music therapy programs has previously been noted in the music therapy literature with Baker (2013) specifically articulating this from the perspective of music therapists working in inpatient mental health settings. In her study which explored music therapists views on the factors that influence the song writing process, music therapist participants reported that when music therapy groups were compulsory, there was an increased resistance among mental health consumers to attend the group, while voluntary attendance facilitated increased engagement in sessions. Bryce and Wettone (2007) argue optional
attendance in music therapy is particularly important in settings where other aspects of the therapeutic program are mandatory. This further supports the importance of creating a flexible environment surrounding singing groups in inpatient settings where people can have control over the nature of their contributions to sessions.

Another feature of the inpatient participants was that they placed importance on their singing group not being based around gaining musical skills or having musical talent. In an inpatient setting where participants are acutely unwell and require therapeutic input, the group singing facilitator prioritises health outcomes over music skills and aesthetics. An Australian study by O’Grady and McFerran (2007) found that music therapists always prioritise the participant and their health needs, regardless of setting or state of health. Music therapists have insight into the association between music, health and development and an ability to work with people, and to meet their needs (Threlfall, 1999). O’Grady and McFerran’s theory of the role of music workers (music therapists and community musicians) provides a basis for understanding the different focus that each of the facilitators in my study brought to their group. These authors argue that a person’s state of health care is the most important factor influencing how the music facilitator works with them. The authors developed a health-care continuum which depicts health as a changing process and involves four major stages: acute illness/crisis, rehabilitation, community and wellbeing. The music worker adjusts their intention depending on where their music participant is situated on the continuum. As the music participant moves further along the health-care continuum toward well-being they start to move their focus from being just on themselves and their health (the internal), to include other people and the music itself (the external).
If participants are in an inpatient setting (presumably in the acute illness/crisis stage of healthcare), there is an increased need for the facilitator’s therapeutic input. It is likely in this setting that the participant would benefit from using music as a tool for the improvement of their health. Additionally, the participant in this stage has a reduced ability to learn new or use their existing music skills. Thus, in an inpatient setting where singing group participants are in an acute stage of illness, the music worker, who is therapeutically skilled, places importance on using music for health. This explains why participants in the inpatient settings of my study placed importance on being part of a group which did not focus on music skills, as it was not a priority for them or the music therapist facilitating their group at this time. Conversely in the community setting (presumably where people are in the rehabilitation, community and wellbeing stages of healthcare), the worker also focuses on music-making and the aesthetic value of the music. This may explain why participants in my study who were part of community singing groups placed more importance on learning or improving vocal skills, because their facilitator emphasised this as being the most important outcome of their group. The community musicians in O’Grady and McFerran (2007)’s study also tended to prioritise aesthetic value and social change when facilitating groups with people in the community.

There has been recent discussion within the music therapy community around the appropriate facilitators of mental health specific music groups in Australia. Currently in Australia there are a number of mental health specific community choirs facilitated by musicians. However, there is concern within the music therapy community that community musicians do not have the skills or capacity to facilitate the complex nature of these groups, and that they may be better facilitated by a music therapist. It could be that participants of singing groups who are in mental health
recovery living in the community need more therapeutic support to cope with the intense emotional reactions they experience in response to music, than what community music facilitators are trained to provide. However, the results from my study illustrate that this may not always be the case. A person’s reaction to and ability to cope with being emotionally triggered by music is dependent on many conditional factors including their mental state. Further, people with mental illness in the community are often more able to cope with their responses to music themselves without requiring external support.

This concern around the facilitation of mental health specific music groups in the community also relates to the fact that there is a growing number of organisations in Australia that are employing a combination of music and arts practitioners (music therapists, community musicians and other arts and health practitioners) with no clear distinction between their different roles and responsibilities. This has also been identified by music therapists in Europe and the UK (Ansdell, 2002; Tsiris, 2014). The lack of distinction between music workers’ roles in health settings has resulted in an uncertainty around professional boundaries and legitimisation in the music therapy community which has led to some music therapists becoming over-protective of their work, perceiving this uncertainty as a threat towards the de-professionalisation of music therapy. With the growth of user-led approaches within music therapy contemporary practice, music therapists are more commonly finding themselves working in domains traditionally occupied by community musicians. Although it is positive that music therapy is beginning to extend out to include practices beyond the traditional healthcare settings, it also means that community musicians are increasingly working with people experiencing complex illness and disability towards health-related outcomes (Clennon, 2013; Higgins, 2012).
There are many similarities between music therapy and community music practices, but the two professions are also differentiated on historical, professional and disciplinary levels. Their similarities and differences must be understood by considering their professional origins and their future directions. While the research and practice within the music and health domain continues to grow, I argue that our primary concern should not be that community musicians who are not therapeutically skilled may take music therapists’ positions in community mental health services, but that the individuality of each of our fields and the different skills we have to offer people with mental illness will continue to be ignored if we do not communicate with each other to articulate this. Overlooking the unique frameworks and skills associated with our practices could lead to unnecessary clashes for professional legitimacy. Instead, an ongoing exchange and curiosity between music therapists and other music and health practitioners is needed so that we can learn about and from each other. I choose to believe that choir facilitators in the Australian community have the capacity to facilitate community singing groups with people during their mental health recovery, and are doing this kind of work already. Of course, there are times when community musicians might benefit from consultation with music therapists to assist in their work, just as there might be times that we could benefit from the knowledge of community musicians in many aspects of our work.

Cross-disciplinary training and education could be used to facilitate the sharing of skills and knowledge between music workers who facilitate singing groups with people with mental illness. Oosthuizen, Fouche and Torrance (2007) offer a fine example of working in collaboration with local community musicians in their community music therapy project in South Africa with children who were vulnerable. The music therapists and musicians co-facilitated groups with the children, and while
the music therapists contributed an “awareness of and responses to group dynamics and interpersonal relationships that played out through the music” (p. 8), the musicians brought “concrete, defined musical skills and cultural knowledge” to the project (p. 5). The music therapists also facilitated a training session for the community musicians which taught them basic skills for working musically with groups and being sensitive to the individual and social needs of participants. Such training sessions would not be aimed at encouraging or teaching musicians to do the work of music therapists, but to offer them skills that they could use for facilitating music groups, and to learn to become aware of the complex dynamics that participants bring. Further, community musicians could offer useful cultural and contextual knowledge to music therapists working with people within their local communities. Naturally, there may be challenges to navigate when working together with, or teaching professionals who may feel that they do not need further training in this area. However, rather than controlling or dictating the area of community group singing and attempting to remove or disapprove of each others work with groups with people experiencing mental illness, I believe it is our role as music therapists to, where possible, offer clinical insights and considerations to community musicians, to help guide them towards helpful ways of working with their groups and in turn re-negotiate the borders of music therapy, generating space for collaboration and discussion with similar disciplines.

Peers.

Another major finding from this study was the experience of connectedness and belonging reported by the majority of participants. The homogenous nature of the singing groups, which only included people with a lived experience of mental illness, contributed to this experience. A number of participants in the inpatient setting
commented on the importance of being with others with lived experience in their group, which led to feelings of safety, shared understanding and a sense of being accepted by others. Mental health literature illustrates that peers are frequently identified as a source of support and encouragement during recovery (Mancini, Hardiman & Lawson, 2005). Jetten and colleagues (2014) argue that people who have a shared identity with another person or group, consider the relationships within that group particularly supportive. In this sense, homogenous singing groups which facilitate a shared experience of mental illness may shelter consumers from the social stigma and exclusion commonly experienced by mental health consumers in the wider community. Margaret was particularly articulate in describing her experience of being accepted by others in her group by comparing this with the stigma she experienced in her local community. Margaret identified feeling excluded because of her mental illness within her wider community, but in her singing group she did not feel judged for being unemployed or for living in supported accommodation. Absence of stigma and exclusion is also a common theme in singing and health literature with Lagace and colleagues (2016) highlighting how participation in homogenous singing groups can change how consumers identify being ‘a person with a mental illness’ to a ‘singer’ or a ‘choir member’, due to the absence of stigma within these groups.

It is noteworthy that it was the inpatient participants who valued a homogenous group including only other people experiencing mental illness. These participants also tended to describe using the support of their facilitator and peers much more than the community participants. Thus, for consumers in inpatient settings, homogenous groups are perhaps preferred as these people tend to use the support of their peers more often. Homogenous singing groups or singing focused music therapy groups are most commonly offered in inpatient settings anyway. In
community settings, however, both homogenous and heterogeneous singing groups are often available, and consumers must select a group which best suits their needs. An important factor in this decision is the timing or pacing of their recovery. Timing and pacing is an important feature in social inclusion and community mental health integration literature, with Bradshaw and colleagues (2007) particularly highlighting the importance of consumers’ changing needs during different stages of their recovery. They argue that it is not until several years into one’s recovery that they aspire to participate in ‘non-ill’ communities and activities. For the first two years after leaving hospital, consumers are more concerned with coping with their illness and gaining autonomy and control in their lives. After a number of years in recovery, however, consumers are often ready to not just receive services but to contribute to their wider community. Therefore, although homogenous singing groups are particularly important for consumers in acute stages of healthcare, and indeed were valued by inpatient participants in this study, consumers in community stages of healthcare may not be in need of attending a homogenous singing group.

Community participants appreciated the connectedness and sense of support they experienced through their singing group, but also described coping with challenging emotions using their own internal supports rather than drawing on the support of others. Homogenous groups may even be constricting to consumers who are in the later stages of recovery. Mental health and social inclusion research suggests that participation in community activities and groups should not restrict consumers only to a life of a ‘mental health consumer’ but rather should lead them to participate in mainstream community life when they are ready (Davidson et al., 2004; Fieldhouse, 2012; Mazzino et al., 2006; Wong et al., 2014). Shevellar and colleagues (2014) strongly argue that consumers must be supported to participate in activities
within their wider community when they feel ready. They believe that mental health consumers living in the community are caught in between two worlds; the world of marginalisation and the ‘normal’ world. On one hand, consumers want to belong to and be with people who are from the ‘normal’ world, while others wish to belong to those who are also marginalised, in a space that is warm and welcoming. Of course, if consumers like Margaret have previously experienced exclusion from their community, a singing group which they consider a welcoming and safe space is an attractive substitute to mainstream groups, and importantly allows them to feel a sense of belonging to others when they need this. However, there is a risk that participating in a singing group specifically for people with mental illness long term, will take the place of participation in mainstream community life.

Singing groups can play an important role in supporting mental health consumers to participate in both the mental health sub-community and mainstream community during different stages of their recovery. Consumers can be supported by music workers to make decisions around participation in singing groups, and may be offered different pathways between homogenous and heterogeneous groups based on the timing and pacing of their recovery. Supported re-socialisation is continuously emphasised by community mental health scholars (Mazzino et al, 2006; Davidson et al., 2004; Mandiberg, 2010; Fieldhouse, 2012; Wong et al., 2014) as being important in the pursuit of social activities not only inside the confines of the mental health system but also in the broader community. Mazzino and colleagues (2006) particularly argue that supported re-socialisation is helpful for increasing consumers social abilities and self-esteem in a supported and safe environment before moving on to take greater risks in other settings outside their mental health service.
Fieldhouse (2012) uses the term ‘scaffolding’ to describe the way consumers can be supported to progress through a series of community activities over time through the use of temporarily constructed support. The concept of scaffolding can be adopted to portray a similar type of progression for consumers participating in singing groups during their mental health recovery. The long-term aim for consumers should be participation in a homogenous mainstream singing group where they can connect with people outside of their mental health service and integrate with their local community. To get to this stage, consumers may need a series of ‘scaffolds’ or support options as they progress. These scaffolds could be: the safety of a homogenous group with other people within a community mental health service, participation in a homogenous group in the wider community, or supported participation in a heterogeneous group. These ‘scaffolds’ can be co-constructed through negotiation with the consumer and music worker so together a plan can be developed for the consumer’s progression to and from each group. For a practical example, if Tara, one of the inpatient participants in this study leaves hospital and discusses attending a new singing group in the community with her music therapist prior to discharge. Although she is feeling better in her mental health, Tara appreciated the safety and comfort of a homogenous group in the hospital setting and would like this again. The music therapist suggests she attend a homogenous singing group with others experiencing mental illness within her outpatient mental health service. The music therapist attends the first few sessions with Tara to offer her familiarity and support in this transition period and then leaves her to participate on her own. Tara attends the singing group for several months or a year and creates some connections with people with lived experience in a supportive and accepting environment. When she feels ready, Tara attends a ‘mainstream’ singing group which
is heterogeneous and located outside of the mental health service. At first she attends the new group with support from her music worker and at the same time attends her current singing group. Eventually she continues to participate in the mainstream group by herself and makes connections with other people in her local community. Within this supported framework, Tara would also have the opportunity to go back to the other singing groups or seek more support from her music worker to transition, as her mental health fluctuates.

Adopting a scaffolding approach to group singing participation, allows consumers the option to fully integrate in the broader community, remain in a mental health sub-community, or move back and forth between them both, depending on their mental health needs. This structure challenges the predominant mindset which views consumers as needing to be cared for within the confines of a specialised mental health service (Fieldhouse, 2012). However, this approach provides opportunities for music workers to support consumers to find a place in the community where they can use singing as a way of promoting their musical recovery. The availability of more than one option for music participation enables people to choose themselves what they think they need in response to their fluctuating mental health.

In concluding this section which described three factors (the consumer, the facilitator and peers) promoting musical recovery through group singing, I introduce Figure 2. This diagram depicts the diversity/range of singing group participation using a mental health continuum which summarises the content discussed in this section. A continuum approach to mental illness is often adopted by experts over a fixed ‘either-or’ state such as healthy or unhealthy. Instead, a continuum approach is used to represent mental health as something which changes at various times in our life,
without any clear or staged dividing point (Keyes, 2004). This continuum illustrates the way different consumers might be placed in a group which has differing features (facilitator, focus and group membership) based on their current mental health status and depending on what is available in the setting they are in (inpatient, outpatient or community). The ‘inpatient’ column assumes that consumers will be in a stage of acute illness, the ‘outpatient’ column assumes recovering consumers in a community setting based within a mental health service, while the ‘community’ column represents consumers who may be in settings which are non-mental health specific situated within the mainstream community. By using settings as the category rather than categorising by states or phases of mental health recovery of illness, I attempt to avoid depicting mental health recovery as a stage process (which, as illustrated earlier in this chapter comes with its own challenges). Instead I aim to broadly depict different settings or contexts in which people may be located during their recovery in order to represent a more practical approach to group singing participation. The typical consumer can be seen to move back and forth on the continuum which varies depending on the setting they are in, and also fluctuates depending on their mental health.
The first two rows beneath the continuum depict the different facilitator and primary focus of a group within a certain setting. As illustrated earlier in this chapter, consumers in inpatient settings require a focus on personal health and benefit from the specific input of a music therapist who is skilled in facilitating this. As consumers move through to outpatient and community settings, health outcomes are still important but the primary focus of musical skills and community inclusion is apparent. Consumers attend groups with a skill and inclusion focus which may be best facilitated by community musicians. The third row depicts the group membership which may be appropriate within different settings. As described in the previous section, consumers rely more heavily on peer support in singing groups when they are in inpatient settings and so benefit from being with others experiencing mental illness during this time. In an outpatient setting, a specific mental health group may still be well suited as these groups foster feelings of support and belonging within a sub-community. Once ready to participate in the mainstream community, consumers may
attend a heterogeneous singing group which is not mental health specific and facilitates community integration. Adopting a continuum approach to group singing participation offers a range of options for people who participate in group singing based on their mental health recovery. By responding to each consumers mental health and current setting for receiving services, we are able to offer groups which best suit their needs, fostering the most supportive engagement with music for their musical recovery. Additionally, by identifying and articulating the circumstances in which the different skills of music and health practitioners are needed within the group singing space, we can begin to re-negotiate the borders of music therapy and facilitate fruitful collaboration between similar disciplines.

**Musical Recovery in Music Therapy Practice**

The content discussed so far in this chapter provides an example of the many possible factors involved in musical recovery for people with mental illness. These descriptions are grounded in the group singing context, but different facets of musical recovery may be apparent within the many diverse contexts in which people engage in music making and listening. My descriptions of musical recovery so far attempt to offer examples of the factors involved in this process for the participants in this study, but by no means illustrate a definitive structure of musical recovery. Individual musical recovery journeys are unique to each person and each person’s pathway will be different. The results of this study demonstrate that musical recovery can be promoted within the context afforded by supportive others. The type of supported music engagement where musical recovery is promoted may be based on one’s own musical interests or capacities. However, for musical recovery to be utilised as a helpful framework within music therapy practice, music therapists must understand
and acknowledge recovery-oriented philosophy and its relationship to their work with people in recovery.

The focus on recovery based care has led to a more complex approach to mental health service delivery than that offered by the traditional biomedical model. These changes are reflected in formal policy documents around the world and govern the services in which many music therapists work. However, the quest to shift service delivery to a more nuanced recovery approach which makes room for consumer-led perspectives implies major changes to the traditional medically oriented outlook of music therapy within mental health care. Despite the attempts of scholars to illustrate the congruence between the principles underpinning both music therapy and mental health recovery practice (described earlier in this chapter), representations of music therapy work in this area highlight that recovery-oriented principles have not been fully grasped by music therapists to date. Much of the music therapy literature published in the last few years (as described below), acknowledges recovery as contributing to mental health care policy, and in some cases makes reference to scholars who note the congruence between both practices, however, many of the descriptions of research and clinical work in this area clearly still depicts a biomedical oriented approach to practice. One example of this is a research article exploring pivotal moments for mental health consumers in music therapy sessions. Gavrielidou and Odell-Miller (2016) briefly describe recovery-oriented care in their introduction of the article as being important for contributing to music therapy practice. The authors explore pivotal moments in music therapy which are described as powerful and meaningful moments or experiences for consumers which provoke change. These experiences are explored by interviewing music therapists and by reflecting on a case study from the point of view of one of the authors. Pivotal moments in music therapy
are described as contributing positively to consumers’ mental health ‘recovery’.

However, there is no acknowledgement that the perspectives of consumers (who are the people experiencing these pivotal moments) have not been included. It is important to understand music therapists’ perspectives on practice. Indeed the authors acknowledge that by better understanding the conditions important to contributing to pivotal moments in music therapy, music therapists can provide to encourage more of these experiences for their consumers. However, it must also be acknowledged that representations of work that includes consumers’ perspectives on their experience as well as ‘experts’, would more effectively reflect recovery-oriented practice. Similarly, in Lillian Eyre (2013)’s edited book ‘Guidelines for Music Therapy Practice in Mental Health Care’, there is one chapter out of the 25 chapters in the book, which focuses specifically on ‘adults in a recovery-oriented setting’. The segregation of recovery-oriented work from the rest of the clinical work described in the book, implies that this approach is novel or optional to practice in this area. These examples in the music therapy literature demonstrate the way recovery-oriented work could be seen as a separate approach to music therapy practice which one may choose to adopt in their clinical work. However, the results from this study illustrate that recovery-oriented principles within music therapy, are in fact essential for promoting mental health recovery, and that music therapy can be a process of recovery in itself. Indeed, in Eyre’s book, there are several chapters (i.e. Jackson, 2013; McFerran, 2013) which describe practice from perspectives which are consumer focused, strengths based and collaborative, all key principles of recovery-oriented work. It appears unhelpful then, for recovery-oriented practice to be segregated in this way.

The apparent lack of integration of recovery-oriented principles into practice is not limited to the music therapy literature. Recent mental health literature
demonstrates that although Australian mental health policy clearly articulates recovery as underpinning research and practice, the mental health sector in Australia is struggling to meaningfully collaborate with consumers (Byrne, Happell & Reid-Searl, 2016; Happell et al., 2015). It has been acknowledged that obstacles to consumer participation exist and negative attitudes from health professionals have been identified as a significant barrier to equitable relationships which enable recovery-oriented practice (Bennetts, Pinches, Paluch & Fossey, 2013). A study conducted by Milbourn and colleagues (2014) found that the everyday experiences of people with severe mental illness living in the community do not actually reflect the ideal recovery narrative described in policy. More than half of the 11 participants in their study described what recovery meant for them, but these descriptions did not reflect the reality of their current situation. Instead, a lack of involvement or responsibility in their own treatment was apparent as well as a lack of engagement in meaningful activities which promoted their recovery - two key attributes of recovery-oriented care (Slade, 2009). Similarly, in a study exploring mental health nurses’ views of recovery within an Australian inpatient setting, Cleary and colleagues (2013) identified that the government organisation participants worked in, did not adhere to the principles of recovery-oriented practice. It was noted by participants that although a recovery focus was endorsed at an organisational level in policy, this was not implemented at a practice level. This literature illustrates that although personal recovery may be important to people with mental illness, current descriptions and definitions of recovery do not always reflect the reality for people in recovery. It also demonstrates that the services providing care to these people do not always offer recovery-promoting support.

There are indeed challenges to incorporating recovery approaches into
practice, and, for music therapists who work within a medical model of mental health care, adopting a recovery-oriented framework requires a major shift in attitude and practice. Working in partnership with consumers can be an emotional process, involving the negotiation of new roles and boundaries, uncertainty and conflict arising from opposing objectives and interests, and struggles to obtain mutual gain from the collaboration (Leung & Lam, 2014). It is understandable that music therapists may be hesitant to acknowledge and realise the power of the consumers they work with, and fear the de-professionalisation of their skills and expertise in doing so. However, despite the possible challenges involved in implementing recovery principles into mental health care, it is now the mandated approach in Australian and international mental health policy. Therefore, as workers in mental health settings, it is important that music therapists become aware of and acknowledge their professional alignment with principles of recovery and their ability to practice within a recovery orientation in mental health services. We need to explicitly make links between our everyday practice and recovery principles and take a person-centred leadership role in the implementation of recovery-oriented mental health care in accordance with national policy.

The focus on user-empowerment within recovery-oriented care need not exclude the expertise of music therapists. The results of this study illustrate that music therapists and community musicians have a prominent role in musical recovery and can promote musical recovery through their many contributions to group singing contexts in collaboration with mental health consumers. A collaborative relationship with consumers in music therapy is a process that music therapists can strive for in their approach to working with people (Bolger, 2013). This collaboration is important for supporting consumers to claim ownership of their music experiences and to find
their own path to recovery (Lewis, 2012). However, to promote recovery within our work, a conscious choice must be made to take this collaborative, strengths based and empowering approach to music therapy practice. Continuing to strongly adhere to a biomedical model of mental health care risks fostering an unequal relationship where music therapists’ actions are considered more important than consumers’ contributions (Solli et al., 2013) which can hinder processes of recovery (Slade, 2009). In this way, there is a much greater risk of the de-professionalisation of music therapy occurring through the ignorance of new practice guidelines which require the use of recovery principles, than through being devalued as professionals by embracing a user-led approach.

Music therapy’s strong alignment with recovery principles affords the opportunity for the profession to play an important role in modelling how recovery practice can be realised. The musical recovery framework described in this thesis offers one example of the way music use can promote mental health recovery and illustrates the way music therapy can be a process of recovery in itself. The results of this study illustrate that supporting people’s musical recovery requires a focus on the strengths and resources of consumers and a fundamental belief that people have the capacity to use music as a health resource in their mental health recovery. Music therapy work that focuses on the lived experience of the person in recovery, highlights resources and strengths, and works in partnership with them draws directly on recovery principles as well as many existing approaches to music therapy practice (Ansdell & DeNora, 2015; Rolsvijord, 2010). Just as consumers must determine their own path to recovery and what recovery means to them (Slade, 2009), music therapists must also go through a process of adapting to a recovery-oriented
framework and discovering what this approach can mean to them in their own work (Solli et al., 2013).

**The Limits of this Research and Implications for Further Research**

It is important to critically reflect on the limits of this research to understand how it can contribute to the music therapy, mental health recovery and singing and health discourses. The first limit of the grounded theory study in this thesis was a noticeably less number of participants from community singing group contexts than inpatient contexts. It was difficult to recruit participants from community settings and the smaller number of participants from within this context meant that the theory derived from the data included more perspectives from people in acute episodes of illness than from people who are in recovery in the community. Further research would benefit from exploring the specific perspectives of community participants and how the conditions common to community group singing can promote recovery. This would offer a more detailed perspective on how setting, facilitator and other life factors influence musical recovery. In order to gain these perspectives, future studies may also benefit from a longer recruitment period or recruitment from more than two community singing groups.

Adopting a grounded theory approach to the main study in this thesis, meant it was important to acknowledge my influence as the researcher on the findings. A grounded theory approach embodies an attitude where it is impossible to exclude the role of the researcher, their opinions, assumptions and experience of the research since they are essential to the construction of the findings (Charmaz, 2014). This research was constructed by me, as the primary researcher and the participants who shared their stories with me. Therefore, the findings are contextually based in these perspectives. It is also important to acknowledge that although I strived to represent
the voices of the participants as accurately and strengths based as possible (Fairchild & Bibb, 2016), I interpreted their contributions through my own lens as a person without a lived experience of mental illness.

The use of different epistemological approaches throughout this thesis offered a unique experience for me as a researcher. This study was emergent and took many unexpected turns along the way. I tried to adopt strategies which allowed me to actively reflect on the emergent nature of the thesis. By embedding reflexivity into the writing within and between the chapters of this thesis I attempted to articulate the challenges and strengths that a pragmatic mixed methods approach contributed to this thesis. In this way, I endeavoured to be transparent on how my decisions, assumptions and experiences helped shape the research. There was great value in allowing the emergent findings from each phase of this study lead to and influence the next phase. I learnt to follow my instincts as a researcher and allow the voices of my participants to direct the research. However, there were also times that following an emergent design was messy and unpredictable. Allowing the voices of participants to direct the research required deep critique and reflection on my own perspectives on practice and acknowledging and exploring the limitations of this research design. However, both the challenges and strengths gained from using different epistemological approaches and the emergent design, led to a thesis which embodies the honest representations of people in recovery, the messy reality of clinical practice and the unpredictable nature of conducting research with people.

The results from the first study in this thesis described in Chapter 4 (Bibb & McFerran, under review) illustrate the many challenges involved in conducting research with people in recovery. The research process was experienced as disempowering for participants who reported to not understand the questionnaires
they were asked to complete. And, the Critical Interpretive Synthesis described in Chapter 5 of this thesis (Bibb, Baker & McFerran, 2016), illustrates that future research in the area of mental health recovery is best placed to include the consumer’s voice. This does not necessarily mean that research must only involve interviewing participants about their experiences through qualitative research designs. Rather, the findings from this study indicate that there is great importance in incorporating the voice of participants into the aims and design of the research, and in the tools used in the research that we conduct about them. Incorporating participants’ voices into these processes might mean collaborating with consumers to develop new tools which are understood by them and are sensitive to the fluctuating nature of mental illness. Or it may mean adapting our research designs to ensure that the research we conduct includes topics which are valued by and informed by consumers. User participation in the development of these elements to research, incorporates consumers’ expertise both in knowing what is best for themselves and in knowing how to meet their own needs in the best way (Fisher, 2002). Involving mental health consumers in research also empowers them as they offer accounts and explanations of their experiences (Leung & Lam, 2014). Incorporating these strategies into the research we conduct in mental health practice is imperative for fostering positive and empowering experiences of all epistemological approaches to research.

**Conclusion**

The aim of this study was to explore the role of group singing in promoting mental health recovery. To address this aim, I first conducted a mixed methods study which explored four participants’ experiences of group singing and measured belonging outcomes before, during and after a 10 week community group singing program within a community mental health service. The qualitative analysis revealed
that being with others, being heard, having a sense of purpose, achieving something and group size and setting were important to participants’ experiences of the group. As a result of the difficulties reported by participants in understanding the outcome measures used in the study, an added focus on their experiences of completing the outcome measures was included. The qualitative data related to this topic was analysed and presented separately in an attempt to privilege participants’ experiences of the research process. Results revealed that participants found the outcome measures cognitively challenging and the language used in the measures did not support the empowering intentions of mental health recovery. Then, a Critical Interpretive Synthesis was conducted to critically examine the measures used in mental health research and the assumptions surrounding their ‘reliability’. The self-report measures most commonly used in Australian mental health research in the last ten years were critically examined. Results indicated that many of the measures most often used in Australian mental health research do not align with the current contemporary philosophy of mental health clinical practice in Australia. The results of this study offer future researchers in this area factors to consider when choosing outcome measures which ensure increased accuracy of the data collected and foster positive experiences of data collection for participants.

The second study in this project provided opportunity for further exploration of the research aim by investigating which conditional and contextual factors are apparent in group singing that can promote recovery. A grounded theory approach was adopted which allowed for the exploration of likely explanatory models for understanding group singing in inpatient and community contexts. Collaborative interviews with participants endorsed the privileging of both the participants’ and the researcher’s role in constructing data. The final interpretation of the data, after 29
interviews, presented a theory of the way people experience triggering encounters after hearing and singing songs in the group singing context, and use the conditions of the group to regain a sense of health.

The new concept of ‘musical recovery’ provides a framework for understanding the process of regaining healthy relationships with music to promote mental health recovery. The results of this study demonstrate the many factors which promote and interfere with musical recovery within a group singing context including the consumer themselves, the facilitator, peers, triggering encounters with music and pre-existing music habits. Musical recovery offers a new way of understanding mental health consumers’ diverse and complex relationships with music. The development of musical recovery from this study illustrates that music therapy and group singing have an integral role to play within recovery. Not only do the principles guiding music therapy practice and recovery-oriented practice demonstrate congruence, but music therapy can ‘be’ a process of recovery in itself. This study was set in the context of singing groups for people with mental illness living in Melbourne and therefore must be understood within this context. However, it is also possible that musical recovery processes occur in many different settings where people in recovery engage in supported music use. I hope that the results of this study stimulate further discussion around the integral role music and music therapy can play in promoting mental health recovery, through the use of the musical recovery framework.
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Appendix Preface

Interview transcripts have not been included because of the size of the study. In conjunction with my supervisors I decided that the best representation of the data was to show how people’s statements had been categorised, rather than providing the raw data. As I have included participants statements categorised in their themes for study 2 in Chapter 6, I have only included the categorisation of the raw data for the nine extra participants for this study described in the ‘epilogue’ of Chapter 6.
Appendix A: Categorised Data for Participants in Epilogue

Triggering Encounters with Music

If I’ve related to something in the past and then, I hear a song it might bring up sort of emotions, particular emotions that are…difficult or that I might resist and I just [try to] let them be (John).

There are certain songs that will bring me back to certain times in my life. However, there will be music where certain events well…negative…well not negative but like memories I don’t want to think about….they remind me of home. But I don’t want to cos then I will feel sad because I want to go back…which you can’t do (Hugh).

The song I chose, it didn’t, well it was just nice to sing it out loud and to let it be. There were a couple of songs I didn’t choose, which have had personal meanings to me and they’re quite upsetting, such as a friend’s suicide so I would never ever ask for that song because it would bring back a lot of memories (Des).

I remember singing ‘Stand By Me’ and cos my husband just left me…and just really feeling that he hadn’t stood by me…I just wished that my husband had been able to stand by me, he’s got a new girlfriend now. I don’t think I listen to that song [usually]. It’s just in her [music therapist’s] book. [The song made me feel like this] particularly since coming in here (Bridgit).

You can always find something in every song. You sort of listen to songs in everyday life and you don’t really, you might appreciate the melody or the beat or the way it sounds but you don’t actually pay attention to the lyrics. But when you’re reading them like you do in music therapy, you actually acknowledge the lyrics and the subtlety and you can interpret it differently. I think that’s what makes it really…individual. And what one person may think of a line or what the intended purpose was could be completely different to how you interpret it (Sally).

The one that I really enjoyed yesterday was so much fun and it was a song that I had never heard before. It went along the lines of ‘this is my fight song this is my..’ like kind of I’m going to go out and get them and I’m going to conquer all my problems and…its got that determination to keep going. Yeah like a concrete, let’s fight our way out of our issues and we can conquer things and keep going kind of thing (Kay).

The one that does bring me undone is an old one called The Rose by Bette Midler. Cos I’m on my own and I have probably rotten self esteem and the line about ‘you think that love is only for the lucky and the strong’. I suppose that touches what I believe that that kind of joy won’t ever happen to me. Partly cos I don’t deserve it and partly because I’m sick, I couldn’t be in that kind of relationship anyway. I’ve sort of decided that I couldn’t really be in that kind of relationship because I’m not really well enough and it wouldn’t be fair to impose that on another person. So…it’s lonely. And that song is about…sort of loneness but hope too that there still could be something (Kay).
I wasn’t remembering a specific event…or somebody that I had lost…I was thinking of emptiness (Kay).

The first time I came in I was in a bad place mentally, you could say, very depressed and easily emotionally triggered. The music that we listened to or that we sang along with [music therapist], had very powerful lyrics and I sort of empathized with the writer of the song a lot. And so I was sobbing, like balling my eyes out the whole time. Yeah so like I tried I was trying to sing but I was like I couldn’t get it out. [I left because] I was sobbing too much and I didn’t want to upset people in the room or bring the vibe down (Collins).

[Being more susceptible to being triggered emotionally]I emphasise with the writer of the song, more than the group. Like I wasn’t even aware of the group, it was just me and the book. And I can’t remember the songs that they were but they were…they sounded like they were depressed people when they were writing these songs. So that resonated with how I was feeling at the time and it triggered that emotion to come out (Collins).

‘Country Roads’ was one of the ones that did trigger me the first time…cos I’m from the country…so you know ‘country roads take me home’ all that sort of stuff ‘to where I belong’ and all that and I was like ‘oh I’m missing the country’ (Collins).

Yeah I felt hurt. it’s heart felt. You know it touches on your heart strings. Pulls on your heart strings (Bridgit).

It’s like a wave. Cos it kind of…it gathers momentum and then it kind of peaks and crashes and then settles and then just sort of washes over you. You’re identifying the feeling. And so say it’s a sad song, you’re attributing why it’s sad to you and maybe a particular memory and so it’s sort of all these things are coming to mind and then you get that flood of emotion and then it passes over and then you get another emotion. [When it passes over] that’s the crashing of the wave. It’s like, I guess you can also say, it’s a build up of energy and a release of energy. So you get that release from it as well….after the build up of emotion. So the build up, and then it sort of may be challenging but then you get that release….afterwards (Sally).

One was yeah [of the songs that had meaning for me and someone else chose it] and I got a bit sort of reflective on that. That was a Green Day song ‘I had The Best Day of My Life’. That felt a bit sad because it was a young girl that overdosed [detail removed for confidentiality]. So that was very sad and it just brought back memories of her (Des).

The essence of your soul is being touched, by the music – the tune, and the words and the group (Kay).

It does touch deep things but for me it’s kind of the understanding in the song…that someone can touch how you feel. So I wasn’t finding that I was getting upset with memories that other people were, like getting really teary or almost unable to speak about whatever it meant to them. Whereas, I don’t know if this will make sense but I was nursing it. Like I thought ‘oh this is lovely and someone understands’ and yes it’s
sad but I could just keep on listening to this cos I identify with it. So it was sort of sad, comforting. You know, pain which hurts but it’s nice too? (Kay)

It’s good because normally you’re not allowed to feel that, well maybe in here but certainly in the world out there, you know ‘don’t be sad, be cheerful’. And you’re often not allowed to feel how you want to feel (Kay).

When powerful emotions come up for me…they are liberating, it’s freeing you know it’s liberating it’s nice (John).

Either the title or the first line or something I will just take to it and as I go through it will just mean more and more to me. But it usually tends to stir towards being a nice pleasant feeling for me. So when I choose a song it will be a nice pleasant feeling. And then I’ll perhaps hear another song that might be completely different. So I haven’t chosen it, but for me it will be ok that’s something that I wouldn’t have chosen but I still feel. I wouldn’t particularly choose myself but when it does get chosen I realize that it’s ok I’ve got a connection to that song too, just in a completely different way (John).

With the sad, then you get happy you know and without one you couldn’t have the other, yin and yang all that sort of stuff. And sometimes feeling sad for me has been difficult because of all the ‘shoulds’ and societal views that are being imposed on me and that I’ve worked through because as a man as a person, I’m allowed to feel emotions. And that’s ok because they occur and that’s part of human nature so it allows me to find that balance (John).

The music that we listened to it wasn’t really provoking, rather it created memories instead of re-living them, which was fine. But there was, most of the music I knew which was good. And it was like, it was surprise and wonder (Hugh).

Now there’s actually two songs now that will be associated with that group. Whether it be positive or negative, thinking ‘oh I would like to be back there’ (Hugh).

**Conditional Factors**

**Pre-existing relationships with music**

Every event I’ve ever been to has had some music attached to it somewhere. Every emotion has got attached to it (Des).

*J:* What’s been your experience of listening to that song at home?  
*Kay:* A bit the same. I don’t know whether I can say it’s hugely different on my song. But I could sit here probably and listen to ‘The Rose’ by myself and be the same I think.

The music I listen to generally…it hasn’t changed since I’ve been sick the past two months really, the music that I listen to…it’s kind of consoling (Tara).

The songs I’ve been listening to in this admission are generally songs to kind of help calm you or just something that I listen to for an enjoyment (Tara).
When I was 15 um and I first got quite sick and I was really sick and I was like suicidal and all of that, I remember listening to songs that were quite um…I just remember listening to a lot of John Mayer and it was really kind of…those songs can be really really triggering and like I can’t listen to them now at all. And a lot of my friends have the same thing with certain, with a certain artist or a certain song and yeah I can’t ever listen to like 99% of John Mayer’s songs because I just connect it to that time and that was like the worst year of my life so um yeah it’s really triggering like I can’t listen to any John Mayer (Tara).

J: Yeah ok. So it sounds like your relationship with music has changed then over time then, is that related to your recovery or just as you get older do you think?

Tara: Recovery and also emotional development I guess.

I think that the songs that I sometimes listen to are from a time when I was well. Like there’s this particular Laura Marling album - A Creature I Don’t Know- that I listen to if I’m trying to like get myself in a place where I’m feeling free and great I just remember being well enough to date for the first time. I was 19 but it was the first time, cos I got diagnosed when I was 15, it was the first time as a young person that I was well enough to like…go on cute dates and um just enjoy myself. And I felt really free and it was a really nice summer it was such an important time in my life in terms of being the start of wellness for me. I just remember feeling ‘wow I’m well enough to do this stuff now’ and that whole album was I just listened to it so much and I just remember that summer, like going on dates and like laying in the park with the sun and like eating ice-cream and going to the movies. It just reminds me of a really lovely time. I will still listen to it because I still love Laura Marling but yeah sometimes it is to you know to feel ok (Tara).

There are times where I’ve accidently listened to songs of his [John Mayer] over the years and it just, like I feel…I go into this state of mind where I’m just…like I feel absolutely horrible like….it just brings me straight back to those like how I was feeling in those years….and like oh my god it’s horrible (Tara).

We’ve all told each other what our triggers are, and like I know that you know xxx can’t listen to um Pink Floyd, and yeah and like xxx can’t listen to Bright Eyes and all of this stuff so…like my friends know what’s triggering and my mum…my mum pretty much knows as well because she knows the music that I listened to then. And it’s almost triggering for her as well because yeah it was really difficult for her as well (Tara).

[It can be consoling but] It can also be the opposite (Tara).

I think right now I have a really positive relationship with music but it used to be really not good. But I think it’s also because when I was 15 and I first got unwell, I didn’t have…you know, I was only in my first couple of admissions or whatever…and I think I’ve spent like a year and a half minimum in and out of psychiatric wards since then. So you know I’ve built up, I’ve had to build up like my resilience and all of that kind of stuff. So I think I’ve got myself to a place where my relationship with music is good. But I think then it wasn’t (Tara).

I think I definitely listened to songs that I could relate to in negative ways (Tara).
But I think that also went hand in hand with creating a better relationship with myself in general. Yeah I think that my emotional development and recovery from many different mental illnesses [laughs] went hand in hand with um…with how I listened to music and how I related to music and how I approached listening or…creating music (Tara).

I was listening to it recently and I think that even though…I guess…a lot of more country songs that I listened to when I was unwell, Taylor Swift songs are just somehow…they somehow just escaped the really horrible times. Cos there was a lot of like really horrible times from when I was like a teenager, but somehow maybe her songs were a little bit more positive or something and I don’t really associate them with all the bad stuff. Um yeah…so no I don’t think any songs that I’ve listened to lately have reminded me of stuff….(Tara).

Des: I’ve got an iPod full of you know 1500-2000 songs on it. It’s very diverse, very diverse, from Enya to Bread to Bon Jovi to Pink Floyd to Led Zeppelin…you name it.. everything.
J: So you don’t have the Green Day song or things like that on there?
Des: No no. I would have deleted that song.
J: Ok, so is that the way that you can kind of cope with that, by avoiding it?
Des: Yep yep.

When I came in here [hospital] last time I was actually quite suicidal and I chose some songs I wanted to play at my funeral. And to me, they’re messages to my friends. So as I said, music means many things to many people…and I was going to have somebody read out why I chose those songs. Every emotion is covered by music. You name it, it’s covered (Des).

Yeah I still like them. And that’s still why I chose them. They have a good meaning to me (Des).

Enya is a lot. Like the other day I was feeling a bit anxious so I just lay out there on the deck with a beanbag and put the Ipod on and just listened to Enya quietly and just mellowed. Plus I’ve got a couple of relaxation tapes I listen to as well. (Des).

When I cook. I like to cook and I listen to old Rock and Roll. Yeah so if I’m feeling good, all music yeah… (Des).

J: Ok yeah. And what if you’re feeling bad?
Des: I like Pink Floyd. There’s a lot of good messages in Pink Floyd, some of it the latest stuff. It just resonates with me. ….just some of the words. Yeah just to think about the music. I like music that I like to think about. But if I’m feeling stressed, like I said it’s Enya or a relaxation tape or something. I listen to the words, I listen to the beat yeah. …. I just like listening to music yeah, any sort of music. If I can find a beat in it then yeah it’s good.
J: Yeah ok. Except for the ones that sometimes bring up…
Des: Sad memories yeah. The Green Day one and there’s a couple of others…. 
J: And has there ever been a time where that’s just come on the radio or in the supermarket or…
Des: Yeah, I turn the radio down… if I’m in the car. Yeah and my mind will immediately flash back to that… so if I hear the song like in the supermarket, I will flash back to back girl and oh, take a deep breath and think of her and the suicide. Yeah I just wanna go ‘oh bugger’ you know? ‘I hate this song!’ [laughs]

J: And how would you feel after when the song had finished?

Des: Yeah I’d wait for the next one [laughs]. So whenever it’s done the fleeting thought’s gone. So yeah like I said if I hear the song, I’ll think of her immediately. Like I said, for every emotion, you can name a song, for every emotion. Yeah you know when I’ve been in love there have been songs you know between you and your partner and when you’ve been angry there’s been songs and when you’re breaking up there’s songs and…happy songs, sad songs, songs to dance to, songs to reflect to.

Music has been part of my life all the time. And even when I’m sad, there’s music I listen to. If I’m feeling sad, I’ll listen to reflective music, if I’m feeling happy, I’ll put on some old rock and roll and dance around the kitchen like an idiot and cook like a king [laughs] you know? Depends on how I’m feeling. I just love music (Des).

Yeah I’m just enjoying music again. That kind of dropped off. When I’m unwell yeah, the first thing. Yeah I will still listen to my music, but it’s more the Pink Floyd and…rather than the lighter rock and roll get up and dance when I’m not feeling well, yeah more of the reflective stuff. Yeah so [now] instead of just picking one album on the Ipod, I’ll let it shuffle through. And when it’s playing I’ll find a beat and I’ll enjoy it. Music means a lot to me (Des).

The music’s amazing, it’s… it can make me very sad but then at the same time make me very happy. Even hysterical like… um like if I’m sad I will usually… there’s two types of sadness. I will be deeply saddened where I’ll just play sad music and then there is a little sadness where I will play a bit of sad music and then end it off with some kind of happy music and I will go on about my day (Hugh).

To validate my sadness. It’s a way of expressing it without having to speak it out cos it’s [sighs] I don’t know why I’m sad half the time, it just is (Hugh).

I will sometimes use music as a way to prepare my day like an upbeat music to get me going…not all the time but just sometimes. Usually the same song for about a week in a row (Hugh).

J: Yep. Ok. So is there times where you know you need to feel sad and things and you put on the sad music, like you were saying…

Hugh: Yeah and sometimes the sadness will cause me to put the sad music on too. It goes either way. Sad music includes….like The Fray….And then there’s like neutral songs where it’s not too sad but not too happy and it’s more like calming. Just nice music to listen to…that isn’t too upbeat. Um and I use music to help me cope through…like when I go through the city, cos it’s not the best for me. Music will be a distraction and I do get looks when I start singing it out loud, but basically I don’t care anymore what they think (Hugh).

It would be euphoric… in a way. That’s probably the highest level. There’d be calming, happiness or motivation, and then sadness and then very sad and depressed. There’s like levels of….it really depends. It’s hard to gauge it’s usually
like in the moment. Each song usually feeds on from each. So I don’t have a set playlist (Hugh).

Sometimes [I will use it] to validate my emotion and then sometimes to pick me up or make me sad. Um yeah it really depends (Hugh).

When I am sad, there are certain, I will even go into certain episodes of TV shows to describe it…like there’s a certain line in an episode of xxx right at the end, and I’ll play it over and over. It’s only a 30 second clip, I can basically recite it now. And it’s like music in a way, it validates how sad and how angry and how…I don’t want to be here doing this anymore (Hugh).

I like how I can associate certain memories to music or certain sounds like yeah…oh I love it, I love it but hate it at the same time (Hugh).

I play 3 or 4 songs and then…I dunno I run out of sadness. Maybe it’s a way of putting all my sadness into that song so that I’ve run out of sadness then…I dunno…it usually happens at night, or sometimes in the day time and I’ll sleep it off or just think deeply for 15-20 minutes and then yeah just…yeah I think it’s a way to just put all my sadness into the song and then leave it there and come back to it. I come out of it not as sad (Hugh).

It [music] can put fuel to the fire and then make things worse and then I might not come out of it…or I’ll still come out of it really sad. But at that point I’m not even listening to music. I might listen to one song and then I know that the music’s not going to help and that further help is needed (Hugh).

Yeah cos it gets my mind off things. It will also describe how I’m feeling without telling… Like what I sing in my head will describe what I feel, rather than me saying it out loud. Like I’m going into the city today and I’m already planning on putting on the music, like the happier music—or maybe just the radio which is happier music rather than sad. Like this morning for example, I woke up and was deeply distressed. And music was not an option. So it’s a point where you’re so far to the right that no music will effect me or it will even make me worse, or no I don’t even relate, I disassociate with the music. I pretty much disassociate with the world around me when I’m in an anxious state of mind. So anxious that I space out. Or when I’m really really really really sad like I was this morning. Yeah. I’m not even concentrating on the music. I’m just focusing on my thoughts (Hugh).

J: Yeah. So when you’re feeling well and you’re having a good day in your mental health…
Hugh: I’ll be listening to medium to upbeat music. With the odd maybe sad song, I dunno.
J: And does it effect you? Does it change your mood do you reckon or is it still stable?
Hugh: Ah there’s like little ups and downs but it’s not major. So like usually if I’m sad, it goes up and down majorly. But the most common practice of music playing is when I’m sad I’ll listen to sad music and then slowly move my way up to the happy music, just listening to sad music, and then just listening to happy music.
J: Yeah. What happens when it doesn’t work? What do you do then?
Hugh: I just stay listening to sad music and then just shut it off. So I kind of get bored of the music and I go ‘I’ve had enough of music now’. Cos too much music in the day will ruin it. It ruins the fun and excitement of it.

I basically know what songs will get me going. But if I’m really sad and really anxious, it will do nothing (Hugh).

Music is just amazing. Honestly I reckon it’s saved a lot of anguish, further anguish. It may prevent me from further sadness. Like I said putting all my sadness into a song rather than continuing feeling sad and doing irrational things like hurting myself or just burying myself in the sand…and feeling super depressed (Hugh).

Music is…basically everything for me. It controls emotion, feelings…it even represents moments in my life. Oh I love music so much (Hugh).

Like listening to music [at home] and like getting into the song is something I do when I’m feeling good. I don’t really do it if I’m feeling really bad. Cos it would just make me feel worse cos if I’m feeling really you know raw emotionally…it will just dive in deeper. If I decide to stimulate myself with music yeah it would just get more raw basically (Bridgit).

When I was in a bad place…yeah basically, when I’m depressed I dunno like I feel very empathetic, I do hear the lyrics and I hear the stories and it does sort of trigger me sometimes. But I’m not in that space anymore and now I listen to…lately I’ve been listening to jazz on the TV, which has been nice and soothing and calming (Collins).

[When I’m unwell, I would listen to] sometimes hip hop, like Aussie hip hop, cos I can relate to that a lot. Like they’re Australian people that sing about their trials and tribulations and so I listen to that. Coldplay is a big one. I actually, like…’Fix You’ was…I dunno if this is too much to talk about but….’Fix You’ when I…I did try and commit suicide in xxx. And ‘Fix You’ by Coldplay was the song that was playing by my choice, at the time (Collins).

[If that song came up and I wasn’t in a good place] I wouldn’t have been able to….like….nup I won’t be able to listen to it. It would make me feel like I want to kill myself (Collins).

The other day, I was just listening along on Pandora and it came on, and I was just fine with it. I was like ‘wow this is actually quite a beautiful song, and it’s not horrible (Collins).

Even in the happy place, cos I was just sitting here painting and it came on the radio, and I was thinking about ‘wow like this is my funeral song as well and this was the song that was playing that day’ and how far I’ve come…like mentally (Collins).

I used to listen to a lot of heavy metal and stuff as well. That was a good release for me…sort of thing. Like I find it kind of calming. But not so much anymore now that I’ve found jazz…which is a lot more calming cos there’s no words….
When I was not in a good place mentally I usually listened to heavy metal yeah. I think it’s a bit of a release like…it gets the anger out…like…maybe to have it mirrored back to me kind of thing…like it makes me feel not so alone if that makes sense (Collins).

Collins: If I was unwell and listening to Coldplay, no I would go straight down into depression.
J: Right ok. So it would make you feel worse?
Collins: Yeah. I think sometimes when I have felt pretty depressed I have put it on…I think again it mirrors the frame of mind that I’m in and makes me feel not so alone. So I don’t know whether it did make me feel better or whether it did make me feel worse but I had it on when I tried to commit suicide so it probably made me feel worse at that point in time.

Jazz really chills me out, cos I don’t have to think about words…which could be triggering words. I feel calm and relaxed when I’m listening to jazz or when I’m listening to music that I enjoy, which you know could be a range of things like…it could be anything from rock to heavy metal to pop or anything like that…I feel nice and calm and relaxed. Whereas the sad songs and songs that have been at funerals and things like that, that can drag me down a little bit (Collins).

I do but when I’m sick I don’t [listen to music]. I don’t have the energy to go and put a CD on (Katherine).

I’ll listen to music to lift my mood and I have definitely still listened to music when I’m going through difficult times, in order to, sometimes just to transition. I’ll use that time if I’m feeling down or sad and to identify and attach to that to just to actually feel that emotion and not suppress it or resist that feeling and then, usually that leads onto lifting my mood again down the track somewhere (John).

I’ve got foxtel at home and I just turn channel V on or whatever and let the tunes play and generally when it’s um like electronic music, it’s usually always uplifting. However that’s the sound side to things, then the lyrics on top of that will definitely almost invoke a really pleasing or liberating sort of sadness when I do hear a song that I relate to and it makes me feel for something that’s happened or something going on, and that’s nice. And so I will actually sing along with it and feel into those emotions and that sort of stuff (John).

So if I’m having difficult experiences with emotions, I will generally put some hip hop on that I relate to and lyrics that are meaningful to me. And with the pop and the hip hop, that’s usually nice uplifting music as well and that’s generally what I do now (John).

[It is helpful] if I don’t or when I don’t attach to it too much, cos that can also be…it’s just finding a balance you know? Cos that’s where obsession in any direction gets a bit iffy…I play the song out too much (John).

Sometimes I will just not listen to it until those occasions when I know it’s when I want to feel sad or something like that or I feel sad and I don’t know how to actually feel sad, for whatever reason so that’s been another thing for me. I’ll know that I’m
feeling or going through something but I just don’t know what. So music’s a really good release for that (John).

Unless it just comes on. [And then] I do get into it, because I know that I’m in control of listening to that, and changing it...so yeah so it’s good like that (John).

The Role of the Group

Music therapy when you’re in there is a completely different energy to when you listen at home. Yeah you’re singing and listening with a different purpose. Sometimes I listen specifically to relate to a song [at home], but I never get them as intense as when I’m in a group…and especially with xxx. Just the whole setting, the guitar, her voice and the other people’s voices and the group energy, you just don’t get that through a pair of headphones. It’s the group environment. Cos you’re all coping together. You’re all riding the wave (Sally).

If someone else is experiencing something, I feel into what they’re going through as well. I connect with other people when I feel that they’re going through something cos I’ll understand that (John).

There was a lovely feeling in the group and I don’t think anyone wanted to finish...camaraderie. A sharing of your own and other peoples’ emotions. Normally we do that by words you know in some therapy with some fancy label, And people try to talk about them but this was a different way of doing it and probably not so intellectual. It’s more of a feeling thing when it’s music (Kay).

I think it’s more the sense of connectedness. We all experience in some way, the same feelings... but, we all sang together. And it was like we all understood each other’s appreciation for the music. It was special, we all had something in common (Hugh).

It was really good. I just liked the fact that you could sing and it didn’t matter who else was in the room, it was just like a good thing you could join in and no one was judging you (Katherine).

[It was] in a safe space I suppose as well (Collins).

It was nice just to be in a group of non-judgmental people and join in and stuff, it was nice (John).

It’s a nice environment and it’s a good forum. I know that people are open minded and accepting and that makes it a lot easier. However, I’m getting to a point where I will still say things where it’s appropriate anywhere, but in those forums it’s nice you know, I don’t really feel like there’s any expectation so I can just speak (John).

You could sing as loud as you liked, as bad as you liked and no one was judging you (Katherine).

The Role of the Facilitator

The fact that you could be relaxed and that was good (Kay).
Also how it’s played as well. So you can play a happy song slowly and it may sound like a sad song. And so you can tailor music to how you feel as well. So it sort of works both ways \((\text{Sally})\).

\[\text{Xxx[facilitator]'s got a beautiful voice (Kay).}\]

\[\text{She’s got such a beautiful voice and she plays the guitar so beautifully (Bridgit).}\]

And then sometimes she’ll change up the tempo. And when she changes the tempo, like if it’s a slow sort of song that’s heart felt and that sort of thing…it’s interesting because you will, I will really feel to it. And then the tempo, a change of verse or chorus and she’ll just speed up the tempo and instantly, it almost, it makes me laugh it makes me laugh and I instantly get happier and it’s like a different look \((\text{John})\).

The girl that sung it, she switched from one [song] to the other like…she was really good \((\text{Katherine})\).

Or if people reacted to the songs like they were really sad or it brought up something for them she was really good at just gently saying ‘oh what did that mean for you?’ \((\text{Kay})\).

And she’d say ‘oh but did it make you remember a particular thing’ or...and it was just gentle and people only had to say a sentence or two but I don’t think that was…it wasn’t threatening \((\text{Kay})\).

If I’m feeling something or going through something, it’s spoken to at like housekeeping too. If something’s bothering you and that’s why I speak my mind. I would hope that other people do the same. That’s where the facilitator comes in too, and is very good because they’ll sort of pick up on that too and just facilitate the group really well \((\text{John})\).

She’s just a lovely person, you know it’s just nice being around her \((\text{Bridgit})\).

\[\text{The Role of The Consumer}\]

\[\text{No if I'm feeling better I would probably be able to tolerate those songs (Bridgit).}\]

Your state of mind will definitely affect how you interpret it. Yeah I think that for me, when I have a hyper manic day or a manic day I’m completely blasé about the waves you know you could say I’m like a surfer…I ride them they don’t affect me at all, I love them. But...when I’m depressed sometimes I’m a person who can’t swim and the waves are deadly to me. You know I need a life saver to come and help me \((\text{Sally})\).

There was a couple of the same songs, but I dunno maybe cos of the medication and stuff that I’m on and maybe the things that I’ve learnt over the time. Cos it was about 4 weeks, 4-6 weeks, somewhere in between that, in between music therapy sessions. A lot had changed and you know I was able to…I didn’t feel triggered, I didn’t feel
emotional. I actually just was able to sing like everybody else was. And then I went along to her group just recently, and this was just after I got diagnosed with bipolar so I was empowered by the diagnosis, I was like I understand myself a lot more, medication was a lot better so I was in a lot better place. The first time I came in I was in a bad place mentally, you could say, very depressed and easily emotionally triggered (Collins).

I force myself to pick a happier song [in the group]. It just motivates me, makes me happier. I knew people were going to be doing sad songs, and I don’t want to relate sadness to that type of group, cos it was positive. So we ended up with a happier song and it left a positive memory (Hugh).

[I chose the songs I knew were going to] enlighten me yeah lift the experience yeah. I knew them and they’ve just always been happy songs (Des).

I deliberately chose upbeat songs rather than the really down ones, the real triggering ones so...I had a very different experience. Yeah I didn’t pick any of the slow songs, no (Collins).

Coping Strategies

Relational Coping

Cos you’re all coping together. You’re all riding the wave. So I sort of lean on other people to help me through (Sally).

Just going along with the group dynamic. Just being there, you know and singing with other people. [But] I would always go to music therapy here because here it’s all the supports are around you like you see your doctor everyday and there’s all the nursing staff here. There’s always people around you here you can go and offload onto. So when you’re in here it’s a very supportive environment so to go to music therapy. I’m not worried about getting into my feelings more in here, because it’s ok to feel in here (Bridgit).

I think listening to other people’s stuff was also good. Like somebody who picked ‘Stand By Your Man’, you couldn’t get much more opposite than ‘The Rose’. So that’s not my song, but you could tell that it was meaningful for that person. And if they said a little few words about it, even if they weren’t able to be very honest…it was enough to think ‘oh yeah that’s somebody else’s perspective’ and that was good (Kay).

It was good because other people were affirming it. Or maybe seeing other things or pointing out a different line or…but still saying…yeah it meant something (Kay).

I have had a tendency to not want to feel those emotions because I have been in positions where I feel like I am not able to express those emotions for whatever reason. So the experience becomes pleasant, it’s something that I’ve learned to sit
with and definitely be able to observe and identify what I’m feeling and it’s nice to be able to…I don’t think so much when I just say how I feel (John).

If I don’t speak or express my feelings, my views on these things then it gets even more sort of turmoil…I go inwards and it’s not as nice. So just to talk about things is definitely helpful (John).

So it’s something that I will just sit with and say at the end of the song, ‘yep that brought up this for me’ yeah and then that sort of works through it (John).

It’s a nice environment and it’s a good forum, so I know that people are open minded and accepting and that makes it a lot easier. I don’t really feel like there’s any expectation so I can just speak (John).

Internal Coping

It was in myself. I didn’t feel like I wanted to share…that my husband had left me, with the whole group (Bridgit).

And I didn’t want to leave the class cos I was enjoying it (Bridgit).

That’s where it’s different because someone else has chosen it so out of respect and honour to them, they’ve respected what I’ve chosen, it’s that mutual understanding you know (John).

Practical Coping

Sometimes you don’t know how to put feelings into words. And I think when you sing a song, you not only put them into words but you find a way of expressing. And I found that when they did, my singing…well apparently I can sing!...my singing became more stronger and more passionate and more confident. I think it’s because I felt such a connection with the song. And everybody else is doing the same thing...so you kind of don’t really care what any body else thinks. You’re just at one with that piece of music (Sally).

Well I stopped singing. I was just thinking. Yeah just thinking, I put my head down and yeah was just thinking about the girl (Des).

Regaining Health

Yeah. After a couple of songs, a couple of happy songs like…somebody asked for a happy song and it just uplifted the spirit again (Des).

Invigorated. And very…relieved and like I’d gotten a load off my shoulders. Just complex feelings. Like even feelings of you know loving someone and the complications it brings and just knowing how to put them in words sometimes or how to…yeah the happy songs or like…we sang ‘Fight Song’ and it gives you a sense of power. So there was so many emotions that you come out (Sally).
It’s extremely…it’s excitement, it’s joy, it’s pleasure, it’s happiness, it’s nice. It’s one of those really pleasing moods. Even if it has been something sad, as I said it’s still liberating so it sort of lifts that mood (John).

Like I felt very energized and sort of cleansed as well. Yeah so I don’t feel as blocked up here anymore in the throat (Collins).

I feel much better now and a lot more comfortable in my own voice. Like it doesn’t need to be a Beyonce voice or anything like that, it doesn’t need to be perfect, it can just be my own thing (Collins).

I see beauty in music again, whereas I saw pain in music before (Collins).

The more times I have those emotions evoked and the more times I coped with them and related to them, through maybe a lot of different songs…I think it would improve my mental health cos I reckon I cope better with when those emotions that the songs had triggered come up (Sally).
Appendix B: Study 1 Participant Information Sheet/Consent Form

Participant Information Sheet/Consent Form
Interventional Study - Adult providing own consent
St. Vincent's Hospital, Melbourne

Title
The effect of group singing on experiences of belonging and wellbeing in the recovery of adults with mental illness living in the community.
HREC-A Protocol 066/14

Protocol Number

Coordinating Principal Investigator/Principal Investigator
Jennifer Bibb

Associate Investigator(s)
Associate Professor Felicity Baker, Dr Jeanette Tampin & Professor David Castle

Location
St. Vincent's Hospital, Melbourne

Part 1 What does my participation involve?

1 Introduction
You are invited to take part in this research project. This is because you have a mental illness. This Participant Information Sheet/Consent Form tells you about the research project. It explains the intervention involved. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don’t understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your local doctor.

Participation in this research is voluntary. If you don’t wish to take part, you don’t have to. You will receive the best possible care whether or not you take part.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
• Understand what you have read
• Consent to take part in the research project
• Consent to have the intervention that is described
• Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.
2 What is the purpose of this research?

The aim of this study is to determine whether participation in a singing group has any effect on people with a mental illness living in the community. We aim to collect data that will help us find out about group singing’s ability to assist in your experiences of belonging and wellbeing in relation to your recovery from mental illness. We are seeking to undertake this study to test whether the questionnaires we ask you to complete are able to tell us whether participation in the singing program has any effect on you. This study also seeks to gain an understanding of your personal experience of participating in group singing and if and how this has impacted on your wellbeing. In order to do this, we will ask you some questions in an interview, about your experience of the group singing program and how you felt afterwards.

The results of this research will be used by the principal researcher Jennifer Bibb to obtain a Doctor of Philosophy degree. This research has been initiated by the principal researcher, Jennifer Bibb.

3 What does participation in this research involve?

Should you agree to participate, you would be asked to contribute in the following ways:

First, we will ask you to complete some questionnaires that ask you about how connected you feel with others, your mood, symptoms and general wellbeing. This should take about 20 minutes. Someone will assist you to complete these questionnaires should you require it.

Second, we will ask you to participate in 10 sessions of group singing located at the Hawthorn Clinic in a group activity room. During the group singing sessions you will sing music with about 9 other people who are also clients of St. Vincent’s Hospital Melbourne and participating in the research project. The music therapist is trained to provide these sessions and has experience working with people at St. Vincent’s Hospital, Melbourne. Each session will last one hour and you will participate in these sessions 1 time per week for 10 weeks. The sessions will be conducted on a Monday at 11am-12pm.

After five weeks of the group singing sessions we will ask you to complete the same questionnaires that you completed at the beginning of the study which will take about 20 minutes to complete. Someone will assist you with this should you require it.

After ten weeks of the group singing sessions and the program has finished, we will ask you to complete the same questionnaires that you completed at the beginning and middle of the study which will take about 20 minutes to complete. Someone will assist you with this should you require it. At this time, we will also ask you to participate in an informal interview with your music therapist. The interview will be audio recorded and will take approximately 30 minutes. The interview will be held in a private interview room at the Hawthorn Clinic on a day and at a time convenient for you.

We estimate that the total time commitment required of you would be approximately 13 hours over 10 weeks.

The researchers may access and collect information from your medical record that is relevant to the research project such as your age, diagnosis and contact details.

There are no additional costs associated with participating in this research project, nor will you be paid.
4 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with St. Vincent's Hospital.

5 What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however, you may benefit through connecting with others, feeling in a better mood, and an increased sense of wellbeing.

6 What are the possible risks and disadvantages of taking part?

We do not anticipate any real risk associated with participating in this study. It may be possible that listening to, or singing songs which are meaningful to you may cause you to experience difficult memories or thoughts. However, the music therapist assisting you is highly skilled and able to help you through any difficult experiences you have. If you become upset or distressed as a result of your participation in the research, the music therapist will be able to arrange for counseling or other appropriate support. Any counseling or support will be provided by qualified staff who are not members of the research project team. This counseling will be provided free of charge.

7 What if I withdraw from this research project?

Your involvement in the project is completely voluntary and you are free to withdraw your contributions at any time. If you decide to withdraw from the project, please notify a member of the research team.

If you do withdraw your consent during the research project, the researchers will not collect additional personal information from you, although personal information already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected up to the time you withdraw will form part of the research project results.

8 What happens when the research project ends?

After the research project ends and you are still a client of St. Vincent’s Hospital, Melbourne, you will return to your usual community treatment program provided by clinical staff. There is no intention to continue the singing group after the 10-week program has ended.

If you would like to be given a summary of the study’s results, please notify the research staff or contact the principle researcher via email: ljbibb@student.unimelb.edu.au. A summary of the results can be posted to you once the project is completed.
Part 2  
How is the research project being conducted?

9  
What will happen to information about me?

By signing the consent form you consent to the study doctor and relevant research staff collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. If you consent to participate, we will assign you a number and all the data we collect will only contain your number, not your name to protect your identity. Only the researchers will know your name and number. All information which may identify you will be kept in locked cupboards and in computer files which are only accessible via password protected files. Only the named researchers will have access to this information. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. Information about your participation in this research project may be recorded in your health records.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission. You should note, however, that since the number of potential participants is small, it might still be possible for someone to identify you.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to your information collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please contact the study team member named at the end of this document if you would like to access your information. Any information obtained for the purpose of this research project can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission, or as required by law.

Information obtained for the purpose of this research will be kept for seven years after publication of results and will then be disposed of in confidential waste bins. Electronic and audio files will also be deleted.

10  
Complaints

If you have any questions or concerns during your participation in the research project you will be able to talk confidentially with the researchers. If you have any questions about your rights as a research participant, then you may contact the Executive Officer, Research at St Vincent's Hospital (Melbourne) on Telephone: (03) 9288 3930.

If you have any complaints about any aspect of the study or the way in which it is being conducted you may contact the Patient Liaison Officer at St Vincent's Hospital (Melbourne) on Telephone: (03) 9288 3108. You will need to tell the Patient Liaison Officer the name of the person who is noted above as principal investigator.

11  
Who is organising and funding the research?

This research project is being conducted by a team of researchers – Jennifer Dibb, Associate Professor Felicity Baker, Dr Jeanette Tamplin and Professor David Castle and administered through the University of Melbourne.
12 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of St. Vincent’s Hospital and at the University of Melbourne.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). This statement has been developed to protect the interests of people who agree to participate in human research studies.

13 Further information and who to contact

The person you may need to contact will depend on the nature of your query.

If you want any further information concerning this project you can contact the student researcher and music therapist on (03) 9496 6490 or any of the following people:

Clinical contact person

<table>
<thead>
<tr>
<th>Name</th>
<th>Professor David Castle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Professor of Psychiatry, St. Vincent’s Hospital Melbourne</td>
</tr>
<tr>
<td>Telephone</td>
<td>(03) 9231 4751</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:david.castle@svhm.org.au">david.castle@svhm.org.au</a></td>
</tr>
</tbody>
</table>

Complaints:

If you have any complaints about any aspect of the study or the way in which it is being conducted you may contact the Patient Liaison Officer at St Vincent’s Hospital (Melbourne) on Telephone: (03) 9231 3930. You will need to tell the Executive Officer Research the name of the person who is noted above as principal investigator.

Research Participant Rights:

If you have any questions about your rights as a research participant, then you may contact the Executive Officer Research at St Vincent’s Hospital (Melbourne) on Telephone: (03) 9231 3930.
Consent Form - Adult providing own consent

Title
The effect of group singing on experiences of belonging and wellbeing in the recovery of adults with mental illness living in the community

Protocol Number
HREC-A Protocol 066/14

Coordinating Principal Investigator/Principal Investigator
Jennifer Bibb

Associate Investigator(s)
Associate Professor Felicity Baker, Dr Jeanette Tamplin & Professor David Castle

Location
St. Vincent's Hospital, Melbourne

Declaration by Participant
I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I give permission for my doctors, other health professionals, hospitals or laboratories outside this hospital to release information to St. Vincent's Hospital Melbourne concerning my disease and treatment for the purposes of this project. I understand that such information will remain confidential.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the study without affecting my future health care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print)

Signature Date

Declaration by Senior Researcher

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Senior Researcher (please print)

Signature Date

1 A senior member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature

SVHM Participant Information and Consent Form HREC-A 066/14 v3 dated 20/08/14
Appendix C: Study 1 Recruitment Flyer

Do you like to sing?

We are conducting a music therapy research project to find out about singing and its impact on health for people with a mental illness.

You are invited to participate in this singing group.

**Time:** 11-12 noon

**When:** Monday's starting 13th October (for 10 weeks)

**Where:** Hawthorn Clinic

**Who can attend?**

Any consumer of St. Vincent's Mental Health Service over 18 years old

No music skills or knowledge are required to participate

**How do I sign up?**

Ask your SVMHS health care worker/case manager
Appendix D: Study 2 Participation Information Sheet/Consent Form

Plain Language Statement for participants of choir or singing groups
Group singing and experiences of belonging in mental health recovery.

Researcher details:
Name: Associate Professor Felicity Baker, Melbourne Conservatorium of Music
Email: felicity.baker@unimelb.edu.au, University phone number: +61 3 90353057

Name: Professor Katrina Skewes McFerran, Melbourne Conservatorium of Music – Responsible Researcher
Email: k.mcferran@unimelb.edu.au, University phone number: +61 3 8344 7382

Name: Jennifer Bibb, Graduate Researcher
Email: jbobb@student.unimelb.edu.au, Phone number: 0432 959 014

Project details:
This research project is part of a graduate research project at the Melbourne Conservatorium of Music.

You are invited to participate in this project, which is being conducted by Associate Professor Felicity Baker, Professor Katrina McFerran and Ms Jennifer Bibb of the Faculty of the VCA & MCM at The University of Melbourne. This project has been approved by the Human Research Ethics Committee.

The aim of this study is to get different views about feelings of belonging and mental health recovery through singing together in a group. You are invited to participate because you sing in a choir or singing group. We hope to understand your personal experience of participating in the choir or singing group, including positive and negative perspectives. In order to do this, we will ask you some questions in an interview, about your experience of singing in a group with others.

What will I be asked to do?

Should you agree to participate, you would be asked to contribute in the following ways:

- We will ask you to participate in an interview sometime between June and September 2015 which will take approximately 60-90 minutes. You will be interviewed by Jennifer.
the graduate researcher. You may also be asked to participate in another interview between October and December 2015 which would take approximately 60 minutes. With your permission, both interviews would be audio-recorded so that we can ensure that we make a true record of what you say.

- At the beginning of the interview Jennifer will discuss with you a preferred pseudonym (a ‘made up’ name) for the researchers to use when talking about their research in the future.

Your involvement in the project is completely voluntary and you are free to withdraw from this study at any point. You are free to withdraw any of your contributions to the project at any time until the data has been mixed together and it is no longer possible to separate your contribution to the overall data. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with your choir or singing group.

**How long is my contribution expected to take?**
We estimate that it might take about 60-90 minutes for the interview. As mentioned above, you may also be invited to participate in a second interview of about one hour.

**What are the possible benefits of taking part?**
We cannot guarantee or promise that you will receive any benefits from this research. The information you provide in this study will help us to better understand the experiences of people who sing with others.

**How will any potential risks be minimised?**
We do not anticipate any real risk associated with participating in this study. It may be possible that talking about your feelings may cause you to experience difficult memories or thoughts. However, the music therapist interviewing you is highly skilled and able to help you through any difficult experiences you have. If you become upset or distressed as a result of your participation in the research, the music therapist will be able to provide you with a list of support services where you can seek counseling. You can also speak to any of the researchers or your choir leaders who may refer you to other support services.

Your treating team or choir leaders can help you to decide, independent of the researchers, about whether or not you would like to participate. Your decision to participate (or not participate) will not affect in any way your ongoing membership of your choir.
Will I be able to be identified as a participant in this project?
You are invited to participate because you sing in a group with others. We may use information you provide in your interview in relation to this group, but we would refer to you by a pseudonym (a ‘made up’ name) and would remove any contextual details that might reveal your identity. We would protect your anonymity to the fullest possible extent within the limits of the law and your name and contact details would be kept in a password-protected computer file separate from any data you supply. You should note however, that since the number of potential interviewees is small, it might still be possible for someone to identify you.

What about confidentiality?
Data codes and all identifying information are to be kept in separate locked filing cabinets and in computer files which are only accessible via password protected files. Only the named researchers will have access to this information. There are legal limits to data confidentiality. It is possible for data to be subject to subpoena, freedom of information request or mandated reporting by some professions.

What happens to my contributions after the project has finished?
Materials collected during this study will be retained for a minimum of seven years in accordance with the University’s Code of Conduct for Research. It is possible that the results will be presented at academic conferences and public presentations or published in academic journals or books.

What if I have concerns?
If you have any questions or concerns, or would like further information about the research project, please contact Jennifer Bibb (graduate researcher). Contact details are listed at the start of this Plain Language Statement. If you are concerned about the conduct of the project, please contact the Executive Officer, Human Research Ethics, The University of Melbourne, ph: 8344 2073.

What happens next?
Thank you for considering this invitation to participate in our research project. If you do decide to participate, Jennifer will provide you with a consent form. Please indicate that you have read and understood this information by signing the accompanying consent form and returning it to one of the researchers. Whether or not you decide to participate, this Plain Language Statement is yours to keep.

HREC: 090001 ETHIC APPLICATION ID: 1544059.1 DATE: 4.05.2015 PLS VERSION:3
Consent Form for participants in Choir or Singing Groups
Group singing and experiences of belonging in mental health recovery.

Researcher details:
Name: Associate Professor Felicity Baker, Melbourne Conservatorium of Music
Email: felicity.baker@unimelb.edu.au, University phone number: +61 3 90353057

Name: Professor Katrina Skewes McFerran, Melbourne Conservatorium of Music – Responsible Researcher
Email: k.mcferran@unimelb.edu.au, University phone number: +61 3 8344 7382

Name: Jennifer Bibb, Graduate Researcher
Email: jbibb@student.unimelb.edu.au, Phone number: 0432 959 014

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep;

2. I agree that the researchers may use my contributions as described in the plain language statement;

3. I understand that after I sign and return this consent form it will be retained by the student researcher;

4. I understand that my participation in this research project will involve:
   Being interviewed about my experience of community choir singing

I acknowledge that I have been informed that:
5. This project is for the purposes of research and the possible effects of participating in the research project have been explained to my satisfaction;

6. I am free to withdraw from this study at any point. Further, I am free to withdraw any of my contributions to the project at any time until the data has been collated and it is no longer possible to separate my contribution to the overall data;

HREC: 090001
ETHICS APPLICATION ID: 1544059.1
DATE: 6.07.2015
7. While every precaution will be taken to protect my identity if I choose to remain anonymous or be referred to by a pseudonym, the small numbers in this project may mean that I could be identified;

8. The confidentiality of any personal information I provide will be safeguarded subject to any legal requirements;

9. My contributions to this project will appear under a pseudonym in the Student Researcher’s dissertation and future publications;

10. Outcomes of this research may be published in other forms such as journal articles or conference papers;

11. I understand that the research will not directly benefit me.

12. My contribution to the project will be audio-taped.

Please tick:

I consent to my contribution to the project being audio-taped □ yes □ no

I wish to receive a short summary of the Student Researcher’s findings □ yes □ no

I understand that the outcomes of this research will be published in other forms such as articles or websites □ yes

Name of participant:______________________________________________________________

Participant signature:___________________________________________________________Date:__________________________

HREC: 090001 ETHICS APPLICATION ID: 1544059.1 DATE: 6.07.2015
Appendix E: Study 2 Ethics Approval Letters

16 July 2015

Prof K.S. McFerran
SCHOOL OF MUSICTHE UNIVERSITY OF MELBOURNE

Dear Prof McFerran,

I am pleased to advise that the Humanities and Applied Sciences Human Ethics Sub-Committee approved the following Project:

Project title: Group singing and experiences of belonging in mental health recovery

Researchers:

A/Prof F A Baker, Prof K S McFerran, J Lilb

ETHICS ID: 1344059

The Project has been approved for the period: 15-Jul-2015 to 31-Dec-2015

It is your responsibility to ensure that all people associated with the Project are made aware of what has actually been approved.

Research projects are normally approved for 5 years from the date of approval. Projects may be renewed yearly for up to a total of five years upon receipt of a satisfactory annual report. If a project is to continue beyond five years a new application will normally need to be submitted.

Please note that the following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

(a) Limit of Approval: Approval is limited strictly to the research as submitted in your Project application.

(b) Variation to Project: Any subsequent variations or modifications you wish to make to the Project must be notified formally to the Human Ethics Sub-Committee for further consideration and approval. If the Sub-Committee considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised Project.

(c) Incidents or adverse effects: Researchers must report immediately to the Sub-Committee anything which might affect the ethical acceptability of the project including adverse effects on participants or unforeseen events that might affect continued ethical acceptability of the Project. Failure to do so may result in suspension or cancellation of approval.

(d) Monitoring: All projects are subject to monitoring at any time by the Human Research Ethics Committee.

(e) Annual Report: Please be aware that the Human Research Ethics Committee requires that researchers submit an annual report on each of their projects at the end of the year, or at the conclusion of a project if it continues for less than this time. Failure to submit an annual report will mean that ethics approval will lapse.

(f) Auditing: All projects may be subject to audit by members of the Sub-Committee.

If you have any queries on these matters, or require additional information, please contact me using the details below.

Please quote the ethics registration number and the title of the Project in any future correspondence.

On behalf of the Sub-Committee I wish you well in your research.

Yours sincerely,

Ms Jennifer Hassell - Secretary
Humanities and Applied Sciences HESC
Phone: 93853311, Email: hassell@unimelb.edu.au

Research, Innovation & Commercialisation
Office for Research Ethics and Integrity
The University of Melbourne, Victoria 3010, Australia
T: 603 3134 5234 (internal) F: 603 7167 (internal) W: oree.unimelb.edu.au

304
Ms Jennifer Bibb  
The Melbourne Clinic  
130 Church St  
RICHMOND 3121  

9 December 2015  

Dear Ms Bibb  

Re: Project 271: Group singing and experiences of belonging in mental health recovery.  

I confirm that at the meeting of The Melbourne Clinic Research Ethics Committee held on the 9 December 2015 your letter (dated 11 November 2015) requesting review and approval of the above named study with the following study documents:  

- TMC Application Form  
- Research proposal (dated 11 Nov)  
- PICF Version 3 (dated 4.5.2015)  
- Consultants Permission Form  
- Letter of Approval from the University of Melbourne  
- Initial Interview Schedule Choir/Singing Group Participants (Version 2, dated 12.4.2015)  
- CV for Professor Katrina Skewes McFerran  

were tabled, discussed and approved. The Committee suggested that the study would be strengthened by the addition of a control group.  

Enclosed is the “Acceptance of Researchers Requirements Form.” The Acceptance of Research Requirements Form outlines the terms and conditions of The Melbourne Clinics Research Ethics Committees approval of your project. Please sign and return this form to the secretariat as soon as possible.  

I confirm for the record that although we do not list Committee members by name that the Committee is constituted and functions in accordance with the National Statement on Ethical Conduct in Research Involving Humans (2007) issued by the National Health and Medical Research Council (NHMRC) in accordance with the NHMRC Act, 1992.  

We wish you success with your future research and look forward to hearing from you further.  

Yours sincerely  

Prof Bruce Singh  
Chair  
Research Ethics Committee
Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:
Bibb, Jennifer Louise

Title:
Musical recovery: the role of group singing in regaining healthy relationships with music to promote mental health recovery

Date:
2016

Persistent Link:
http://hdl.handle.net/11343/124271

File Description:
BIBB. Musical Recovery: The Role of Group Singing in Regaining Healthy Relationships with Music to Promote Mental Health Recovery

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