DO YOU HEAR THE PEOPLE SING? THE IMPACT OF A COMMUNITY CHOIR IN A FORENSIC SETTING.

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Do you hear the people sing, singing the song of angry men?

It is the music of a people who will not be slaves again!

When the beating of your heart echoes the beating of the drums

There is a life about to start when tomorrow comes!

Herbert Kretzmer (1985)

Original text by Alain Boublil and Jean-Marc Natel

ABSTRACT

This study considers the health benefits that may be experienced by patients and staff in a medium secure forensic setting when singing in a choir. It also investigates how shared participation in choral experiences might influence the relationships between patients and staff. In addition, framed within the context of Community Music Therapy[1] (Pavlicevic and Ansdell 2004; Stige et al. 2010; Stige and Aarø 2012), this study explores how – and to what extent – the researcher's identity as a music therapist may be altered as a result of including a community-based approach to his work in addition to a clinically-oriented model.

The investigation was undertaken throughout a six-month period in which weekly rehearsals comprising up to eight patients and six members of staff were held; a short performance was arranged at the culmination of the project. Whilst studies exploring the use of choral singing in music therapy for people with chronic mental illness have been undertaken (Eyre 2011), there would appear to be a dearth of literature specifically investigating the potential benefits of this intervention with patients in a medium secure forensic setting. A qualitative methodological stance was adopted. Data were collected and analysed using Participatory Action Research (Stige 2005a; Elefant 2010) and key principles of grounded theory (Glaser and Strauss 1967).

Findings suggest that people may experience overall feelings of wellbeing such as enjoyment, warm-heartedness, excitement and fun as well as an increased awareness of posture and breathing. A sense of belonging, hope and contributing to a group may similarly be felt. In addition, opportunities for learning are provided and a sense of empathy towards others may be fostered. The results also suggest that shared participation in choral experiences can positively influence the relationships between patients and staff through feelings of benevolence for each other, a removal of boundaries and a deeper realisation of being a person in one's own right. Finally, results indicate that the researcher's identity as a music therapist is altered through the inclusion of a more didactic approach, a conscious working towards musical outcomes and a heightened sensitivity regarding the needs and abilities of service-providers as well as service-users.

Keywords: *Community music therapy, choral singing, forensic, medium secure, health, wellbeing.*

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[1] Whilst some authors refer to Community Music Therapy with the first letter of each of the three words in upper case (e.g. Pavlicevic and Ansdell), others maintain lower case throughout (e.g. Stige and Aarø). For purposes of consistency this thesis will adopt the former style of representation.

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1.   INTRODUCTION

Singing does not consist merely of producing notes and melodies, however beautiful, but rather first and foremost of entering into a relationship with another. Singing means being willing to share moments of great emotional intensity . . . To refuse such sharing makes it quite impossible to sing. (Lortat-Jacob and Benamou 2006, p.91)

1.1   General motivation

I work on a part-time basis as a music therapist in a forensic psychiatry clinic. This is a medium secure unit located within a psychiatric hospital that is run by the National Health Service. I am responsible for working with patients on either an individual or small-group basis. The work is challenging yet enormously rewarding and intriguing. As Chiswick states:

> For many, the particular fascination of the subject comes from two main sources. Firstly, in the fabric of individual psychopathology are woven complex social, environmental, cultural and familial threads which make each patient, and the manner of his presentation, unique. Secondly, there is nearly always a legal context to the examination and treatment of the patient which provides an additional, sometimes daunting, dimension to clinical practice. Mentally ill patients commonly present to the forensic psychiatrist in the most dire and tragic circumstances. (Chiswick 1995, p.1)

According to the Royal College of Psychiatrists (RCPSYCH 2014), forensic psychiatry is a "specialty which helps mentally disordered people who are a risk to the public." Within forensic services there are three levels of security: high, medium and low. The website for Mental Healthcare (Mental Healthcare 2013) describes a medium secure unit as a setting "for people who are detained under mental health legislation and pose a serious danger to the public."

Music therapy is well-established in this unit and referrals are made on a regular basis. The British Association for Music Therapy (BAMT 2012) states that "Music therapy can help in many clinical situations, particularly where communication is difficult due to

illness, injury or disability." Yet a dilemma would appear to exist; while this unit is considered to be a clinic, recent developments in music therapy suggest the need for a less clinical and more community-oriented approach to be adopted (Pavlicevic and Ansdell 2004). To set up and facilitate a musical ensemble such as a choir in this environment would afford fresh opportunities to consider potential health benefits and also to establish new relationships between different groups of people. These would appear to represent meaningful therapeutic objectives.

Working with choirs has been my main musical engagement and enthusiasm for many years. This has included conducting church choirs, university choirs and local operatic societies. In general, however, people participating in such ensembles will likely have had prior experience of musical education or training; they have been able, mostly, to read music and to cope with the demands set by regular rehearsing and performing. Thus, to an extent these are closed rather than open groups that may require entrance by audition and pre-suppose a degree of musical ability; at the very least, a commitment to attend on a regular basis and to respect the assumed authority of a musical director or conductor.

My initial aspirations for this choir quickly determined that this would be a different kind of musical ensemble; and for several reasons. Firstly, the prospective choir would comprise two distinct populations: patients and staff[2]. A hierarchy, therefore, was explicit due, not least, to the authority that the latter population would have over the former; while one group *lives* (against their will) in the setting the other *works* in the setting. Secondly, I should not assume that we would be working towards a performance. We would meet, certainly, and rehearse. Yet the members of the choir would decide whether or not we might perform in front of others. The nature of the environment and the inevitable confidentiality that must be maintained with regard to patients would render it highly unlikely that any form of public exposure external to the clinic could be permitted. Thirdly, we would probably not be reading notated music.

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[2] The opportunity was also given for students on placement in the setting to participate.

The need to be able to read music would likely dissuade people from attending the choir; we would learn, primarily, through listening. And fourthly, my own role would seem to be ambiguous; how might I present myself simultaneously as a therapist, a conductor, a piano accompanist, a voice coach, an overall facilitator and, of course, a researcher? Indeed, was it possible – or indeed ethical – to attempt to do this? To an extent, I would be adopting a multi-relational stance which, for some patients at least, could be potentially confusing.

With regard to different relationships, Lave and Wenger (1991) promote the notion of a web of relationships when they discuss communities of practice. Similarly, Leigh Star (2007, p.75) emphasises the inevitability of different relationships when she writes, "Relations between people, between different perceptions of objects, between nature and politics, between laboratories and administrations, to name but a few, *are part of a relational world.*"

In light of the above, a particular challenge would be to maintain a sense of balance and objectivity whilst being actively involved in the research process. My personal engagement was central – and positive – yet necessitated a constantly reflexive attitude. The significance of reflexivity to the research process is highlighted by Etherington (2004, p.32) when she writes that it encourages us to "explore our own construction of identity in relation to the data, our participants and ourselves and provides a bridge between our internal and external worlds." Similarly, as Mruck and Mey (2007, p.519) state, "To be involved personally is not a problem per se: personal experiences may lead to precious insights and perspectives, hardly accessible for researchers unfamiliar with such topics." One part of me acknowledged the fact that I had worked in this setting for almost nine years and that an initiative such as this would be personally energising. Another part, however, was cautious about placing my own musical and research interests before the apparent clinical needs of patients for whom I had a professional responsibility. Yet a desire had already been expressed by both patients and staff with regard to the possible establishing of a choir in this environment.

There was evidence, therefore, of initial momentum for an idea that would sit well with the notion of Community Music Therapy. As Pavlicevic and Ansdell (2004, p.30) boldly suggest when providing a rationale for this particular approach to music therapy, we should "throw theoretical concerns to the wind when appropriate, to follow the needs of people and circumstances, asking not 'what is music therapy?' and 'what is a music therapist', but 'what do *I* need to do *here*, *now*?'." This challenge represented my motivation.

1.2   Structure

This thesis will consider three areas of investigation. These are presented as follows:

- The potential health benefits that may be experienced by patients and staff when singing in a choir.
- The effect of these choral experiences on the relationships between patients and staff.
- A critical reflection of my own role as a music therapist in a clinic working in a more community-oriented way.

A review of literature in chapter 2 will critique specific areas pertinent to this investigation: namely, a broad definition of health that is relevant to the context of this study; a consideration of the relationship between choral singing and health; examples of choral singing that have taken place as part of music therapy practice; and finally, how developments in Community Music Therapy appear to resonate with the aspirations and potential outcomes of this project. The review of literature undertaken affirms that there is a dearth of empirical studies which have a specific focus regarding choral singing within music therapy practice in a medium secure forensic setting.

Chapter 3 will present the three research questions which reflect the areas of investigation outlined above. This chapter will also outline the procedures for obtaining ethical approval and provide details pertaining to location, sampling, recruitment and the distribution of information. Most of this chapter, however, will discuss the implementation of Participatory Action Research (PAR) as one of two approaches

deployed for the analysis of data; this will allow the reader to have an immediate and clear sense of the context for this research investigation.

In chapter 4 the research methodology chosen for this study will be presented. This will argue that a qualitative, interpretivist perspective is most suited for this investigation. Likewise, a justification for the choice of grounded theory and Participatory Action Research as the two research approaches will be made. This chapter will also discuss the procedures for data collection and analysis with regard to the focus group meetings and semi-structured interviews conducted prior to the commencement of the choir rehearsals and also at their conclusion. The process of analysis I applied to my own notes pertaining to each of the rehearsals through the compiling of a Professional Log will also be made. This will include a consideration of my own reflections on these rehearsals.

In chapter 5 I will present the results that have emerged in relation to the first area of investigation; the findings will then be compared to the earlier review of literature. Chapters 6 and 7 will discuss the results pertaining to the second and third areas of investigation respectively.

Chapter 8 will present a conclusion to this study which will offer reflections on the investigation as a whole. An overall discussion which will include recommendations for further research will mark the end of this thesis.

1.3   Conclusion

The quotation presented at the commencement of this chapter from Lortat-Jacob and Benamou (2006) emphasised the importance of entering into a relationship when singing alongside another person. Such a relationship, according to the authors, requires a willingness "to share moments of great emotional intensity" (p.91). A particular focus of this thesis is concerned with the perception of relationships. At the heart of this is my relationship with patients and staff in a healthcare setting. Yet it is also about the relationships *between* patients and staff. Furthermore, it concerns the relationships between different concepts of health and also of therapy. It is my view

that the *quality* of relatedness between different populations as well as between different paradigms is most significant. Within the broad context of therapy, Totton writes:

> What every therapeutic relationship needs is to be a *relationship*: a place where two subjectivities meet with each other, with all of the difficulty and painfulness this implies, but also with a developing willingness and capacity to tolerate the other person's otherness. (2011, p.243)

A laudable aspiration might be to move from a tolerating of otherness to a genuine embracing. This thesis will argue that choral singing can be a significant catalyst for this transition to take place.

2. LITERATURE REVIEW

When a people's voice rings out ennobled by art, one believes one hears the voice of an ennobled people. (Nägeli, cited in Ahlquist 2006, p.267)

2.1 Introduction

A search of databases, journals and key texts suggests that there is a dearth of literature regarding choral singing within music therapy practice in a medium secure forensic setting. This provides a sound rationale for the review of four distinct yet related areas that might helpfully address this central focus. Firstly, as the study is concerned with potential health benefits that may be acquired through choral singing, a consideration of what is meant by health in this particular context will be discussed. This will be followed by a review of literature pertaining to choral singing and health. Choral singing within current music therapy practice will then be explored. Finally, I will offer a brief review of some of the key concepts of Community Music Therapy as this represents a broad contextual frame for much of this thesis. The relationship between these chosen sub-sections and the central focus is presented in the Venn diagram below (Fig. 2.1)
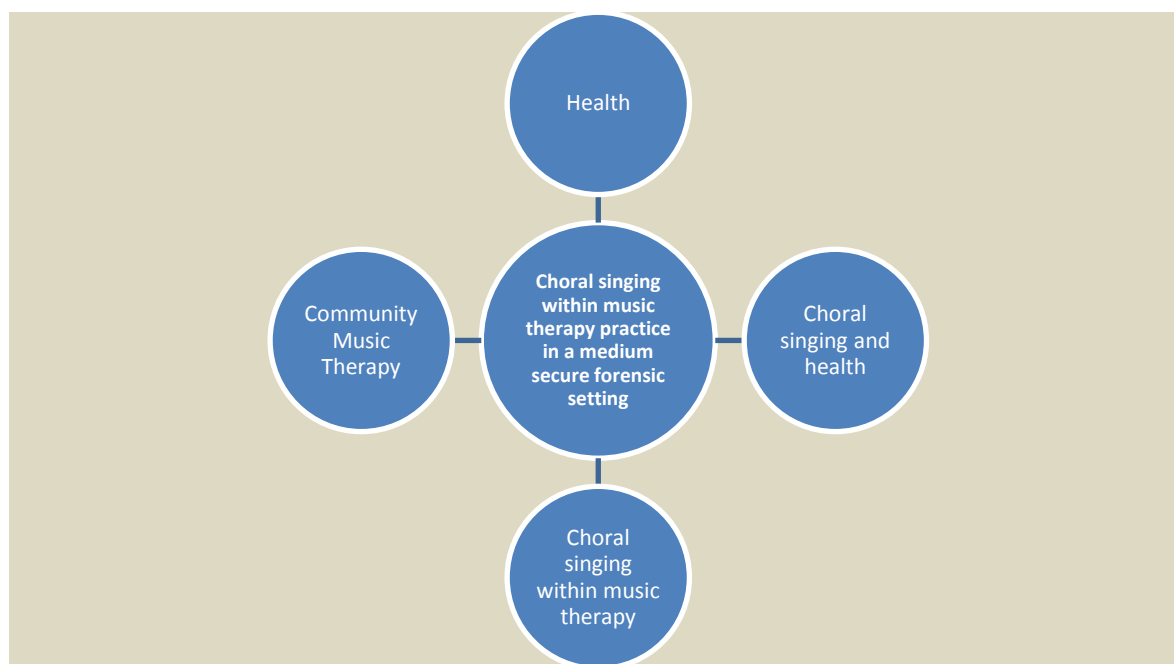
Fig. 2.1 The relationship between sub-sections and the central focus

2.2   Health

The aim of this sub-section is to consider a definition of health that is relevant to the focus of this study. The context of a clinic within a hospital that is run by the National Health Service has inevitable medical connotations. Yet a medium secure forensic unit represents a series of communities. These communities may be disparate and, to an extent, time-limited.   While they are situated within a health environment, a medical/biomedical model of health with a predominant focus on illness, treatment and quantifiable outcomes is one of several ways in which health might be implemented and evaluated in this setting. Practitioners – according to their training, experience and general philosophical approach – will practise in different ways. This study is based on a qualitative methodology and while seeking to discover if health benefits have been acquired, the research process does not feature invasive procedures such as the taking of blood samples or measuring of heart rate. Whilst not denying the relevance of these procedures to evidence-based practice, such processes do not feature in my own way of working which is primarily based on the quality and outcomes of the therapeutic relationship through musical interaction.

In 1947 the World Health Organisation (WHO) defined health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (1947, p.100). It is interesting that this remains the definition of health promoted by the World Health Organisation to this day. Arguably, it is all-embracing yet would appear difficult to attain or indeed sustain. Camic (2008, p.294) states that the WHO definition implies "innovation, adaptation and acceptance" which lend themselves favourably to experiences of emotional pain and grief; less medical in definition, perhaps, yet encounters that we all have to face at different times in our lives. Camic believes, however, that the healthcare systems of many countries appear to locate health almost exclusively within medical practice and therefore give scant attention to "the social and cultural fundamentals of society" (2008, p.294). He advocates that the arts offer a unique opportunity for the promotion of health in more natural and humanistic ways. White (2006, p.132) takes this further by proposing that the arts "encourage health-themed events where people can support each other and foster better lifestyle choices." Implicit within this statement is that the arts might offer

meaningful opportunities for health to be attained and that this may be achieved through mutual collaboration rather than, necessarily, a health professional treating a person within a medical context. To an extent, the concept of health becomes less hierarchical with regard to those involved in the process. Such collaboration would appear to be relevant and conducive to this thesis.

In light of the above it is clear that the World Health Organisation is cognisant of the importance of collaboration regarding mental health issues. In their 'Mental Health Action Plan 2013-2020' (WHO 2013) a particular emphasis is placed on a service delivery that is community-based:

> The core service requirements include: listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise. (WHO 2013, p.14)

Blaxter (2010) makes reference to the social model of health and how it draws upon holistic influences which are increasingly pervasive amongst Western societies. With regard to this particular model she writes, "health is a positive state of wholeness and well-being, associated with, but not entirely explained by, the absence of disease, illness or physical and mental impairment" (p.19). This would appear to represent a more inclusive and benevolent approach towards health and may therefore be favourably compared to the directions being promoted by WHO with regard to the area of mental health.

Health, ultimately, is experienced by individuals who will have their own understanding and opinions as to what health is. Blaxter (2010, p.49) acknowledges the complexities of myriad definitions by referring to the significance of "lay perceptions of health." Crawford (1984), for example, takes the view that:

> Health, like illness, is a concept grounded in the experiences and concerns of everyday life. While there is not the same urgency to explain health as there is

to account for serious illness, thoughts about health easily evoke reflections about the quality of physical, emotional and social existence. (Crawford 1984, p.60)

By making reference to the emotional dimension of health, one might infer that the potential emotional impact of a musical experience (such as participating in a choir) could have health benefits; for some people at least.

In a UK-wide study undertaken by Blaxter (1990) people were asked to reflect on what it felt like to be healthy. The sample size was 9,003 and comprised men and women of 18 years of age and over. Five main categories were identified: health as not-ill, health as physical fitness and vitality, health as social relationships, health as function and health as psychosocial wellbeing. This latter category proved to be the most prevalent definition amongst the majority of the different age groups, affirming the view that "health is a state of mind" (Blaxter 2010, p. 56). Once again the holistic emphasis is considered central to health and wellbeing and, as Blaxter (2010, p.69) later states, "To be healthy is to be happy, and the causes of many – perhaps most illnesses – lie in the psychosocial realm." This resonates with the current Health and Social Care Integration Narrative which seeks to establish closer links between health and social care professionals in Scotland (Scottish Government 2014).

The author and surgeon Atul Gawande writes movingly about perceptions of health – most notably within the field of palliative care – in his book 'Being mortal: illness, medicine and what matters in the end' (2014). While Gawande acknowledges the power of medical science in helping people to cope with the struggles of mortality, he argues that the medical professions have failed to admit the limitations of such power. Something else matters in the end. The author boldly states:

> We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive. Those reasons matter not just at the end of life, or when debility comes, but all along the way. (Gawande 2014, p.259)

Gawande is therefore asking each of us to consider the reasons why we wish to be alive; and in so doing lies the potential for wellbeing, to be well. Despite the limitations of life – even towards the end of life – the opportunity to be well can be a realistic aspiration.

A concept that may be considered to draw parallels with the psychosocial model of health is that of social capital. Halpern (2005) believes that social capital consists of three main components: a social network which comprises relationships between individuals and groups of individuals; social norms which determine the values and expectations of the respective community; and social sanctions which are the various means by which the norms are maintained. The political scientist, Robert Putnam, believed that social capital was a property of individuals and communities. An outcome of this is enhanced collaboration and a greater sense of social trust and organisation. He writes, "For a variety of reasons, life is easier in communities blessed with a substantial stock of social capital" (1995, p.67). This concept, however, is not without its critics; Bourdieu (1986), for example, suggests that social capital may be used to heighten social divisions and inequalities rather than alleviate them. Notwithstanding this view, Daykin (2012, p.68) notes that inequalities can be "contested as well as reproduced" and that participatory music-making (thereby including choral singing) may be one important way of redressing divisions.

Linked to this is the suggestion by Campbell and McLean (2002) that such processes may lead to members within groups forming a collective identity. This implies that identity is a fluid rather than a fixed construct and may have particular relevance for this thesis due to the two populations of patients and staff meeting through choral experiences. Dingle et al. (2012) discuss the significance of identity within the framework of social identity theory when noting the social and mental health benefits experienced by disadvantaged adults when singing in a choir. The authors state that there can be benefits acquired by individuals through strong identification with a group as well as simply being with others in a social context. Additionally, a negative impact upon wellbeing can be the outcome for people when leaving or changing groups such as a choir.

There is a sense here of personal investment amongst individuals in order to create meaningful communities; a need to acknowledge the importance of others and of forming relationships *with* and *for* others. One example of this is the work undertaken in Australia by Thiele and Marsden (2003). Using the medium of art with marginalised young people in Melbourne, the authors affirm the "social development potency" (p.83) of balancing artistic function with artistic outcome. Commenting on this project, Putland (2008, p.271) highlights the significance of art as "not simply a tool, but is always central and highly visible." Similarly, Stafford (1998, p.17) is keen to emphasise the "public and carnivalesque elements" of art – i.e. the product – as being no less significant than the process. Putland (2008, p.267) also writes of the health benefits that can accrue as people work together when she calls for a stronger focus on "groups and populations rather than treating individuals, the contributions of a range of sectors working co-operatively and the importance of participation by community members in initiatives to improve health." Lupton had earlier referred to this as "community empowerment" (1995, pp.52-53).

Underlying the notion of social capital and of the health outcomes that may be realised as a result of people working together is the sense of a positive experience. Feelings of enjoyment and pleasure may be motivating in themselves and therefore contribute to a greater sense of wellbeing. McQueen-Thompson and Ziguras (2002, p.31), for example, highlight the "durable and definitive" outcomes of such intense experiences and "physical sensations such as a 'shiver down the spine', a feeling of elevation, a brief moment of selflessness." A similar defence of pleasure and enjoyment as meaningful health outcomes are proposed by Coveney and Bunton (2003) and Matarasso (1997b). Arguably, the notion of the promotion of health through the cultivation of pleasure (especially when working alongside others) counters the more established view of health as a means of treating the illnesses of individuals.

Philippe et al. (2009) consider that passion may be a significant factor in contributing to the wellbeing of people. The authors undertook two studies in Canada to investigate the differences in wellbeing between passionate and non-passionate people comprising different age groups. A Dualistic Model of Passion was used (Vallerand et al. 2003;

Vallerand 2008) in which passion is described as "a strong inclination or desire toward a self-defining activity that one likes (or even loves), finds important (high valuation), and in which one invests time and energy" (Philippe et al. 2009, p.4). The findings suggest that wellbeing may indeed be enhanced when the level of passion experienced is harmonious rather than obsessive; i.e. when the desire to engage in the respective activity is under the person's control. With regard to this thesis this may relate to someone who wishes to engage in choral singing for the sake of the activity itself rather than as a means to further one's own status through public performance, for example.

While acknowledging the potential clinical benefits that may be acquired through participating in a choir, the particular focus of this study will instead consider possible interpersonal and social outcomes as well as the cultivation of a greater sense of wellbeing. According to Daykin (2012) the social context of participation in the arts has received relatively little research. The emphasis on relationships within and between communities appears to have some resonance with the concept of social capital and the overarching psychosocial model of health.

In conclusion, this section has alluded to the significance of mutual collaboration and a less hierarchical approach between individuals and communities in the attainment of health within a psychosocial model. At the heart of this is the sense of belonging and collective identity that may then be acquired. Feelings of pleasure, selflessness and passion – all of which may be associated with choral singing experiences – are contributors to health. Thus, for the purpose of this study it will be within this context which health is considered, explored and evaluated. This is the framework for the first area of investigation for this thesis: a consideration of the potential health benefits that may be experienced by patients and staff when singing in a choir.

2.3   Choral singing and health

This sub-section will provide a brief overview of literature pertaining to studies that may be considered non-clinical in nature – i.e. studies that have not been undertaken within the context of music therapy. Notwithstanding the considerable recent interest in the media regarding the implementation and proliferation of choirs (Malone 2013), empirical

studies investigating the potential health benefits of choral singing are relatively sparse. In one of the earliest papers, Clift and Hancox (2001) report the findings of the perceived benefits of singing as expressed by members of a university college choral society. The results were obtained from written questionnaires and indicated positive themes such as "meeting new people, feeling more positive, increased control over breathing, feeling more alert and spiritually uplifted" (p.248). Benefits, therefore, could be categorised as social, emotional, physical and spiritual.

A range of qualitative studies suggest that singing can have a mood-enhancing effect (Bungay et al. 2010; Clift and Hancox 2010), that it can help to bring people together (Latimer 2008; Lally 2009) and that self-confidence and self-esteem might be positively affected (Bailey and Davidson 2005). Studies of a more experimental nature measuring mood, emotional state or wellbeing of participants have generally been positive (Valentine and Evans 2001; Unwin et al. 2002; Cohen 2007; Sandgren 2009).

Clift (2012) reports, however, that while several research investigations have been made, these have often lacked a strong evidence base and have generally been exploratory in nature. While there would appear to be a broad recognition of the health benefits associated with singing, more controlled and robust research, according to Clift, is needed. Indeed this author has contributed to several studies which have sought to bring such robustness to the research process. One such study by Clift and Morrison (2011) explored how people with enduring mental health issues might benefit from taking part in choral singing. By adopting a widely used quantitative measurement tool – a CORE questionnaire – along with qualitative feedback from the participants, the authors noted significant improvements in mental health and wellbeing as a result of the experience[3]. The authors suggest, however, that the findings are limited due to the absence of a control group. Furthermore, they state that there is a need to "investigate the relative merits of social interventions of this kind compared with the use of anti-depressants and psychological therapies" (p.95). It is interesting that Clift and Morrison make no reference to music therapy in their study as one may reasonably ask why such

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[3] This is a self-report questionnaire which requires the client to respond to 34 questions each week as to how they have been feeling with regard to their mental health. A 5-point scale is used. (CORE IMS 2014)

an intervention as choral singing might not be included within the scope of music therapy practice.

Earlier, Clift et al. (2008b) undertook one of the largest studies in this field exploring the views of 1,124 choral singers from Australia, England and Germany. While findings were positive (e.g. improved mood and an enhanced quality of life), Livesey et al. (2011) subsequently researched in more depth the qualitative responses of a sub-sample from this large-scale, cross-national survey. The authors noted that benefits of singing were similar regardless of age, gender or nationality. These included social benefits (such as acquiring a sense of belonging) and physical benefits (such as improved breathing). In comparison to previous studies undertaken was the unique observation that choral singing was felt to actually promote health-seeking behaviour. Of particular significance to this thesis is the finding that participants who were considered to have high mental wellbeing reported similar responses to those who defined themselves as having low mental wellbeing; this significance is due to the potential comparison that may be made between staff and patients when singing together in a medium secure forensic setting. An indication, perhaps, of the pervasiveness of the choral experience regardless of one's mental health status.

Implicit within this sub-section is a consideration of the potential benefits to health acquired as a result of singing *with* other people; singing, therefore, as part of a group or a community. Within such contexts singing may promote belonging which would lend itself favourably to the psychosocial model of health discussed above. Barz (2006), for example, discusses the significance of the *kwaya* (choir) in Tanzania, East Africa. In addition to the opportunities for singing together the *kwaya*, according to Barz, acts as a "unique, interdependent social system" (p.21). Thus, the members of the *kwaya* are a community in their own right as well as part of a much larger community. Those who belong to the *kwaya* meet to pray and offer support and advice to each other as well as to sing. One might reasonably infer from this that without coming together to sing, additional outcomes from participating in the *kwaya* may not be so easily realised. Barz goes on to say, however, that such communities are not fixed or static; rather they are "fluid social structures that allow people of similar or dissimilar

backgrounds to cooperate on shared objectives" (p.25). This fluidity suggests that there is an openness to change and a continual need for new members. There is the sense, perhaps, of a demand to balance belonging with beckoning; the need to establish a group or community but to remain inclusive and inviting to others. Socially, at least, this would appear more likely to promote health.

The significance of choirs promoting the benefits of belonging to a community has also been discussed by Russell (2006). Within a different cultural context of the American city of Decutar in the state of Illinois, Russell comments on the diversity of choirs and musical traditions that may be observed in this environment. Notwithstanding the specific objectives that each choir might have, such as using music to entertain, to celebrate and protest, the common objective of each choir is "to express group solidarity" (p.56). This opportunity to belong and to unite seeks to include those listening to the choir – i.e. the respective audience – as well as the singers themselves. It is interesting to reflect on the power of singing not only to unite but to unite *against*; at least when the underlying motive is one of protest. Thus, it may be inferred that adversity breeds solidarity which can be powerfully expressed through singing *with* – and listening *to* – others.

The notion of protest as a unifying force through choral singing is countered, however, by Wolensky (2006). When reflecting on the significance of the chorus in the American labour movement throughout the latter half of the 20th century, Wolensky comments that choral singing – rather than a form of protest against others – helped to "establish a presence, deliver ideological messages, and align itself with progressive politicians and social policies" (p.244). In this context, therefore, singing not only becomes a force for good but may help to foster relationships between disparate populations. This theme of adversity is also highlighted by Berg (2006) when he discusses the significance of choral singing to the Russian Mennonites. Despite the hardships frequently endured by these communities, choral singing played a "vital and sustaining role" (p.71) in demonstrating unity throughout such difficult times.

A more recent population to demonstrate the effectiveness of belonging to a group such as a choir – as well stating the benefits that may be felt in the area of emotional health – is the gay, lesbian, bisexual and transgendered community. Coleman (1999), artistic director of the Seattle Men's Chorus since 1981, comments that the objectives of Gay and Lesbian Association Choruses (GALA) were primarily non-musical. These included the provision of emotional and spiritual support for its singers as well as the nurturing of positive self-esteem, establishing stronger relationships with society as a whole and, perhaps most importantly, offering "to care for member singers affected by HIV/AIDS and other traumatic life experiences" (p.105-106). Similarly, Strachan (2006) notes that part of the mission statement affirmed by members of the Lesbian and Gay Chorus of Washington D.C. included the objective to "foster gender cooperation" (p.255). Therefore, notwithstanding the discrimination often felt by the gay and lesbian communities, choral singing was used as a means of reaching out to the larger society rather than protesting against it.

Malone (2013) has worked extensively in the setting up of choirs in different workplaces throughout England. These have included an airport, a Royal Mail centre and a National Health Service hospital. To a large extent, therefore, Malone has had to sensitively intrude on busy environments which comprise large and disparate populations. His underlying rationale would appear to be that the respective organisation might work more efficiently if the opportunity was afforded for people to come together and sing. Thus, the health of the workplace might be improved. In particular, the hierarchical structures implicit within such environments may become less pronounced; a removal of boundaries, perhaps. Of particular relevance to this thesis are Malone's reflections on working with staff in a hospital setting. He writes:

> I spoke off camera to a pharmaceutical porter called Aaron who told me that through being in the choir he had a new appreciation of how much pressure those further up the chain were under. Eddie, a tough-talking vascular surgeon, always entered rehearsals looking slightly flustered and had probably just come from cutting some poor soul apart with a very sharp scalpel. Sitting in the choir humanised them both. (Malone 2013, p.290)

There is, arguably, a degree of irony in a setting such as a National Health Service hospital, which is largely concerned with care and compassion, apparently lacking in the need to *be human*. How might, for example, such an attitude be subsequently felt by the respective patients? A reasonable assumption may be made that if choral singing can foster relationships between staff in a hospital environment – and thereby help those involved to feel better through belonging – such benefits may be observed and experienced by the patients.

As noted earlier, Lortat-Jacob and Benamou (2006) believe the sense of belonging that may be felt when people come together to sing in a choir can promote feelings of intimacy and emotional intensity. According to the authors one cannot help but become personally involved when singing. Such involvement, nevertheless, may be problematic as it is satisfying due to the potential of shared singing to be "a lightning rod for the emotions" (p.92). One might infer from this that it is difficult when singing not to be genuine; that one cannot hide when vocally expressing – with others – in this manner. To an extent, therefore, singing requires surrendering to the music that one is performing; an unconditional acceptance of the emotional direction of the composition. Furthermore, feelings of intimacy and emotional intensity when singing in a choir may be heightened due to the absence of another musical instrument being played. Marsh (2014), for example, writes of the vulnerability felt when singing unaccompanied in comparison to simultaneously playing a guitar. One's voice, therefore, represents oneself and such personal exposure may be daunting yet also personally enhancing.

Similarly, Nelson (2006) comments on how participating in a choir requires neither access to an instrument nor formal musical training. The sense of belonging may be facilitated due to the accessibility of an organisation such as an amateur or community choir. Yet Nelson also notes the particular significance that singing afforded the people of Russia both before and after the revolution in providing a creative outlet as well as developing the "aesthetic sensibilities and thus raise the cultural level of the Russian people" (p.141). Music – and choral singing in particular – is being seen here not only as a means of harnessing the collective energy of people during a period of extreme adversity; it is also a way of releasing and refining creative impulses that can lead to

greater artistic insight. In relation to this thesis it is interesting to reflect on whether adversity itself (as experienced most notably by patients) might act as a catalyst for the expression of aesthetic and artistic responses.

The potential of singing as a means of having an uplifting effect on society is discussed by McGuire (2006) when he considers the Tonic Sol-fa movement introduced by John Curwen in the nineteenth century[4]. Essentially a method of assisting people with the process of sight-singing, Curwen sought to use this as a form of establishing greater morality; not least amongst the working-class populations of the time. McGuire writes that the didactic qualities of Tonic Sol-fa helped to create "comradeship through the uniting of voices for a good purpose" (p.120). Within this context, therefore, the teaching of singing might instil a sense of discipline which in turn may foster a stronger moral compass within individuals, groups and – potentially – society itself.

An investigation by Kreutz et al. (2004), however, drew mixed results. The authors studied the effects of choir music regarding the immunological responses, stress responses and also the emotional states as experienced by members of an amateur chorale. While findings indicated that active singing helped to increase positive emotional states, it was also observed that listening to choral music had an increase in negative affect as well as a decrease in stress response. Young (2009) comments on this study by drawing attention to the perceptions held by participants regarding the purpose of a musical activity and also the potential impact of the lyrical content of particular pieces of choral music.

A specific way in which choral singing might benefit health is presented in the form of an individual case study by Balsnes (2012). By placing the findings within the context of a theoretical framework by music therapist Even Ruud (2010), Balsnes successfully demonstrates how singing in a choir can assist in the areas of "developing competency and empowerment, producing vitality, and as a resource for building social networks as well as a way to provide meaning and coherence in life" (p.249). Whilst Balsnes – who

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[4] Whilst the inclusion of this movement may be primarily of historical interest to the reader, its particular relevance to this thesis will be discussed in chapter 3.

is also the conductor of the choir featured in the study – is passionate about the potential health benefits of choral singing, an over-subjective tone is avoided due to the inclusion of Ruud's framework. Indeed, she makes several recommendations as to how these ideas might be further implemented through, for example, choral singing on prescription and the opportunity for choral directors to be trained how to work with choirs comprising specific populations. Her use of the term "musical fellowship" (p. 256) is thought-provoking and she helpfully aligns her findings to the concept of social capital as discussed earlier by Putnam (1995). Yet despite her clear allegiance to Ruud's model (2010) Balsnes does not make specific mention of the application of music therapy in her article.

A study undertaken by Davidson and Faulkner (2010) explored the ways in which frail, elderly people and their carers collaborated through singing in a choir. The choir was facilitated by two community choral leaders. The authors reflect on the considered way in which the two leaders encouraged the varied responses of the choir members: "There was never a sense of failure, and all individuals and all vocal sounds were accepted" (p.168); yet the use of carefully selected warm-ups and the inclusion of optional harmony parts afforded levels of challenge proportionate to the abilities of the members. The results of the study indicated significant improvements in social interaction between the carers and those who were being cared for; at times even to the point of the former population becoming dependent on the latter when singing together. Feelings of empowerment and greater physical wellbeing were noted. Surprisingly, perhaps, notwithstanding the value the authors bestow on music therapy (including community approaches to music therapy), they state that for this kind of choir "it is fitting and appropriate for groups to be run by community musicians and not specialist music therapists" (p.164). Arguably, Davidson and Faulkner (2010) seem unwilling to consider how Community Music Therapists might facilitate such groups with at least the same level of skill and sensitivity.

With regard to the effects of group singing in relation to changes in physical and mental health, one study undertaken by Cohen et al. (2006) revealed positive outcomes. This invited healthy elderly people to participate in singing activities over a two-year period

(for thirty weeks in each year) while a comparison group did not receive the intervention but did participate in the assessments. While the authors report positive outcomes from this study, such as less medication use and fewer falls for the intervention group, Clift et al. (2008a) identify problems with the presentation of data (e.g. the particular way in which the conclusions were established from the results) and suggest caution should therefore be applied with regard to the findings.

Dingle et al. (2012), however, undertook a longitudinal qualitative study in Australia with adults engaged in a choir over a period of twelve months. The majority of the twenty-one adults who participated had a range of chronic mental health problems; others had either physical or intellectual disabilities. Within a framework of social identity theory the authors observed three main findings from their study. These were personal impact (e.g. the experiencing of positive emotions, increased energy and emotional regulation), social impact (e.g. a sense of greater connection with each other as well as with the audience and the wider community) and functional outcomes (e.g. benefits to one's health and a stronger sense of routine and structure). The authors are careful to note that for people with mental health problems membership of a choir may also have negative consequences. The requirement, for example, to sing in tune and to remember words of songs may be stressful for some people as well as the need to simply get on with those around you throughout the rehearsal process. The authors appear to be acknowledging here the tendency that we have to self-judge our musical and social abilities in comparison to others. To put this more simply, perhaps, singing in a choir may reinforce feelings of inadequacy as well as heighten a sense of individual worth. Thus, there is an element of risk to consider if appropriate support mechanisms are not put in place.

The idea of bringing together different populations to sing together in a choir is discussed by Merkt (2012). The choir 'Voices' was founded in 2010 in Dortmund to address the United Nations' Convention on the Rights of Persons with Disabilities (2006). The emphasis on the choir was inclusion and it comprised mainly of people with disabilities and students of the Faculty Rehabilitation Sciences at TU Dortmund University. Comments from the students following a period of rehearsals and

performance indicated the experience had resulted in a heightened sensitivity towards the needs and abilities of people with disabilities. As such they maintain that an organisation such as an inclusive choir may help to establish a more inclusive society. Yet it is intriguing to note an apparent paradox with regard to Merkt's (2012, p.95) democratic approach whereby "The singer (and not the music) is at the centre of attention, which is different from the common ideal of traditional choir music", while the repertoire chosen to sing is solely at the discretion of the conductor. Her rationale for this is that "this choir is meant to provide new musical experiences for everybody, and not to repeat well-known pieces" (p.97).

Mellor (2013) reports on two studies which considered the views of university music students regarding singing, health and wellbeing as a group process. The findings of these studies have relevance to this thesis for two reasons. Firstly, both studies attribute particular significance to the emotional, inter-relational and psychosocial outcomes of singing as a group process. Secondly, Mellor highlights in the second of the two studies, reflections made by the participants on the concept of the leader of a singing group. The author presents the notion of 'relational consciousness' when she describes this as "becoming more consciously aware of the relational or psychosocial implications of the group process and how this is co-constructed, particularly between the leader and the group. This leads towards an understanding of a more inclusive pedagogy" (p.191).

While literature pertaining to the effects of choral singing in a medium secure forensic unit appears to be scant, some studies have been undertaken in prison and correctional settings. Nelson (1997), for example, found that 21 high-risk adolescent males experienced a positive shift regarding areas of self-perception when taking part in choral programmes. A qualitative study undertaken by Silber (2005) reported that adult females in an Israeli prison choir felt the experience to be a meaningful alternative to a criminal context and afforded opportunities for listening, forming new relationships and accepting criticism. Indeed, Silber was clear that an objective of her work with the choir was to devolve more musical decisions and responsibilities to the members themselves (e.g. the choice of repertoire) thereby challenging normal hierarchical structures

commonly observed in choirs. Similarly, Richmiller (1992) studied the residual effects of 17 prison choir participants and 10 members of the prison staff 29 years after a project undertaken between 1963 and 1966. There was a unanimous view that the experience had been positive. Indeed, one former member of staff reported that "A choir teaches that through cooperation with other people and through persistent and hard work the participants can produce harmony and inter-dependence and enjoyment for themselves and others" (Richmiller 1992, p. 49). Thus, a key factor in the work independently undertaken by Silber and Richmiller is the quality of the relationship between the conductor and the choir members as well as between the choir members themselves.

Cohen (2009) undertook two studies in which she compared wellbeing measurements between a group of prisoners singing in a choir with those not singing in a choir. The first study indicated a development of interpersonal skills for those taking part in the choir. Similarly, in the second study (in which the choir comprised prison inmates and also volunteers) quantitative data suggested that singing in a choir may enhance the wellbeing of the prisoners. With this latter study it is interesting to note that an important contributory factor to improvements to wellbeing were as a result of a public performance external to the prison setting. The music performed was mainly from the classical repertoire. Cohen writes:

> After the concert, the inmates received accolades from audience members while standing in a reception line. The evening concluded with inmates and volunteers sharing a home-cooked meal. These social experiences contrasted dramatically with daily interactions between inmates and staff at the correctional facility. (Cohen 2009, p.60)

It seems reasonable to suggest, therefore, that similar findings to the above studies may be found when working with patients and staff in a medium secure forensic setting. Studies such as these provide a rationale for the first two areas of investigation for this thesis: namely, the potential health benefits that may be experienced by patients and staff when taking part in a choir and the possibility of closer relationships between the two populations as a result of doing so.

In conclusion, it is clear that areas of commonality exist between themes which have evolved in this sub-section and those presented earlier in the discussion on health. These include the significance of belonging and a lessening of boundaries between disparate populations. The aspiration of a more inclusive society – the roots of which may be observed in an organisation such as an inclusive choir – links with the notion of social capital and a psychosocial model of health. Thus, it is evident that singing with others actively promotes health.

2.4   Choral singing within music therapy

A review of the literature suggests that diverse client populations have participated in choral singing activities as part of music therapy practice. This sub-section will first consider populations considered to be significantly different from those which comprise the main focus of this thesis. This will be followed by a review of studies which concern the areas of mental health, criminality and forensic settings.

2.4.1   Client populations external to the focus of this study

One of the earliest references in the literature to the use of choral singing in music therapy comes from Ragland and Apprey (1974); it is significant to note that the title of this article is 'Community Music Therapy with Adolescents'. The authors write of their experiences with 22 delinquent adolescents from the black community in Kansas. The goals they set were essentially behavioural; positive outcomes were noted with regard to attendance at school and general motivation. Furthermore, the authors noted how such outcomes could be witnessed in the overall community: "This has reinforced our belief that music therapy can be an effective tool in reshaping chaos and furnishing hope in the black community" (Ragland and Apprey 1974, p.155).

A much later project – although with some similarities to the one above by Ragland and Apprey (1974) – was undertaken by Canadian music therapist Vaillancourt (2009). This involved the mentoring of apprentice music therapists working with co-researchers towards social justice and peace through music. One of the co-researchers, Anna, commented on the ways in which children with behavioural problems came together in a unique way when singing in a choir:

> You know that in their regular classes they are no more than 10 [in number] because of their behavior problems. But when they come with me, they know very well that the goal of the choir is not to have inappropriate behaviors . . . They know this is a place of respect and right there it creates a 'bubble of peace'. (co-researcher Anna, in Vaillancourt 2009, p.154)

A study which was not originally undertaken within a music therapy context (Bailey and Davidson 2002) was later revisited by the same authors (2003) and considered in relation to the music therapeutic theory of Ruud (1997). This theory posits that musical activities which are culturally relevant to the respective participants can enhance quality of life. The original study by Bailey and Davidson considered how amateur group singing with homeless men in a French Canadian city might be used as a therapeutic instrument. The conductor of the choir was neither a music therapist nor a professional musician yet was described as having "special humanitarian qualities which contributed to the success of the choir" (Bailey and Davidson 2003, p.29). The authors note that his approach to facilitating the choir was both egalitarian and dictatorial; the former attribute related to his overall relationship with the choir members while the latter corresponded to his desire to have complete authority over decisions pertaining to the running of the choir, such as the choosing of repertoire to sing. It is interesting to note that on occasions the emotional content of some of the songs acted as a catharsis for some participants' earlier experiences which were difficult or even traumatic. This suggests, perhaps, a genuinely therapeutic impact rather than the use of music to potentially suppress or deny more challenging feelings. Through the use of semi-structured interviews, the findings of Bailey and Davidson (2003) closely related to those of Ruud. These included improvements to emotional health, mental stimulation, the cultivation of a sense of belonging and interaction through rehearsing and performing with others, and a heightened perception of identity.

Clark and Harding (2012) undertook a systematic review of literature pertaining to psychosocial outcomes of active singing interventions for therapeutic purposes. This comprised an analysis of fourteen studies; eleven of these were quantitative and three were qualitative. One of the quantitative studies (Leung et al. 1998) has particular

relevance for this thesis as it featured adults with schizophrenia who attended a psychiatric day centre[5]. The focus of the study was to compare the effects of karaoke singing and simple singing. The findings suggest that while karaoke singing appeared to have superior capacity for improving social interaction, some of the participants reported an increase in their anxiety levels. Clark and Harding (2012, p.94) noted that of the eleven studies based on a quantitative methodology only three indicated "statistically significant findings that were exclusively attributable to an active singing intervention": these were VanderArk et al. (1983) in their investigation with elderly adults in a residential care facility; Lesta and Petocz (2006) when working with adults with dementia; and Myskja and Nord (2008) regarding their study with older adults in residential care. Clark and Holding conclude their review by stating that the three qualitative studies appeared to yield findings which indicated the positive benefits of singing within therapeutic contexts more effectively than the eleven quantitative investigations. These comprise the study mentioned above by Bailey and Davidson (2002) regarding the perceptions from members of a choir for homeless men; a further study by Bailey and Davidson (2005) concerning the effects of group singing and performance for marginalised and middle-class singers; and an investigation by Pavlakou (2009) in which therapeutic group singing was offered to eight females with eating disorders.

It is interesting to observe distinctions within the music therapy literature regarding a choir of staff members singing *for* clients in comparison to a choir in which staff sing *with* clients. With regard to the former, Aasgaard (2004) discusses the benefits observed in a paediatric hospital setting when a staff choir performed songs to the children who were in-patients. His role was as an accompanist and deputy conductor, and while the children attended within an audience capacity, the choir – as part of its repertoire – performed songs that had been composed by the children themselves. Thus, the children had a specific contribution to make to the choir despite not being active participants. Rio (2005), however, reports on his work with a group of homeless people who were involved in a church gospel choir. In addition to engaging in the

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[5] Although this study may have more reference for section 2.4.2 it is discussed here in order to maintain continuity with the systematic review of Clark and Harding (2012).

performance of music, the participants contributed to the composing of the material used. In so doing, issues such as homelessness, substance abuse and interpersonal relationships could be explored in a new and creative way.

The opportunity for a choir to bring together different groups of people with disabilities is described by Elefant (2010) in her discussion of the *Renanim* choir in Israel. This choir comprised adults with physical disabilities and their experience of performing with another choir – *Idud* – whose members had intellectual disabilities. Elefant had noted the difficulties that arose during a performance when the *Renanim* choir appeared to be overshadowed by *Idud* in terms of volume and presence. Through listening to the opinions of the *Renanim* members – and working with them – they gradually found a way of interacting and performing more meaningfully with the other choir. Thus, the need to democratise the process of confirming protocols for the running of the choir was essential for the subsequent choral singing. It would appear that what may be termed as therapeutic qualities of flexibility, openness and client-centredness were necessary attributes for the facilitator of the choir and no less important than specific musical skills. In addition, there is a clear implication here from Elefant that the rehearsals are much more than a means to a public performance. Arguably, it is within the rehearsals that delicate yet deep work is taking place with regard to the unifying of different needs and abilities. Elefant affirms this by stating:

> A public choir performance is an event where the choir members and the audience experience and live jointly the same music at a given time. However, the times before and after performance are equally important as during the performance. (Elefant 2010, p. 211)

In 2009 the Centre for Brain Research in the University of Auckland set up a social singing group for people with neurological conditions and their significant others – e.g. carers and relatives. This was entitled the CeleBRation Choir and was the first of its kind in the southern hemisphere, focussing on people who had suffered a stroke or who had Parkinson's disease. Talmage et al. (2013) write that the study was framed within the context of person-centred self-management rehabilitation (Rogers 1961; Buetow 2011), Community Music Therapy (Pavlicevic and Ansdell 2004) and Neurologic Music

Therapy (Thaut 1999). Within this framework the concept of Choral Singing Therapy was devised. The authors state that "Choral Singing Therapy offers an accessible approach to communication, rehabilitation and improved quality of life for people living with neurological conditions" (Talmage et al. 2013, p.3)[6]. A particular feature of this concept was the choice afforded to participants with regard to the setting of goals, the format of warm-up activities, choice of repertoire, performance and the dissemination of research outcomes; the participants, therefore, had ownership of the choir. One example of the ways in which the conductor had to demonstrate flexibility is indicated by the authors when they write:

> Group singing of familiar songs may produce inconsistencies, i.e. several simultaneous versions of a phrase. Such songs may benefit from rhythmic or melodic simplification, and compromise may be needed where members are familiar with different versions of a song. (Talmage et al. 2013, pp.6-7)

Quantitative and qualitative data indicated positive perceptions from the participants regarding social and therapeutic benefits; these research outcomes have helped to further refine the model of Choral Singing Therapy.

Similarly, Tamplin et al. (2013) report on a study conducted with a community choir which comprised people with aphasia who had suffered a stroke, and their caregivers. The study involved quantitative and qualitative methodologies and took place over a period of six months. The findings indicated a reduction of psychological distress for those with aphasia as well as the establishment of five themes: increased confidence, peer support, enhanced mood, increased motivation, and changes to communication. The authors exercise caution with the findings as a result of a small sample size and the absence of a control group. The study, however, appeared well-constructed due to the adoption of a team approach; while a music therapist conducted the choir and was involved in the research process other professionals, volunteers and researchers contributed to the management of the project as well as providing an objective analysis of the findings.

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[6] The page numbers pertaining to this article are taken from the ProQuest edition; the original article from the New Zealand Journal of Music Therapy is stated in the References section of this thesis.

The benefits that may be acquired through choral singing as part of music therapy sessions for elderly people appear to have been frequently investigated. A study undertaken by Summers (1999) considered the experiences of elderly people in an institution when singing in a choir. This led to the author creating a reflective model of music therapy practice which affirmed the sense of community that such an idea can offer this population. In particular, Summers identified three core elements for this model: the establishment of a 'hello' space, the significance of the relationship, and the setting of a creative environment. Zanini and Leao (2006) introduced a therapeutic choir for elderly people and, through a qualitative study, observed an improvement in areas such as self-expression, self-fulfilment, consciousness, thinking and hope for the future. Knardal (2007) observed that choral participation for elderly people afforded opportunities for improvements regarding the maintenance of memory as well as physical and emotional benefits, and the provision of a sense of community. Stige (2010) discusses the significance of a *Senior Choir* for people aged between 70 and 92. In addition to helping with physical issues such as passivity and breathing difficulties, Stige notes the importance of creating a "culture of care" (p.269). Similarly, Myskja and Nord (2008) reported an increase in depression in a nursing home for residents with dementia when activities such as group singing ceased after the music therapist took leave of absence. Maydana and Brasil (2014) incorporated the use of chanting within a therapeutic choir for people ranging in age from 52 to 90. The choir had a particular cognitive focus and participants were introduced to aspects of music theory, harmony and the learning of different languages as part of the choral experience. Findings suggested that participation in this choir may lead to improvements in memory which, in turn, could facilitate better family and social relationships.

The significance of relationships between elderly people and university music education/music therapy students when singing together in a choir was explored by Bowers (1998). This intergenerational choir required both populations to rehearse and perform together; a 'buddy' system was implemented to facilitate the bonding between each student and one elderly person. The study revealed an increase in positive attitudes between the university students and the elderly participants; most noticeably

with regard to the attitudes held by the elderly members toward the students. Bowers notes that "Of particular interest was structuring opportunities to attack stereotypical behaviors often held by each group toward the other group" (p.8). It is clear from this study that care was taken to foster relationships between the two populations through simply *being* with each other as well as *singing* with each other.

The establishment of a choir for people experiencing grief as a result of the loss of a loved one is discussed by Wilkerson and DiMaio (2013). The CarePartners Grief Choir was facilitated by music therapists with the aim of creating a "therapeutic space where grievers may share the experiences of their grief journeys with each other – and with the community – through re-creative music experiences" (p.89). The authors are very clear that therapeutic needs are being addressed and that certain criteria are met before people can become members or "clients" (p.92) of the choir; these include the completion of a "comprehensive grief assessment created by the Bereavement Department" (p.91) and that they are felt to be appropriate for group work. While Wilkerson and DiMaio emphasise the therapeutic dynamic of the choir it would appear that the actual rehearsals have an educational element; this is exemplified by the inclusion of discrete musical goals such as singing in four-part harmony. The authors report that the experience affords the members – individually and collectively – a new sense of identity as well as helping to acknowledge their grief in a supportive environment.

Young (2009) investigated the potential health benefits of community-based singing groups for adults with cancer. She observed improvements in the social interactions between group members and also physical benefits through increased relaxation as well as heightened energy and motivation. With regard to emotional changes expressed as a result of group singing the author writes:

> It is almost impossible to sing without feeling emotion and this can lead to a needed shift in mood although the group facilitator needs to be prepared for a wide range of emotions to emerge. These emotions can be worked through musically as well as through group support. (Young 2009, p.20)

As a result of this study, Young provided guidelines for people who may wish to facilitate singing groups for people with cancer. Several of these guidelines would likely be equally applicable when working in a forensic setting – e.g. the requirement that participants should avoid being critical of any individual's musical abilities, and the need for the facilitator to be culturally sensitive to the respective backgrounds of the group members. There is a degree of contradiction, perhaps, when she states that the facilitator of the singing group should be "a skilled musician and a trained mental health professional which makes a music therapist educated at the graduate level the ideal candidate for this role" yet follows this almost immediately by saying that the facilitator should not have "any hidden therapeutic agendas. The healing processes are meant to occur through the musical and social experiences" (p.21). One may infer from this a dilemma or element of paradox with regard to the identity of the therapist; a dilemma which is a significant aspect of my own thesis. Thus, there may be a need to differentiate between the *abilities* and the *responsibilities* of the therapist; while the former is concerned with the sensitive implementation of musical events for people with disparate needs and abilities, the latter is more focused on clinically-oriented therapeutic outcomes. Young also recommends that the facilitator is a leader rather than a conductor and that participants should be afforded the opportunity to select which songs to sing. Yet it is pertinent to note that she highlights the need for sensitivity on the part of the therapist on such occasions when certain songs may evoke poignant emotional responses. Likewise, the decision as to whether the group might perform needs to be approached "with extreme care and caution" (p.22).

A more recent study by Young (2014) in Canada has investigated how singing might promote health and wellbeing for adults with high functioning autism/Asperger's syndrome. The results of this study were positive with the author arranging them under three headings of: Being (who one is); Belonging (connections made with the singing group environment), and; Becoming (achieving personal goals, hopes, and aspirations)[7]. It is interesting to note that the findings of this study are being used to develop training workshops for music therapists and other related professionals who wish to implement high quality singing programmes for people with complex or special

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[7] Taken from the author's PowerPoint presentation.

needs. This suggests a willingness to integrate the use of choral singing as a key part of music therapy practice.

Finally, a collaborative project between the Australian Music Therapy Association and an organisation called 'Music: Play for life' has particular relevance for this thesis. The project entitled 'Making Music Being Well' sought to bring people with and without disabilities together through different musical experiences. One such context was the Glorious MUDsingers in New South Wales which, through choral singing, facilitated a sense of community with disparate groups of people (Making Music Being Well 2012).

2.4.2   Client populations related to the focus of this study

A study by Eyre (2011) discussed how individuals with chronic mental illness benefited from their engagement within a therapeutic chorale. The choir comprised 16 people who were outpatients from a psychiatric department of a large hospital. A particular feature of this choir was that participants were bilingual; speaking either French or English. The responses from a self-completed questionnaire suggested that people felt positive as a result of their participation. In particular, individuals reported that areas of self-esteem, emotional expression, mood alteration, coping with stress, comfort level within the group, and the establishment of a regular routine had been helpfully addressed through rehearsals and performances. It is pertinent to note that while the actual thought of performing in front of others caused anxiety for some members, the sense of achievement that was felt following the respective performance was of significant value. While Eyre notes the potential benefits that a music therapist might address through the facilitating of a choir, she states that:

> There is nothing in the literature, however, that examines the reported effects of choral singing among persons with a chronic mental illness, nor is there research that describes the role of the therapeutic amateur choir as a mode of therapy for this population. (Eyre 2011, p.153)

The specific value that the setting up of a choir offered young people who were vulnerable to criminal influence is discussed by Pavlicevic (2010). This project, situated

in schools in South Africa, depended equally upon flexibility of roles and working alongside other professionals such as teachers as it did upon musical experience and expertise. Indeed, Pavlicevic is careful to point out that the music therapists involved in this project were not just *collaborating with* but also *dependent on* the teachers for a range of responsibilities. She writes:

> It is the teachers who help the music therapists access the schools and arrange the choir auditions, and help the music therapists get to know the drivers (and their phone numbers). (Pavlicevic 2010, p.229)

A project which is perhaps most closely related to the focus of this thesis is that undertaken by Merrick and Maguire (2012). Merrick, an occupational therapist and Maguire, a music therapist set up a choir for staff and patients at Broadmoor High Secure Hospital in England. The choir, known as the Broadmoor Vocal Group, was established in order to promote aspects of social inclusion. Patients and staff were invited to contribute their views through focus group discussion midway through the implementation of the project. Merrick and Maguire were keen to ensure that their approach was non-directive and sought to deploy a "servant leadership" style. While this was ultimately appreciated by those taking part there did appear to be some initial concerns about the devolving of responsibilities in a high secure environment. The facilitators of the choir, however, felt that the experience resulted in an increased sense of empowerment and ownership; indeed, they stated that "patients and staff principally found it inclusive, levelling, enjoyable and recovery focused" (Merrick and Maguire 2012).

There is therefore an absence of literature which looks specifically at the potential benefits that may be acquired by patients and staff in a medium secure forensic setting when engaged in choral experiences facilitated by a music therapist. Indeed it is interesting to reflect that the project initiated by Merrick and Maguire above was located in a high secure setting which, arguably, would have been a more difficult environment in which to challenge normal hierarchical structures. A sense of community, therefore,

is being fostered through the temporary removal of boundaries between staff and patients.

In conclusion, this sub-section suggests that aspects of the *profession* of music therapy – e.g. measurement and evaluation – as well as attributes of the music therapist as a *professional* – e.g. the ability to contain a wide range of emotional responses and the manifestation of caring, humanitarian qualities – provide clear justification for the facilitation of a choir as an event within music therapy *practice* in a medium secure forensic setting.

2.5   Community Music Therapy

This final sub-section of the review of literature will briefly consider the potential of music therapy to promote community and the different perceptions which may then arise when such steps and shifts are taken. The existence of an approach to music therapy which is called Community Music Therapy suggests a movement within the profession that should not be seen exclusively within a clinical context. This contrasts with Camic's view that, in general, "the arts therapies tend not to make use of community-based arts interventions nor consider non-clinical aspects of health care" (2008, p.288). Dissanayake (1988), however, believes that the continued existence of the arts as a powerful force owes much to their potential to promote feelings of mutuality between different people; arguably, a definition of community.

While it may be claimed that music has always been a form of therapy, it has only been in the past fifty years that music therapy as a profession has been formally recognised. In the UK, the establishment of postgraduate training programmes in the 1960s and the subsequent employment of music therapists paved the way for state registration of the profession of music therapy by the Health Professions Council in 1999 (Bunt and Hoskyns 2002)[8].   Daykin (2012) notes, however, that the transition to professionalisation may lead to an undue emphasis on medicalisation. Thus, it may follow that music therapists will draw less from their artistic roots in this process. Likewise, while music therapy has always been apparent in community contexts and

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[8] This organisation is now known as the Health and Care Professions Council.

initiatives, the concept of Community Music Therapy is relatively recent (Pavlicevic and Ansdell 2004; Stige et al. 2010; Stige and Aarø 2012)[9]. The development of this concept may be seen as a significant shift from more clinically-oriented forms of interaction in which client confidentiality, boundaries, pathology and an emphasis on the treatment of illness are more prominent. Instead, therapists will give greater consideration to the *place* rather than (only) the *person within the place*. As Stige et al. (2010, p.16) write, "Community Music Therapy is *not* a unified theory and practice, but a broad perspective exploring relationships between the individual, community, and society in relation to music and health." Similarly, Talmage et al. (2013, p.4) observe that this approach "positions the music therapist as an enabling therapeutic musician rather than a medical or psychotherapeutic practitioner."

The implementation of Community Music Therapy in clinical settings, therefore, requires careful consideration of the notion of medicalisation and also of boundaries. With regard to the former, Totton (2011, p.237) argues that there is an urgent need to halt what he describes as the "re-medicalisation of therapy" and the development of the "normal practitioner." Although Totton is referring here to therapy in general rather than music therapy in particular his views resonate closely with this profession. He urges caution against the professionalisation of therapy where it aligns itself too closely to medical models of working and a "safety-obsessed culture" (2011, p.233). Implicit within this is the risk that the therapist will lose a degree of individuality and authenticity as a consequence of maintaining therapeutic boundaries. Indeed, Totton is quick to point out that the concept of therapeutic boundaries did not start to appear in the respective literature until the 1990s. He writes:

> Therapy is as much about questioning boundaries as about asserting them; as much about supporting clients to break out of the rules as about teaching them to observe the rules. For some clients, often those who have been abused in childhood, it is crucial to know that the therapist will act within a defined frame. For others – or even for the same client at a different point in therapy – it is equally crucial that the therapist dances outside the frame, and that a trust can

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[9] These publications represent the more recent international interest in Community Music Therapy; due respect, therefore, is given to the article by Ragland and Apprey (1974) discussed in section 2.4.1.

be established which is based on authenticity rather than predictability. (Totton 2011, p.243)

It is likely that those embracing a community or more social model of music therapy would welcome the provocative tone of Totton and seek to 'dance outside the frame' on the occasions when it is clearly in the best interest of the clients to do so. Yet in reclaiming the notion of music therapy as a social movement there is the suggestion that Community Music Therapy has potentially crossed into the area of community music (Ruud 2008). Ansdell and DeNora (2012) offer a simple question which acts as a recurring theme for defining Community Music Therapy; that is, how might music help. Arguably, this cuts through different theoretical justifications for the therapeutic potential of music by framing this phenomenon within the broad spectrum of helpfulness. The authors note that within a hospital setting in London a particular way in which music helped was to remove the barriers between patients and staff through the opportunity to "cultivate more positive perceptions and relationships" (Ansdell and DeNora 2012, p.99).

Within the profession of music therapy, Community Music Therapy is a contested concept. Erkkilä (2003, p.3) maintains it is essential that music therapy affirms its link with the medical professions; claiming that to do otherwise would be "professional suicide." Similarly, Barrington (2008, p.71) believes that the rift between Community Music Therapy and other approaches is "potentially destructive." Conversely, Procter (2008, p.77) is critical of the music therapy profession in the UK for not sufficiently reflecting on "the complexity of the implications of professionalisation for the roles music therapists play for their clients." Stige et al. (2010, p.304), on the other hand, suggest that instead of considering the possibility of de-professionalisation the concept of "re-professionalisation" through closer partnerships between professionals and participants might be explored.

One of the most noticeable transitions from a predominantly clinical stance has been the status given to performance as a therapeutic context and objective. To perform implies to perform *to* another person or a group of people. This suggests that the more private and confidential arrangement normally associated with the development of a

therapeutic relationship may be compromised. Likewise, the emphasis that music therapists have tended to give to *process* (rather than *product*) might be interpreted as a justification *not* to perform. The performance – as a product – implies a degree of risk that may overwhelm people for whom being publically visible (and audible) sits uncomfortably with the notion of therapy as it is more generally perceived. A particular example of this is the work of music therapist, Alan Turry (2005). Turry writes of the work with his client Maria Logis who requested that the music she was improvising vocally in her sessions with Turry be 'taken out' of the therapy room and performed in different public contexts. This caused Turry to reflect on his practice and on the boundaries that are normally expected to be maintained in clinical work. This work had a profound effect on Logis who wrote an article in collaboration with Turry regarding the freedom and exhilaration of the music therapy process undertaken in this study (Logis and Turry 1999). Stige and Aarø (2012) comment on this work and note that this was an example of the therapist taking directions from the client and therefore moving from the private and confidential space to the public arena. The authors also note the organic development of this process when they write that this was an instance of Community Music Therapy "growing out of more conventional music therapy, emerging 'from within,' so to say" (p.11). Furthermore, Stige and Aarø cite this as an example of crossing a boundary (which is helpful to the client) in comparison to violating a boundary (which is harmful to the client).

A study undertaken by Norwegian music therapists Tuastad and Finsås (2008) has relevance for this thesis as its focus is on the significance of performance in music therapy within the discipline of criminology. While not concerned with the specific context of choirs, the 'Music in Custody and Liberty' programme afforded participants the opportunity to engage in rock band activities while they were held in custody and also later when they were discharged into the community. The underlying approach of empowerment philosophy allowed participants to become accountable for their musical and therapeutic pathways. This would seem to suggest that the therapists adopted not only a client-centred approach but one that was increasingly client-led as they appeared to gradually withdraw from the process of facilitating music therapy sessions to devolving responsibility to the participants themselves.

This issue of the role and status of the music therapist in Community Music Therapy is discussed by Elefant (2010). Elefant considered her fluctuating role as a music therapist working with individuals and groups to leading choir rehearsals that comprised members from her conventional client caseload. While Elefant acknowledges that this may be confusing for both therapist and clients she also states that:

> I believe that when the music therapist is able to broaden her professional identity so that it is possible for her to move from one form of therapy setting to the other, she will be more available to help her client move from one setting to the other. (Elefant 2010, p.210)

This implies that the multi-layered role of the therapist is actually helpful – rather than harmful – by preparing the client to adapt to new challenges and contexts when he or she moves away from the clinical setting. Similarly, a multi-layered role implies different musical responsibilities that need to be acquired and developed by the music therapist. Pavlicevic (2010), for example, comments on the occasions when music therapists may require to adopt a teaching approach in their work with the clear aim of facilitating the development of musical skills. Stige et al. (2010, p.288) define the therapist's responsibilities as "scaffolding" when deploying myriad skills during rehearsal or performance contexts as well as in music therapy sessions. It may therefore be inferred that the therapist will be required to carefully prepare and practise in accordance with the respective musical demands of each situation.

This shifting role from, for example, individual music therapy to group music therapy to ensemble participation and performance was proposed by Wood, Verney and Atkinson (2004) by allowing clients the opportunity to engage freely in different music therapy formats. In so doing the client is empowered to make choices and decisions that may not have been so easily available in a more traditional clinical environment. This negotiation between therapist and participants is discussed by Rolvsjord (2007, p.236) when she writes that this "does not necessarily mean holding the power to control all decisions, but having possibility to influence and making one's voice heard." A democratic approach, therefore, would seem to underpin the general notion of Community Music Therapy. Indeed, a link may be observed here between this approach to music therapy and social capital as discussed in section 2.2. Procter

(2004) notes the parallels between the two within the psychiatric system in the UK. In particular, he is critical of the over-reliance on pharmaceutical interventions such as drugs which focus on the illness of the individual rather than greater consideration of the wellbeing of the community as a whole within the respective mental health setting. He writes:

> Social capital is accrued through musical participation. Perhaps then we could even talk of musical capital: inherently social in that it is of and between people and increases the chances of positive change within society, but also inherently musical in that it carries opportunities for aesthetic self-realisation and self-experience. (Procter 2004, p.228)

It may be inferred from this review of literature that the environment of a forensic setting (with its emphasis on security and boundaries) and the approach of Community Music Therapy (with its focus on flexibility and collaboration) do not sit easily with each other. Furthermore, whilst there is a considerable body of literature pertaining to Community Music Therapy there is relatively little which considers the implementation of music therapy (in general) within forensic establishments. Yet this gap appears to be decreasing and the recent publication 'Forensic Music Therapy: A Treatment for Men and Women in High Secure Settings' (Compton Dickinson et al. 2013) brings together for the first time the writings of different music therapists in the UK concerning their experiences – most notably – of working in high secure settings. It is interesting to note, however, that within this publication the emphasis is placed on approaches to music therapy from predominantly psychodynamic or psychoanalytical schools of thought. Indeed, in the index to this book there are no references either to Community Music Therapy or to any of the authors most frequently associated with this approach – e.g. Aarø, Ansdell, Pavlicevic or Stige. Of the fourteen chapters only one could be said to have leanings towards Community Music Therapy. In this particular chapter, Maguire and Merrick (2013) talk about the deployment of the recovery approach in a high secure hospital[10]. They note the tensions and dilemmas that arise when

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[10] The recovery approach is often referred to as the 'recovery model' which, within the area of mental health, places greater emphasis on a "holistic view of mental illness that focuses on the person, not just their symptoms" (Mental Health Foundation 2014).

developing a patient-led music therapy group in this environment. The authors write of the experience:

> Such creative tension prompted all of us to tread carefully . . . respecting the need for patience and negotiation by both patients and staff. These parallel shifts in the power dynamic, a mutual relinquishing of control, left all involved initially uncomfortable, but ultimately with a feeling of success. (Maguire and Merrick 2013, p.118)

One might also infer from the subtitle of this book ('A Treatment for Men and Women in High Secure Settings') that a particular adherence to the medical model of health is being suggested; a sense, perhaps, of a 'how-to' approach that is more therapist- than patient-led[11].

Stige and Aarø (2012) argue that Community Music Therapy is not just a particular approach or way of working in this field; rather, it is a force for good within the area of human rights. They believe, for example, that it may be described as a "rights-based practice" (p.179) and challenge the notion that issues pertaining to human rights are generally reserved for those in positions of authority such as politicians and lawyers. Such a shift in thinking assumes particular significance when the environment in question is forensic-related. For myriad reasons the rights normally afforded to people in these settings may be restricted or withheld on grounds of safety and security. Yet the authors maintain that the emphasis on relationships between communities within hierarchical structures – rather than a focus on individual pathology – offers Community Music Therapy a powerful level of influence. They write:

> Hospitals and prisons exemplify institutions where human rights restrictions are considered legitimate by the authorities. Patients and inmates do not have the opportunity to exercise basic freedoms and they are sometimes denied cultural and social rights, such as the right to education. We often think of these rights restrictions as necessary, but community music therapy practices may evolve in these milieus because restrictions are disputed or because they are acknowledged as problematic and problem-producing. (Stige and Aarø 2012, p. 178)

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[11] My own reading of this book does not fully concur with its definition as a treatment and that there is a frequent emphasis on ways of working which are predominantly patient-led.

If this is indeed the case then it could be argued that a music therapist working in a community-oriented ('rights-based') way in a forensic setting will require conviction to withstand potential challenges from those in authority who may resist a greater devolution of rights to patients. Music therapy remains a relatively young profession and its status, politically, is not especially prominent. It would be interesting to reflect on how music therapy training programmes might take note of the views of Stige and Aarø (2012) by considering the *profession* of music therapy no less than the *discipline* and *practice* of music therapy.

This point is also made by Rolvsjord (2010) when she writes about the concept of resource-oriented music therapy within the context of mental health care. Rolvsjord, who strongly challenges the emphasis placed on the medical model within mental health care, believes that it is inevitable the music therapist is part of the political make-up of the respective setting. She states:

> Any practice of music therapy is linked with political conditions and decisions on various levels of the institutional and cultural contexts, whether the music therapists are involved with social activism or they comply with the ideological and economical systems in which they are posited. (Rolvsjord 2010, p.18)

The literature suggests that comparisons may be observed between resource-oriented music therapy and Community Music Therapy. Both focus on the significance of collaboration, relational working, empowerment and a changing perception of the awareness and attitude of the music therapist. Indeed, Stige and Aarø (2012) comment on the "resource-oriented quality of community music therapy" (p.21) and claim that such resources comprise "the personal strengths of participants, such as musical talents and interests, relational resources, such as trust and emotional support, and community resources, such as music organizations and traditions" (pp.21-22). It is interesting to note that Rolvsjord (2010, p.viii), while also highlighting the importance of "democratic participation and equality", suggests that this can be achieved when "less weight is put on the therapist's techniques." One might counter this by positing that the actual range of techniques deployed by a therapist may need to be expanded; to include conducting a choir, for example.

When discussing the place of music therapy in psychiatry generally (rather than with a forensic focus), Pedersen (2014) asks whether we require specialisation based on the reduction of diagnosis-specific symptoms or, alternatively, on the development of the resources of the patients themselves. She concludes by suggesting that both options are needed and that this can be achieved by building bridges between the science of humanities and the science of health. Pedersen believes that an overarching approach of "*psychiatric music therapy*" (p.191) should be affirmed. This would require therapists to be able to specialise in working with people who have specific diagnoses while also having the capacity to generalise to different resources and responsibilities within the respective setting. One might argue, however, if the need for the therapist to be focused yet flexible is not equally applicable in many if not all clinical contexts.

The increasing prominence of Community Music Therapy, the potential health and social benefits of group singing, and the specific populations that constitute a forensic psychiatry unit suggest a need for research to be undertaken which considers the relationships between these areas. This final section also suggests it is likely that a contemporary music therapist may be required to fluctuate between a clinical and a community model at regular intervals within the one setting. The identity of the therapist, therefore, is fluid rather than fixed which, potentially, could confuse clients who may be attending music therapy in both contexts – e.g. an individual music therapy session followed by a choir rehearsal facilitated by the same person. Arguably, this presents a dilemma as well as an opportunity and is a sound justification for a critical reflection of my own role as a music therapist in a medium secure forensic setting – a clinic – yet working in ways that are not exclusively clinical.

In conclusion, Community Music Therapy presents a robust and logical framework within which to undertake this study. The first three sub-subsections of this chapter concerning health, choral singing and health, and choral singing within music therapy resonate well with this particular approach to music therapy. This chapter, however, has identified key gaps in the literature (e.g. choral singing as part of music therapy practice in a medium secure forensic unit and the adoption of a community-based

approach by a music therapist is this environment); such gaps beckon new and exciting questions to be addressed. It is these questions which form the basis of this study.

3.   RESEARCH QUESTIONS AND CONTEXT

3.1   Research questions

In light of the foregoing review of literature, the main research questions for this thesis are as follows:

1   What health benefits are experienced by patients and staff in a medium secure forensic setting when singing in a choir?

2   How does shared participation in choral experiences influence the relationships between patients and staff?

3   How – and to what extent – is my identity as a music therapist altered as a result of including a community-based approach to my work in addition to a clinically-oriented model?

3.2   Research context

3.2.1   Ethics

The proposal for this study was submitted on 25 June 2012 as the main requirement of the Doctorate Research module (XD011) for the Professional Doctorate qualification. A Queen Margaret University Application for Ethical Approval was included as part of this proposal (available on request). The involvement, however, of patients and staff from a National Health Service hospital in the data collection process required ethical approval from the health authority within which the study would be undertaken. In particular, it was necessary for me to complete an on-line application for the local NHS Research and Ethics Committee (REC Project Number 12/SS/0218) and the Research and Development Office (R&D Project Number 2012/P/PSY/39). A Site-Specific Information Form was also submitted. I was invited by the Research and Ethics Committee to attend an interview on 5 December to discuss this application. Following some suggested changes I received a letter confirming ethical approval from the Research

and Ethics Committee (appendix 1) and also from the Research and Development Office (appendix 2).

3.2.2   General location and sampling

The study was located exclusively in a medium secure forensic unit within a psychiatric hospital. It may be helpful to consider this environment as 'the community' which is in keeping with the general notion of Community Music Therapy. As such, the broad inclusion criteria comprise those who either work or live in this community. There was one exclusion criterion which applied to those patients who – for purposes of safety to self and others – were not permitted out of the ward area. A summary of potential participants for sampling is presented as follows:

- Patients who are situated in any of the three wards of this unit (there is no exclusion regarding the duration of time they have been in the unit).
- Out-patients who previously attended music therapy and have since been discharged but continue to maintain close links with the unit.
- Clinical staff – e.g. doctors, psychologists, social workers, occupational therapists, arts therapists, therapy assistants, nurses, nursing assistants, a dietician and a pharmacist.
- Administrative staff – e.g. managers, secretaries and clerical assistants.
- Domestic staff – e.g. porters and cleaners.
- Students – e.g. medical students, nursing students, occupational therapy students and arts therapies students.

3.2.3   Recruitment and distribution of information

I chose four ways in which to inform people about this project in order to maximise awareness throughout the unit. These were as follows:

- Email correspondence to all staff.

- Presentation of posters throughout the unit in general and the three wards in particular.

- Arranging meetings on each ward to explain to staff and patients what the project would entail.

- General word-of-mouth to staff and patients through informal conversation.

An information sheet was made available and a copy of this is included in appendix 3.

This process obliged me to carefully reflect on how my role within this setting was changing. It was helpful to be the on-site music therapist and therefore to know many of the people from the patient and staff populations. Within this new context, however, I was no longer taking referrals for music therapy sessions; instead, I was actively seeking participants to join a choir and also to give consent to be part of a research project. I quickly became aware of people's perceptions of themselves in terms of their musical abilities as well as their previous musical associations or experiences. There were moments of humour as well as a tendency for some people to be self-deprecating about their perceived quality of singing. It was poignant, for example, to learn on several occasions how people had been dissuaded (almost ridiculed) when being considered for singing in their school choir. People had grown up believing that they were "unmusical" or that they "couldn't sing." Daykin et al. (2007b, 2008b) believe that such observations are more likely to be socially constructed rather than inherent; due in part to "celebrity culture and media representations that influence many people's perceptions of the arts" (Daykin 2012, p.67). This, therefore, required sensitivity on my part to acknowledge their often deep-rooted feelings whilst gently encouraging them to consider joining the choir. Although these conversations were not contextualised within a therapeutic relationship, there was a need to be mindful of therapist-attributes that may have influence on the subsequent decisions people would make.

It was important to emphasise to people that if they wished to join the choir they could do so. No auditions were to be held. My intention was to promote a feeling of welcome and unconditional acceptance prior to the commencement of the choir. In so doing this might help foster a sense of respect for each person which may hopefully permeate and

flourish throughout the rehearsals. The ethos of the project could therefore be established through this considered process of initial, informal conversation. Strachan (2006) notes the significance of not holding auditions for the Lesbian and Gay Chorus of Washington D.C. when she writes:

> Unlike the unsavoury experience of "being chosen," the person chooses to join. The act is healing and the opposite of the social experience of many glbt people, who have been invisible in and to mainstream groups. The choice empowers the individual voice on two levels. First, the individual is empowered because his or her voice is recognized. Secondly, this empowerment is reflected in the development of the individual choral voice. The task of music making as a group is nourished by the journey of the individual. (Strachan 2006, pp.258-259)

According to Strachan the devolving of the responsibility to join the choir to each person, rather than at the discretion of the conductor, is in itself a healing process. Furthermore, upon reflection of this thesis it would not be inappropriate to replace the above acronym "glbt" with the words "patients in a forensic setting."

At the heart of this project was the requirement that people would engage in a series of choral experiences. This particular choice of words was deliberate and implied that singing music as part of a weekly event was not the sole experience. In conventional circumstances a choral conductor would normally determine the repertoire to be explored, the format of rehearsals and how the music should be interpreted. This study, however, aspired towards a more organic and democratic approach. Parallels may be observed here between this way of working and Strachan's (2006) comments with regard to the conductor, Mark Bowman, when working with the above choir. According to Strachan, while Bowman "possessed powerful leadership qualities and the competence to create the organization himself, he used a collegial approach with the singers" (p.255). Strachan later uses the term "consensus governance" to describe the ways in which all decisions affecting the management of the choir were undertaken (2006, p.258).

Thus, participation in choral experiences would require each person involved to contribute to these events in both general and musical ways; the normal hierarchical relationship between conductor and performers would be deliberately less pronounced.

A consent form was given to each participant that they were asked to complete prior to their involvement in the study; this can be found in appendix 4. Naturally, this consent form required to be completed by patients and staff. Daykin (2012) notes that this process needs to be facilitated in a sensitive manner. With regard to a research project involving patients and staff it had been felt that the formal requirement of completing a form might hinder the creative process. Yet as Daykin observed, "the experience of giving consent sometimes reinforced participants' positive experiences of choice and decision-making" (2012, p.71).

3.2.4   Physical location for rehearsals

The rehearsals did not take place in the room normally used for music therapy sessions. This particular room would not have been big enough to accommodate the potential number of people attending a choir rehearsal. Furthermore, for patients in the choir whom I was also seeing for music therapy sessions, it may have been confusing and unsettling to participate in different musical contexts in the same environment.

A larger room opposite the music therapy space was subsequently identified as being most appropriate. This was situated in the activities area of the unit and was therefore familiar to the patients. The acoustic was favourable and the room was available at the designated time each week.

3.2.5   Participants

In total, fourteen people participated in the project; eight patients (three male and five female) and six members of staff (one male and five female). The average age of the participants was 38. Staff represented the following areas within the unit:

- Two occupational therapists.
- One occupational therapy student.
- One social worker.

-	One nurse.

-	One administrator.

Of the eight patients, seven were currently in the unit while one was a former patient who was now living in the community although was in occasional contact with the unit.

3.2.6   Number of rehearsals and performance

Throughout the six-month period of data collection there were 23 rehearsals each lasting approximately 45 minutes. There was one performance at the culmination of the rehearsals. An overview of participant attendance at rehearsals is given in Table 3.1. All of the rehearsals and the performance were audio-recorded using an Edirol (Roland) R-09HR recorder. I have used this on many occasions due to its high quality of recording, the ease of use and its discreet visual presence. This allowed me to listen back to the work that had taken place each week, to make a detailed analysis of the respective rehearsal and to note my immediate reactions. In so doing the opportunity was afforded to reflect on the musical content and general dynamic of the rehearsal. Furthermore, this assisted me in the planning of subsequent rehearsals and how these might be structured. The documented evidence of this formed the basis for the Professional Log.

P = Patient   S = Staff   R = Rehearsal   PER = Performance

	P1	P2	P3	P4	P5	P6	P7	P8	S1	S2	S3	S4	S5	S6
R1	♪	♪	♪			♪	♪				♪	♪	♪	
R2	♪	♪	♪				♪		♪		♪		♪	
R3		♪	♪		♪		♪				♪		♪	
R4	♪	♪	♪				♪			♪	♪	♪	♪	
R5	♪		♪				♪		♪	♪	♪		♪	
R6	♪	♪	♪				♪		♪		♪	♪		
R7	♪	♪	♪				♪			♪	♪	♪		♪
R8		♪	♪							♪		♪		
R9	♪	♪	♪							♪	♪			♪
R10	♪	♪	♪				♪	♪		♪		♪		
R11	♪	♪	♪				♪	♪			♪	♪		♪
R12	♪	♪	♪				♪	♪		♪	♪	♪		
R13	♪	♪					♪			♪		♪		
R14	♪	♪	♪				♪					♪		
R15	♪	♪	♪				♪		♪		♪	♪		
R16	♪	♪					♪		♪		♪	♪		♪
R17	♪	♪	♪				♪				♪	♪		♪
R18	♪	♪	♪				♪				♪	♪		
R19	♪	♪	♪				♪		♪	♪	♪			
R20	♪	♪	♪				♪		♪		♪	♪		
R21	♪	♪	♪				♪		♪	♪	♪			
R22	♪	♪	♪				♪		♪		♪			
R23		♪	♪				♪			♪	♪	♪		
PER		♪	♪				♪		♪	♪	♪	♪		♪

Table. 3.1 – Overview of attendance at rehearsals. With regard to the above, P4 attended the first focus group meeting but then chose not to attend the rehearsals. P5 and P6 were transferred from the unit shortly after they attended their respective rehearsal. P1 was transferred from the unit after the 22nd rehearsal but kindly agreed to take part in an individual interview prior to his departure.

3.2.7   Participation and facilitation of choir rehearsals

Introduction

The most visible part of my role was the facilitating of rehearsals. I was aware that this would likely be more complex and challenging (yet also intriguing) than the *conducting* of singers. There were myriad responsibilities which included the preparation of the rehearsal space, providing the song lyrics and/or the arranging of music in a manuscript format, the setting up of the recording equipment and ensuring that staff on the three wards in the unit were available to bring patients through to the allocated room as necessary. In addition, I felt it appropriate to avoid the customary appearance or demeanour of a conductor as may be portrayed through, for example, the use of a baton or communicating in a didactic manner; rather, I felt it important that people should feel safe and respected. To an extent, although the choir rehearsals were not music therapy sessions, the notion of an underlying therapeutic relationship that might permeate these choral experiences would likely be helpful.

Musical responsibilities

It is interesting to reflect as a music therapist on how seldom a standing position is adopted. Consciously or otherwise, certainly in the area of forensic mental health, I am nearly always seated when engaging with a patient. Aside from the practical advantages of playing a piano or percussion instrument when sitting down, it is helpful and appropriate to be at a similar height and position when working in a therapeutic context. Conversely, a conductor will frequently be upright; not least for purposes of being seen most easily by either singers or instrumentalists. I chose, therefore, to 'conduct' from the piano; a digital piano was used due to its portability and, more importantly, that less of a 'barrier' was apparent in comparison to an acoustic piano. In addition, I did not have a separate piano accompanist so it was necessary for me to similarly fulfil this role.

Notwithstanding my inclination to avoid an over-formal ambience, it was important that people should feel a sense of respect for the 'event' of a choir rehearsal. Thus, it was helpful to prepare the room carefully beforehand so that when people entered the space there was a feeling of order and readiness. Two rows of chairs were arranged in front

of the digital piano. Each rehearsal would commence by warming up our voices through the singing of simple vocal exercises. These would mainly comprise scales and arpeggios; thereby allowing the care of one's voice to be highlighted and also that we might focus immediately on listening to each other and thus promote the notion of singing with 'one voice'. I was immediately aware of a sense of commitment and purpose that I found genuinely moving. The sound was raw and not necessarily in tune but there was spirit in the overall response and an appreciation that something new was taking place. A Tonic Sol-Fa Modulator – which exemplified a method of sight-singing as introduced by John Curwen in the nineteenth century (McGuire 2006) – was displayed to offer musical structure and assist people in the singing of scales (Figure 3.1). As discussed in the review of literature this was an intriguing resource that had the effect of providing a learning context by means of a visual stimulus. I had been aware in the initial focus group discussions that the ability to read music varied amongst the participants. The Modulator had a certain nostalgic element. Furthermore, as this was a resource with which neither staff nor patients were familiar, a degree of parity and mutual interest could be sensed by all participants.

An important objective in the opening rehearsals was to consider the most helpful way in which we might aspire to a certain musical standard or vocal accuracy in relation to the sound being presented. To put this more simply, how demanding should I be as a conductor? How important was it for people to sing in tune? Was there a risk, perhaps, of sacrificing a degree of natural enthusiasm in order to attain particular musical skills? Might this lead to people choosing to leave the choir? The maintaining of a Professional Log allowed me to reflect on these issues. It became apparent that my experience as a therapist provided the opportunity to deploy what I propose to describe here as *therapeutic sensing*; I felt I could not *not* be a therapist. This was a useful attribute. Patients and staff needed to feel secure; musically and personally.

Therapeutic sensing, I suggest, comprises the need to listen and to inform through negotiation with oneself and the participants with whom one is working. In this context a personal knowledge was required of the kinds of responses and reactions that may

Fig. 3.1 – Tonic Sol-Fa Modulator.

be manifest by patients in a medium secure setting. Yet it also required sensitivity with regard to the feelings of the staff. To an extent, service-providers were now service-users. Thus, it was necessary for me to contemplate the vulnerability that might be experienced by staff members at the removal of a metaphorical barrier between themselves and the patients. Within the framework of Community Music Therapy, Ansdell and Denora (2012, p.103) outline what they consider are the professional competences required for engaging with people in this way. These are stated as the need to "attend to and accompany people musically; to be sensitive to people's own relationships to music; to foster musical communication and musical community." For the purpose of this project and this thesis I consider these words to resonate closely with what I wish to term as therapeutic sensing.

I surmised that the form of listening required by a musician who is coordinating the responses of other musicians is relatively straightforward; that is, the former must know the standard that the latter may be reasonably expected to attain, then listen to the quality of response being offered and inform accordingly in order to reach the optimum level of musical achievement. There is more likely to be a focus on performance and rehearsals are therefore a clear means to a musical end.

As a music therapist, listening is at the heart of my work although the focus of this listening is concerned with my interpretation of the patient as presented, moment by moment, through his or her music-making; indeed, this *informs* me. It is unlikely in my clinical work that I would seek to inform patients as to how improvements might be made in relation to their musical responses. My role as a conductor, however, required me to be *informative*. No matter how open and democratic I intended these rehearsals to be, I had a responsibility to provide constructive feedback. I found myself listening more closely to what I was saying, and how I was saying it. The relative familiarity that I had with most of the patients in the choir could not allow me to forget that these are people who are unwell and may present significant mental health difficulties such as anxiety or depressive states. In addition, such responses can often be framed within a tragic narrative in light of the respective patient's personal history and experiences.

Therefore, through my musical interactions and verbal exchanges, therapeutic sensing was always prevalent; albeit in a covert manner.

Musical objectives

The opening rehearsals allowed me to gauge individual responses and abilities which in turn helped to affirm an appropriate level of musical challenge to which we might aspire. This process required subtlety; the absence of any form of audition or solo 'testing' meant that musical decisions had to be made through my impression of each person as I listened to the collective sound; opinions I may have held about the quality of individual voices could not be expressed as they otherwise might be in other choral contexts. On reflection this did not appear to matter; indeed, the removing of any element of competition seemed to have a motivational influence as the group swiftly began to form its own identity. In addition, the relatively small size of the choir helped to promote an appropriate level of intimacy and trust. I quickly became aware of the pitch range of each person, people's ability to read music and different ways of blending individual voices in order to produce a unified sound. Specific musical objectives were gradually formulated and these included the following:

- Singing either in unison or two-part harmony – i.e. the main melody of a song and a harmony part (or backing vocal).
- The alternation of verses sung by, for example, women only or men only.
- The incorporating of solo verses for anyone who wanted to take this particular role.
- Respect for the words of songs and how these might be most appropriately expressed through the medium of music.
- Acquiring clarity of diction.
- The cultivation of a sense of musical phrasing.
- Developing respect for one's own vocal technique through attention to breathing and posture; linked to this was the need to respectfully warm up the voice at the commencement of each rehearsal.

-      Increasing awareness of musical notation by means of the Tonic Sol-fa Modulator.

-      Developing listening skills and a respect for the sound of each other person.

As the rehearsals progressed I began to review my initial concerns about being perceived as what may be termed a 'conventional' conductor. I reflected that this may have more to do with my own perceptions of this role rather than the members of the choir. The commitment demonstrated by each person was indicative of a genuine desire to *work*. This sense of purpose, I believe, was a direct outcome of being respectfully yet constructively challenged. I would frequently ask the members how they felt we were doing and how improvements might be made; they were honest and accurate in their answers. I surmised that with choirs I had worked with in the past, I tended not to ask these questions; I had informed rather than allow people to become self-informed. Arguably, the democratic ethos of this choir enabled members to feel more confident in presenting their views.

Musical choices

The increasing popularity of choirs in recent years has attracted people who may not have considered joining a choir before to now do so (Malone 2013). Choirs, arguably, appear to be more accessible. This flourishing of vocal ensembles may be in part due to a perceived shift as to what now constitutes choral repertoire. Songs that were originally written for a solo singer or a band can easily be rearranged and performed by choirs. A consequence of this is that choral members are afforded more scope to choose music they would like to sing. This was convenient to the promotion of a democratic ethos within our own choir; yet this may be accompanied by a degree of risk as to the likelihood of a range of musical tastes and preferences being offered by different people. Such negotiation, however, can be conducive within a therapeutic context (Silber 2005; Young 2009; Talmage et al. 2013).

Throughout the six-month period of choir rehearsals we rehearsed eleven songs (Table 3.2). Of these, ten were chosen by the participants; it is interesting to observe an underlying theme of hope in several of the song titles which may have significance in

relation to the aspirations (conscious or otherwise) of the patients. The song that was chosen by myself was 'Do You Hear The People Sing?' which is the final chorus from the musical 'Les Miserables' (Kretzmer and Schönberg 1985). This, in my opinion, was a sufficiently challenging song that would lend itself well to a simple choral arrangement. Furthermore, it may be seen from the lyrics presented at the beginning of this thesis that a strong impression of hope permeates this song which, arguably, would have deep emotional resonance with at least some of the members of this choir. It is intriguing to reflect that at the time I was not specifically aware of this resonance; indeed, when choosing this song I had not fully realised the potent symbolism of the title; that is, that *hearing people sing* – with regard to people whose freedom and choice were understandably restricted – might echo a voice that would not normally be given such a platform for expression.

It can also be observed from this list below that the majority of songs are from the 1970s. Indeed, the most recent song of the eleven was released in 1988. For several of the participants this may relate to the "reminiscence bump" (Janssen et al. 2011, p.1) in which people may appear to have a particular preference for songs from their early adulthood.

TITLE	ARTIST(S)	LYRICIST/COMPOSER	YEAR OF RELEASE
Ob-La-Di Ob-La-Da	The Beatles	John Lennon & Paul McCartney	1968
Here Comes The Sun	The Beatles	George Harrison	1969
Bridge Over Troubled Water	Simon & Garfunkel	Paul Simon	1970
You've Got A Friend	James Taylor	Carole King	1971
Top Of The World	The Carpenters	Richard Carpenter & John Bettis	1972
Annie's Song	John Denver	John Denver	1974
Knowing Me, Knowing You	Abba	Björn Ulvaeus and Benny Andersson	1976
Don't Stop	Fleetwood Mac	Christine McVie	1977
Skye Boat Song	Barbara Dickson	Sir Harold Boulton and Annie MacLeod	1984
Do You Hear The People Sing?	Cast of 'Les Miserables'	Herbert Kretzmer & Claude-Michel Schönberg	1985
Sunshine on Leith	The Proclaimers	Charlie Reid and Craig Reid	1988

Table 3.2 – List of songs rehearsed throughout the period of data collection.

Musical performance

It is generally accepted that a choir will meet to rehearse and to perform; making the transition, therefore, from the private to the public. Within a medium secure forensic unit, legal procedures would make it highly unlikely that patients could leave the hospital environment to perform in front of the general public. A performance within the unit itself, however, may be possible if the general consensus of the participants was supportive of this idea. My personal view was that to work towards a performance would be desirable and thereby provide an extra impetus to our rehearsals; yet I chose not to articulate this opinion as I was clear this was an issue that needed to be decided by the members themselves.

Smith (2006) conducted a study with an amateur symphonic choir in Australia in which the members were asked to comment on the significance of the actual rehearsal experience. Members indicated that:

> . . . rehearsals were not regarded as merely a means to an end – the all-important performance. Singers valued the rehearsal experience in itself. It was clearly seen as the core of their leisure activity, and they wanted it to be enjoyable even though they had to work hard. (Smith 2006, p.298)

This seemed to be the feeling amongst the members of our own choir and it was important that such a choice should be offered in a sensitive and transparent manner. The process for reaching a decision was facilitated in two ways. Firstly, this was a specific question which was asked in the focus group meetings held prior to our first rehearsal. For those who were unable to attend the meetings they were provided with a list of the questions to which they could then submit their answers in writing at a time convenient for them. The precise wording of the question was:

- ***Might we wish to perform to other people in the unit or do we prefer to sing only for our own pleasure?***

The responses indicated that two patients (P6 and P7) and four members of staff (S1, S3, S5 and S6) were clear in their preference to perform in front of others. One patient (P1) was clear in his preference that we should sing only for ourselves rather than perform. The remaining seven participants (i.e. half of the membership) appeared

undecided although one of these participants (P8) attended only rehearsals 10, 11 and 12 and was too unwell to either complete the list of questions on the focus group form or engage in a verbal discussion about this issue. Thus, prior to the commencement of rehearsals I felt it appropriate to delay a decision and instead follow the majority view of adopting a 'wait and see' approach.

The second way in which I sought to gauge the opinion of the choir members with regard to the possibility of performing was the distribution of a form following rehearsal 14 (appendix 5). This listed the nine songs that we had sung up to this point and asked participants the following two questions:

> ***Could you possibly let me know if you would like to take part in a short informal performance that would be held in the clinic? If you would like to take part, please indicate (in order of preference) which three songs you would like us to do.***

Of the fourteen participants who had taken part in the first focus group meetings, eleven now remained; P4 chose not to attend rehearsals following the meeting with patients and P5 and P6 subsequently left the clinic. Forms were therefore distributed to the remaining members at rehearsals 15 and 16 or by giving them personally by hand at a different time. As mentioned above, P8 did not return to the choir following rehearsal 12. Of the ten people who had taken the form six were returned. These were collected anonymously so that people could feel safe in indicating how they felt about this particular issue. Each person stated that they would like to perform in front of others; one person revealed a slight reluctance although would be happy to go with the majority decision.

The request was made that people might indicate their three songs in order of preference. By allocating the number 3 to the first choice, 2 to the second and 1 to the third, the scores pertaining to the choice of songs are outlined in Table 3.3.

SONG	NUMBER OF POINTS
Do You Hear The People Sing?	8
Knowing Me, Knowing You	7
Bridge Over Troubled Water	6
Here Comes The Sun	5
Annie's Song	3
Ob-La Di Ob-La Da	3
Skye Boat Song	3
Top Of The World	1
Skye Boat Song	1

Table 3.3 – Scores pertaining to the choice of songs that may be performed.

It is interesting to note that each of the nine songs was chosen at least once. A suggestion was made by other staff in the clinic that a suitable context for a performance might be the summer barbeque. The timing of the barbeque coincided with the conclusion of the six-month rehearsal period. The choir members were amenable to this idea as the performance would be part of a larger occasion rather than a main event in itself. The period of time between the collation of this form and the summer barbeque was approximately two months. It was decided, therefore, that a final decision on which three songs we would perform could be delayed for a further few weeks. Ultimately, we agreed as a group that the original main choice of song – 'Do You Hear The People Sing?' – would be included. The views of the choir members changed, however, to have 'Annie's Song' and 'Ob-La Di Ob-La Da' as the other two songs.

Performance perspectives

The performance took place on 22 August 2013. The choir comprised three patients (P2, P3 and P7) and five members of staff (S1, S2, S3, S4 and S6). I wish to reflect on the performance from three different perspectives: those of a conductor, a music therapist and a researcher.

As a conductor I was aware of feeling a level of musical responsibility akin to my own previous experiences of directing a choir in a more formal performance largely based on music from the classical repertoire. My subsequent decision to pre-record the three songs on the digital piano allowed me to conduct the choir without simultaneously

having to play. In turn, this afforded more control of musical expression, phrasing and technique; an example of this might be the precise timing of the ending of a word being sung by everyone at the same moment (e.g. "fores**t**"). Thus, out of respect for the performers as well as the audience, it was important that we presented a standard of musical accuracy that would be appreciated. A continuous negotiation on my part was the consideration of attention to detail which was proportionate to the abilities of those involved.

As a music therapist I was aware of the responsibility of presenting patients in a public context. We had moved out of the relative comfort zone of the rehearsal space to being viewed and heard by approximately twenty people. The audience comprised other patients as well as members of clinical, administrative and domestic staff. The notion of therapeutic sensing was once again helpful as the possibility existed of patients becoming over-anxious prior to the performance and, potentially, not taking part. It was also important for me to be sensitive to the feelings of members of staff in the choir. I therefore adopted a strategy of deliberately presenting myself as 'low-key' in the moments prior to the performance. In truth, we were all nervous and several of the choir members articulated this to me. I sought to address this expression of nerves in two ways: firstly, by taking time with each individual member beforehand to listen and to reassure that it was perfectly natural to feel anxiety at this stage; and secondly, by working collectively with the choir members through a series of breathing exercises and vocal warm-ups in order to give focus to our singing and listening as well as helping to foster a sense of team spirit.

As a researcher I was aware that this performance marked the conclusion of my role as a participant in the action of the research (PAR). Although the collection of data by means of further focus group meetings and interviews was still to take place, the performing of the three selected songs symbolised the ending of the music and, possibly, the choir itself. Care was taken to ensure that the performance space (a large corridor which opened out onto the garden where the barbeque was being held) was sufficiently prepared in terms of safety, acoustic and maximum visibility of the singers. Our final rehearsal had been held in this area to help provide a degree of familiarity

between this event and the subsequent performance. As with each of the rehearsals, the performance was audio-recorded. On this occasion, however, I deployed two Edirol (Roland) R-09 recorders at different recording levels as it was difficult to predict the volume of the incoming sound due to the change of environment. The performance was recorded for the following five reasons:

1)   Evidence of data pertaining to this event.

2)   An opportunity for the subsequent focus groups and interviews to commence with the listening back to the recording which could then help as a stimulus to the ensuing discussion.

3)   An educational resource for teaching purposes or conference presentation.

4)   A further opportunity to critically reflect on the actual sound of the singing as well as the experience overall.

5)   An appendix for this thesis (appendix 6).

Performance reflections

In this final section I wish to reflect briefly on the feelings that I experienced at the conclusion of the performance. The views of the choir members themselves were to be articulated in the weeks following the performance through focus group discussion. As with the above section these feelings are contextualised from the perspectives of a conductor, a music therapist and a researcher.

As a conductor I was very satisfied with the quality of singing presented by the choir. Each person demonstrated warmth, commitment and enthusiasm. Arguably, these attributes were in evidence from the first rehearsal and sustained throughout the six-month duration of the project. In the performance, however, I was aware of a level of skill and musical accuracy that gave testament to the concentrated work that each person had invested in this project. At the heart of this, I believe, was a deep respect for the words and the music of the three songs. The defiance of the opening song, 'Do You Hear The People Sing?', represented a statement of intent that these people did indeed wish their voices to be heard. A challenge for the choir that we had previously discussed in rehearsal was to then swiftly change this mood to reflect the sense of gentle dedication in 'Annie's Song' and, finally, the element of fun as portrayed in 'Ob-

La-Di Ob-La-Da'. All of the participants – patients and staff – had demonstrated courage in taking this step to perform in front of their fellow-patients and colleagues. The warmth of the reception (which included a request for an encore) validated this decision.

There is a subtle yet definite distinction between a rehearsal and a performance; every rehearsal is a performance (to each other and to the conductor) but a performance can never be a rehearsal. A performance, no matter how informal, is an occasion that is defined by parameters which require to be respected by the players and the spectators. It does not necessitate a stage or a podium, an entrance ticket or a programme. Rather, a performance is a relationship between two distinctive populations; it is time-limited, fleeting, energising yet also contains an element of risk. As the conductor of this performance I occupied the space that separated the choir from the audience. In this sense I was a boundary yet also a connection; a barrier and also a bridge. The relationship between myself and the choir members was well-established; the relationship, however, between the choir and the audience had not been formed until this performance; each knew the other through previous personal and professional interactions but this occasion appeared to represent a new kind of relationship. It was a musical relationship and while one group offered music, the other offered gratitude for the musical experience. In order for this to be realised I felt it necessary as a conductor to maintain a low profile and, during the actual performance, to 'get out of the way'. Therefore, while occupying the space between the choir and the audience I was keen to be as unobtrusive as possible. My conducting gestures were clear yet minimal and my words of introduction and explanation welcoming yet to the point. To an extent, my work had been done in the previous six months; in the performance, however, it was important for me to let go – and let the people sing. Indeed, these people – the participants – had 'become' a choir.

As a music therapist I was conscious of the fact that the patients in the choir had not only coped with the demands of the performance but had been inspired as a result of the experience. Indeed, the facial expressions and verbal comments offered by the patients revealed a deep sense of satisfaction with what had happened. No-one had

been harmed or adversely affected through such public exposure. I was aware of asking people, literally, how they felt with regard to the quality of the vocal sound they had produced. It occurred to me that within the more conventional context of a music therapy session, it would be highly unlikely for me to ask patients to evaluate the standard of their musical performance. Yet this was an informal narrative rather than a fixed set of questions that people were required to answer. At the risk of being over-subjective I felt in no doubt that health benefits had been acquired and that people – quite simply – seemed better. While it would be necessary for me to provide more robust evidence for these reflections through the forthcoming focus group discussions, I felt it important that the immediacy of the experience should be conveyed through spontaneous conversations with those involved. The moment would soon pass.

It seems pertinent to add that the above comments pertaining to the patients could be equally applied to the staff members of the choir. The expressed emotions, comments and responses were indicative of a team effort and the notion of a boundary between patients and staff had dissipated. I found this to be particularly noticeable as people returned to the garden area to resume the barbeque. The formation of small groups comprising patients and staff eating, drinking and chatting belied the reality that this was a medium secure unit with necessary boundaries; tangible and otherwise. Whilst I had been aware of similar informal gatherings in the past, this – in my opinion – appeared distinctive *as a result* of what had just taken place. The interrelationships appeared heightened in 'spark' and intimacy; yet respect was mutually maintained. Arguably, the therapeutic effects of a musical experience had facilitated a deeper level of community.

Daykin (2012) writes of a participatory arts project involving patients and staff in a mental health setting. This had afforded the opportunity for senior staff within the setting to visit the project at different times to see at first-hand what was happening. The author writes:

> One manager commented that the project had challenged accepted hierarchies, making working relationships more equal. A key perception of staff was that the project brought together professionals and patients from different units, creating

> a sense of community within the hospital. Further, the project allowed new connections and external partnerships to be formed. (Daykin 2012, p.72)

As a researcher of a qualitative study I was aware of the importance of giving value to my personal feelings – the *felt* experience – rather than seeking to suppress them in order to ensure an objective emphasis was maintained (Forinash 1995). In the spirit of PAR I had *participated* in the *action* of the *research* and had been moved by the rich contributions that each person had made. Therefore, from these experiences of my formation of and involvement with the choir, it was apparent to me that sufficient data would be available to pursue the three research questions set out at the beginning of this chapter.

4.   METHODOLOGY

4.1   Research methodology

To address the research questions presented in chapter 3 I chose to adopt a qualitative methodology. As Silverman (1993, p.29) states: "Qualitative research is a particular tradition in social science that fundamentally depends on watching people in their own territory." Furthermore, by assuming the stance of a participant observer or "data-gathering instrument" (Ansdell and Pavlicevic 2001, p.136), I had the opportunity to engage first-hand with the research participants; this required me not only to *watch* but to *work with* the patients and staff in this setting. In so doing I was able to maintain my status as a music therapist working with patients. From a therapeutic perspective, therefore, it was helpful to avoid the addition of other personnel in the research process. As Smeijsters writes:

> Because music therapists are most close to the therapeutic context in qualitative research, the roles of music therapist, observer, and researcher are often filled by one person. If the person who is most committed to the client is most able to "research," then is it impossible for a non-participating person to understand what is going on? (Smeijsters 1997, p.16)

In response to the question posed by Smeijsters I would suggest that while it may not be impossible for a non-participating person to understand what is happening, the involvement of other people in the process may potentially feel overwhelming for the patients in this environment. I was anxious to adopt a 'soft' approach in order to be viewed primarily as a musician and perhaps less so as a therapist or a researcher.

Denscombe (2007, p.333) writes that qualitative research affords "an interest in patterns of behaviour, cultural norms and types of language use." At the heart of this investigation was the need to interpret the meanings of the experiences felt by patients and staff as a result of singing in a choir. Wheeler (1995, p.559) states that interpreting is the "task in processing qualitative data that involves any attempting to discern or suggest what data mean." Such interpretation took place in the moment of each choir rehearsal and therefore influenced my thinking and subsequent speaking to the participants.

Underpinning this decision was the acknowledgement of my outlook and approach to this particular study as non-positivist rather than positivist. The emphasis on different forms of relationship – not least my own relationships with patients and staff – contrasted with the view of a positivist researcher to "believe that the researcher and subject are independent entities" (Wheeler 1995, p.66). In addition, Wheeler states that non-positivists "believe that researcher and 'participant' are linked together through their relationship, and that together they create their own truth and reality" (1995, p.67). Similarly, the notion of truth as being influenced by individual people and their respective social experiences is affirmed by Guba and Lincoln (1994, p.111) when they consider such truths to be "more or less informed and/or sophisticated." Any generalisations that emerged from this study would be context-bound rather than context-free. The central focus was on the lived experiences of those of who took part in a series of musical events within a specific environment. In light of this, the incorporating of a more objective measurement tool such as the Oxford Happiness Scale, as discussed by Hills and Argyle (1998a; 1998b), may have felt too intrusive for at least some of the participants. As noted in chapter 2, Clark and Harding (2012) found that it was studies based on a qualitative methodology which appeared to demonstrate more tangible findings regarding psychosocial outcomes of singing interventions for therapeutic purposes. A qualitative methodology, therefore, was most appropriate, respectful and relatively unobtrusive.

In order to address the three research questions, and to explore the meanings of experiences for those involved, I chose two particular approaches to conducting qualitative research for this purpose: Participatory Action Research (as presented in the previous chapter) and grounded theory. A methodological justification for these approaches is given below.

4.1.1   Methodological justification for Participatory Action Research

Participatory Action Research implied my own active engagement in the research process; in this case the planning, implementing and evaluating of a series of choral experiences. Similarly, the involvement of a choir assumed the contributions of other

people through singing and also in the research process itself. Thus, I was one of several participants and the potential success of the choir was dependent upon a collaborative effort. Stige (2005a, p.405) describes PAR as "a communicative approach, where collective reflections for identification of problems and solutions are essential. But the process does not stop with thinking and talking; practical actions are implemented and evaluated as a basis for new collective reflections." Furthermore, Elefant (2010) believes that this approach sits comfortably within a therapeutic context as it carries similarities with the significance of collaboration, flexibility and a client-centred focus; this would seem an essential consideration when working with people who may present mental health issues. A music therapist herself, Elefant adopted PAR in the study of a choir for people with physical disabilities in Israel (2010). For my own study, the regular maintaining of a Professional Log constituted as written evidence for this part of the research design. This was an important document as it comprised a detailed and reflective analysis of each rehearsal.

The incorporating of PAR as central to this qualitative stance linked well with the notion of 'gentle empiricism'. Ansdell and Pavlicevic (2010) are critical of the contemporary requirement for music therapists to provide evidence for their work which reduces or replaces the phenomenon being studied with abstractions or generalisations. They draw from the writings of Goethe in the affirmation of human experience being at the heart of an attitude to research. The authors state that 'gentle empiricism' "retains a firm root in the fundamental phenomenon of *people-in-music*, alongside the pragmatics of putting 'music's help' in action with different clients and in varying situations" (Ansdell and Pavlicevic 2010, p.131).

4.1.2   Professional Log

While the implementation of PAR was outlined in detail in section 3.2.7, this particular section describes how the written evidence for this research approach was documented. This is the rationale for the Professional Log and is central to answering the third research question.

Reference was made in section 3.2.6 to the audio recording of each of the 23 rehearsals. The opportunity to listen back to each rehearsal allowed me to critically reflect on what had taken place and therefore plan accordingly for the following rehearsal. Notwithstanding the value of this aural record it was important to formalise this experience within a written record of the event. For this purpose I applied the process of indexing (Nordoff and Robbins 2007). The use of index sheets is an established way of obtaining a written account of aural events in music therapy practice. As Nordoff and Robbins themselves state:

> Indexing the recording of a session can augment the first-hand experiences gained from the session itself. Inevitably, studying a recording will often reveal events or processes in therapy that were missed or only partially recognized during the actual session. In this way, the indexing of the recording can serve to broaden, supplement, or even correct, impressions gained from the session itself. (Nordoff and Robbins 2007, p.182)

The process of indexing, therefore, allowed me to document any significant verbal responses of the participants during each rehearsal as well as the music used and the general musical responses of the choir as a whole. Following the principles of Nordoff and Robbins (2007) I devised the particular template for this process; an example of the index sheets pertaining to one rehearsal can be found in appendix 7. The opportunity was thus afforded to see what happened at precise moments during the respective rehearsal. More specifically, it was then possible to swiftly notice and reflect on the relationships between the music used, the musical responses from the participants and any subsequent verbal responses.

4.1.3   Grounded theory

Grounded theory was originally devised by two American sociologists, Barney G. Glaser and Anselm L. Strauss; in essence they defined it as "the discovery of theory from data – systematically obtained and analysed in social research" (1967, p.1). Their rationale was to devise a methodology which was different to a quantitative perspective in which emphasis was placed on the testing of hypotheses or prior theories. Instead they were concerned with "how reality is viewed by the participants themselves" (1967,

p.254). Particular attention, therefore, was given to the context as well as to the topic *within* the context. Thus, the interrelating between the broader context and the specific topic (or participants) being studied is pertinent to this thesis which is a central reason for the adoption of grounded theory as a research methodology. Indeed, Strauss and Corbin (1997, p.vii) state this "mode of qualitative study has spread from its original use by sociologists to the other social science and practitioner fields." According to Denscombe (2010, p.109) grounded theory "has its roots in pragmatism."

Grounded theory allows for the analysis *of* data and also for the generating of theory which is grounded *in* the data. The process involves multiple stages of data collection and the gradual refining of codes in order to produce clear theoretical formulations. Data, therefore, are systematically obtained and analysed. The generating of theory from data requires the researcher to approach the respective investigation without preconceived theoretical ideas. It is therefore recommended that the undertaking of a literature review should not commence prior to the collection of data. In so doing, the researcher is not unduly influenced by the findings from the literature; in short, they do not contaminate the subsequent findings which emerge from the data. Glaser (1992), however, is quick to point out that this should only happen in the initial stages of the research process and that once data begin to be collected, literature related to the researcher's own preliminary findings should then be reviewed; a difference, therefore, between emergence and forcing. Urquhart (2013) notes that within the context of a doctoral study proposal or funded research it would generally be expected that a review of literature is carried out in advance of data collection and analysis in order to have an overview of the broad area identified for research. Denscombe (2010) advocates approaching the data with an open mind – which is nevertheless informed – rather than a blank mind.

A key part of the process of grounded theory is the systematic coding of data (Strauss and Corbin 1997). This involves the researcher becoming thoroughly immersed in the data and assigning units of meaning (codes) at various stages of the research process. The gathering and refining of codes represents the detailed analysis of data and it is from this inductive procedure that theories may then be realised. According to the

particular form of grounded theory being applied the process of analysis may include, for example, open coding, theoretical sampling and saturation, axial coding, selective coding, theoretical sensitivity and synthesis (Amir 2005). At the heart of this is the inclusion of constant comparative analysis which requires the researcher to continually revisit the codes in order to identify similarities and differences as relationships begin to emerge.

Since the original text by Glaser and Strauss in 1967 different interpretations and versions of grounded theory have led to contrasting opinions as to what actually constitutes this particular method. Holton (2007, p.265), for example, claims that grounded theory is a methodology rather than a method and, as such, is distinctive from a qualitative methodology; her use of the term "classic grounded theory" affirms the view she holds. Glaser and Strauss themselves latterly differed as to how grounded theory might be defined and implemented; Urquhart (2013) notes that Glaser was concerned Strauss appeared to be promoting an overly prescriptive approach to coding procedures, such as the use of a coding paradigm. Willig (2013) differentiates between a full implementation and an abbreviated version of grounded theory. She states that with the former the researcher is required to "move back and forth between data collection and analysis" (p.73) whereas the abbreviated version involves only the coding of data. Mruck and Mey (2007, p.516) encapsulate the disparate perceptions of grounded theory when they claim that not only is the method inconsistently used but so are "some concepts of the method itself, sometimes even within one publication."

Notwithstanding the range and diversity of interpretations outlined above, grounded theory represents a well-founded and rigorous approach to qualitative research yet must also retain a degree of flexibility (Denscombe 2010). This may be observed especially in the process of theoretical sampling in which the researcher requires to be responsive to the data and "go where analysis indicates would be the most fruitful place to collect more data that will answer the questions that arise during analysis" (Corbin and Strauss 2008, p.145).

There are three reasons why grounded theory is an appropriate choice of data analysis for this thesis. Firstly, as Denscombe writes (2010, p.106) it is particularly relevant for researchers who are "engaged in small-scale projects using qualitative data for the study of human interaction, and by those whose research is exploratory and focused on particular settings." Secondly, as a means of theory building this approach lends itself favourably to generating substantive rather than formal theory; the former being more closely localised and linked to the respective empirical situation whereas the latter is concerned with a more conceptual theory and with subsequently wider coverage (Denscombe 2010). And thirdly, the corroboration between grounded theory and Participatory Action Research adds robustness to the findings and assures greater transparency and trustworthiness. This would seek to avoid an over-subjective tone as a result of my deep engagement with the field work. Indeed, Amir (2005) notes that within music therapy practice researchers often apply grounded theory with another research method in order to acquire a more holistic overview of the findings.

4.2   Data collection

4.2.1   Focus group discussion

Focus group discussions were arranged at the commencement and conclusion of the project. These will be referred to respectively as Focus Group 1 and Focus Group 2 meetings. Patients and staff were arranged in separate groups in order to eliminate a potential hierarchy between the participants. According to Morgan (1998, p.9), focus groups are "fundamentally a way of listening to people and learning from them." Similarly, Bloor et al. (2001, p.18) state that such groups "may be used to democratize the research process by functioning as a forum for public participation." This was a convenient way of gauging the views of people who had chosen to be participants. In addition, it provided opportunities for a spontaneous and creative group debate in which narratives that might not have arisen through one-to-one dialogue were observed. When considering the perceived benefits of singing as a result of preliminary surveys undertaken with a university choral society, Clift and Hancox (2001, p.252) reflected on their choice of questionnaires as the chosen method for collecting data by stating that

"Further work, exploring such ideas in greater depth using focus group methods and interviews would be of considerable interest."

I had three objectives in the moderating of the Focus Group 1 meetings. These were as follows:

- To provide a forum in which we all might meet in a safe and respectful environment.
- To know how people were feeling about taking part in this study.
- To find out how people would like the rehearsals to be organised in terms of structure and repertoire.

The questions I asked in these first meetings can be found in appendix 8 along with a rationale for each one and a potential prompt. The initial meetings for patients and staff were helpful in informing me how to plan the first rehearsal.

Similarly, I had three objectives in the moderating of the Focus Group 2 meetings. These were as follows:

- To provide an informal forum in which I could express my gratitude to all who had taken part.
- To offer an opportunity for people to reflect on their experiences of the project.
- To afford specific discussion concerning the potential health benefits acquired as a result of taking part in these choral experiences (first research question) and hearing the views of patients and staff with regard to the influence this had on the relationships between the two populations (second research question).

The questions I asked in these second meetings can be found in appendix 9 along with a rationale for each one and a potential prompt.

Although there were separate focus group meetings for patients and staff, the same questions were asked to both groups. The Focus Group 1 meetings were held in the room used for music therapy sessions. While this was personally convenient as it did not require me to prepare another room in advance, I was aware that this may have

potentially confused patients with whom I had worked as the relationship between us had altered; it was no longer 'strictly' clinical. At this particular time, however, no other room was available and I accepted that the familiarity of the room may indeed be helpful.

The difficulty for each participant to attend one or both of the focus group meetings due to, for example, work shifts or transfer to another hospital, meant that additional arrangements had to be considered. The opportunity was therefore made available for those people to articulate their views either through a written response to the focus group questions or by means of a semi-structured interview.

4.2.2   Semi-structured interviews

The context of a semi-structured interview is different to that of a focus group meeting. Inevitably, more people are involved in the latter and the flow of discussion will likely feature a wider range of views. Thus, the researcher is required to consider his or her questions – and how they may be asked – with due sensitivity to the respective milieu.

Drever (1995) promotes the use of semi-structured interviews as a helpful midway point between the process of an interviewer reading out a set of questions with a selection of answers from which the interviewee must choose, and the context of an entirely non-directive style of discussion between interviewer and interviewee. As such, the semi-structured interview allows the researcher to plan the interview in advance by preparing an interview schedule with a series of carefully selected questions. From this schedule, a flow of discussion can evolve between both parties that is contained within a clear structure. The sensitive use of prompts and probes by the interviewer ensures that the schedule is adhered to, yet sufficiently flexible to facilitate moments when the interviewer wishes to explore an issue in greater depth; or gently challenge or cajole. This may be especially relevant when there is an emphasis upon open rather than closed questions.

Ansdell and Pavlicevic (2001, p.190) promote the use of semi-structured interviews as a form of conversation that is "an *equal dialogue*." Likewise, Kvale (1996, p.2) suggests that a qualitative research interview is "literally an *inter view*, an inter change of views between two persons conversing about a theme of mutual interest." Kvale (1996) also presents the different metaphorical stances that the interviewer may take as either a *miner* or a *traveller*. Whereas the miner approach to interviewing considers knowledge as "buried metal and the interviewer is a miner who unearths the valuable metal" (p.3), the traveller approach is concerned with the interview as a "journey" in which the interviewer is "wandering together with" each of the participants (p.4). This point is echoed by Spradley (1979) when he describes the role of the interviewer in the following way:

> I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand? (Spradley 1979, p.34)

For reasons of fairness, however, it seemed appropriate that the questions posed in the focus group discussions should be similarly deployed in the semi-structured interviews. This would also facilitate the process of analysis and, in particular, the corroboration of different forms of data collection (Urquhart 2013).

An overview of patent and staff participation/attendance at focus group meetings and semi-structured interviews is given in Table 4.1.

	FG1	FG1(WR)	FG2	FG2(WR)	SSI(Post)
P1	♪				♪
P2	♪		♪		
P3	♪		♪		
P4	♪				
P5	♪				
P6		♪			
P7		♪	♪		
P8					
S1	♪				♪
S2	♪		♪		
S3	♪		♪		
S4	♪		♪		
S5		♪		♪	
S6		♪		♪	

Table 4.1   **Overview of patient and staff participation/attendance at focus group meetings and semi-structured interviews.**

FG1   Focus Group 1
FG1(WR)   Focus Group 1 (Written Response)
FG2   Focus Group 2
FG2(WR)   Focus Group 2 (Written Response)
SSI(Post)   Semi-structured Interview (Post Rehearsals)

4.2.3   Duration and dynamic of meetings

The durations for each of the focus group meetings and semi-structured interviews are stated in Table 4.2. It can be observed that the length of time for the first focus group meeting with the patients lasted less than twelve minutes. Of the five patients who took part in this discussion three had attended music therapy before; the other two patients were relatively unknown to me. I found the dynamic of the group to be unsettling and the task of moderating the discussion frequently challenging. This was due largely to the interrelationships between the participants; in particular, the dominance of one participant created an underlying tension between herself and the others. People remained polite yet the mood was delicately balanced between tolerance and potential disquiet. Furthermore, the need for two people to be assured that the meeting would not curtail the hourly smoking break on the ward was a prominent concern. Yet each person contributed helpfully to the discussion and all of the questions were addressed; the data were relevant and rich.

Upon reflection I was aware of the significance of therapeutic sensing as I had to carefully maintain an open yet safe environment for this group. In so doing, I was reminded of a key difference between a music therapy group and a talking therapy group; while the former allows people to simultaneously communicate through collaborative musical interaction, the latter requires the verbal contributions of one person to be listened to by the other members. I was perhaps naïve not to have contemplated this more fully beforehand; these are people who may present significant mental health difficulties and often within a complex life narrative. To have attempted to have prolonged the debate would, I believe, have been counterproductive. Thus, while I was anxious at having to ensure that equilibrium was observed in the discussion, I was also deeply privileged to have been entrusted with their honesty and openness with regard to the significance of music in their lives.

FORMAT OF MEETING	DURATION
Focus Group Patients 1	11 min. 57 sec.
Focus Group Staff 1	22 min. 23 sec.
Focus Group Patients 2	24 min. 18 sec.
Focus Group Staff 2	23 min. 14 sec.
Individual Patient Interview	31 min. 34 sec.
Individual Staff Interview	16 min. 24 sec.

Table 4.2 **Durations of each of the focus group meetings and semi-structured interviews.**

The above table also indicates that the semi-structured interview with P1 lasted longer than any of the focus group discussions (or the interview with S1). This represented a poignant moment in the data collection process as I was aware that it was the last time I would see this particular patient. His transfer to another hospital the following week meant that he would not be able to attend the final rehearsal and, most significantly, the performance. P1 had attended music therapy sessions on a group basis for approximately two years and our professional relationship was well-established and warm. Our discussion was partly framed within the context of a farewell event although this did not have a negative impact on the data collection process. I was aware of an intimacy in his views about participating in the choir as well as his general feelings about how music had featured in his life at different periods. Thus, while the conversation would occasionally move into topics not directly related to the question being discussed, this afforded the opportunity for a profound discourse. On reflection this was another instance when my presence and familiarity as a therapist within the environment (therapeutic sensing) facilitated a level of discussion that a more objective interviewer may not have been able to achieve.

4.3   Data analysis

4.3.1   Analysis of focus group meetings and semi-structured interviews

In remaining faithful to some of the central principles of grounded theory I have deployed open, selective and theoretical coding in order to present thematic conclusions to this study. These have been underpinned with a consistent emphasis on critical self-reflection or reflexivity (Urquhart 2013). More detail with regard to the implementation of these procedures in relation to the three research questions is given in the respective chapters of this thesis.

The Focus Group 1 meetings, as intended, provided a broad baseline indication as to how people were feeling about the project and their general states of wellbeing at the time. Furthermore, the responses were invaluable in alerting me as how best to proceed with the rehearsals. They were not intended to specifically answer the three research questions. This was the rationale for the Focus Group 2 meetings (research questions 1 and 2), and the Professional Log (research question 3). Thus, the analysis of the Focus Group 1 meetings is not included in this thesis[12]. The actual themes that evolved from this analysis, however, are presented in appendix 10. In addition, there are occasions when reference is drawn to some of the observations from the Focus Group 1 meetings in discussing the findings pertaining to the Focus Group 2 meetings[13] and the Professional Log. The findings of the analysis of the Focus Group 2 meetings are presented in chapters 5 and 6.

The initial stage of the process of analysis involved listening to the audio recordings of the focus group meetings. This allowed me to *purely* listen from an objective standpoint in comparison to my earlier role of moderating the discussions. I then completed a verbatim transcript of the meetings followed by detailed line-by-line open coding as suggested by Willig (2013). In order to capture the immediacy of this process these codes were descriptive rather than analytical and I indicated them in the right-hand margin of the transcripts by using the Microsoft Word 'New Comment' icon.

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[12] This analysis can be made available upon request.
[13] The theoretical codes which emerged from the Focus Group 2 meetings can be found in appendix 11.

Following this I organised the open codes into selective codes. Urquhart (2013, p.49) states that "selective coding is a process of scaling up your codes into those categories that are important for your research problem." These selective codes would later be located within larger over-arching categories. This was achieved through the process of constant comparative analysis which requires the researcher to "refocus on differences within a category in order to be able to identify any emerging subcategories" (Willig 2013, p.71).

This procedure was similarly adopted in the analysis of the written responses submitted by individual participants unable to attend the focus group meetings as well as the verbatim transcripts of the semi-structured interviews. The stage of theoretical saturation was reached when no new instances of the identified selective codes could be found. Whilst this study is based on a qualitative methodology, a quantitative perspective was partially applied when the incidences of codes were counted pertaining to the number of patient responses and staff responses (separately and collectively); Urquhart (2013, p.39) refers to this as "content analysis."

The next part of the coding process (following on from open coding and selective coding) was theoretical coding. Urquhart (2013, p.26) describes this as the moment when "we relate the [selective] codes to each other and look at the nature of the relationships between these codes." Finally, these theoretical codes were refined and presented as themes. An example of this sequential process is given below from the Focus Group 2 meeting pertaining to patient members from the category 'Rehearsal experiences'.

Verbatim statement: "We felt very strong because we learned something, we learned to sing, we learned the discipline."
P7: lines 91-92

Open code: Sense of discipline through learning.

Selective code: Opportunity to learn through the experience of music.

Theoretical code: Patients may acquire an increase in confidence and self-pride through learning in music as well as a deeper appreciation of freedom, space and kindness.

Theme: Opportunities for learning.

In following this process the adoption of grounded theory as a form of data analysis as well as a means of theory building can be observed. Thus, while it may be argued that the above compares more closely with an abbreviated rather than a full version of grounded theory as defined by Willig (2013), several of the key principles of this particular approach to research are being maintained.   The findings for this are presented in chapters 5 and 6.

4.3.2   Analysis of Professional Log

The Professional Log represented the written evidence of the weekly rehearsals. To an extent it may be described as a diary comprising details of the 23 rehearsals of the research period. In addition to the detailed indexing of each rehearsal, however, the Professional Log afforded the opportunity to make the transition from this necessarily descriptive procedure to one that required greater analysis. Once again several of the principles of grounded theory were applied to this process. These are outlined below:

- Following each rehearsal I would listen to the audio recording in its entirety – i.e. without pausing the recording or taking notes. This would allow me to gain an objective overview of the respective rehearsal. The opportunity to notice *how I felt* was provided.

- I would then listen to the rehearsal again and index as outlined in section 4.1.2. I would write comments in four columns pertaining to the following headings: Time, Musical Content, Musical Responses and Verbal Responses. Thus, the significant moments of the rehearsal – musically and verbally – could be documented.   The opportunity to consider *what actually happened* was provided.

- Following this second listening I then made a list of points for me to consider in preparation for the next rehearsal. The opportunity for me to consider *what I might do next* was provided.

- At the conclusion of the six-month period of data collection I listened to each rehearsal once more. This retrospective listening allowed me to reflect more deeply on the progressive nature of the rehearsals and to consider changes in the dynamic of the choir, the overall choral sound and differences in my approach as a conductor as we worked towards a performance. The opportunity for me to *reflect on the overall experience rather than each separate rehearsal* was provided.

- I applied the processes of open and selective coding in order to determine the significant themes which emerged from the data. I began by indicating my observations in the right-hand margin of the index sheets by using the Microsoft Word 'New Comment' icon. I then revisited these observations and considered them as general points for me to consider in planning for the next rehearsal; I have referred to these as open codes. A deeper level of analysis of these open codes allowed me to then refine them as selective codes. I was then able to arrange these selective codes into overarching categories. I labelled these categories as 'Reflections on myself', 'Reflections on participants' and 'Reflections on rehearsals'.

In order to notice changes and developments throughout this six-month period I arranged the analysis into three blocks of six rehearsals and one final block of five. By comparing and contrasting the selective codes within each of the three categories it was then possible for me to consider specific theoretical codes at different stages of the data collection process. These were then reduced further and arranged finally as themes. Thus, the opportunity to *refine my original observations and to allow the theory grounded in the data to emerge* was provided. An example of this process is given below; this comes from the index sheets pertaining to the category 'Reflections on myself' (rehearsals 7-12):

Open code: Interesting to hear how I ask questions to the participants, almost like a teacher.

Selective code: Self-awareness of tendency to ask questions like a teacher.

Theoretical code: As therapists we may find ourselves adopting a more didactic approach when working with larger numbers of people.

Theme: The tendency to adopt a more didactic approach.

The findings of the analysis of the Professional Log are presented in chapter 7.

5. ANALYSIS OF THE HEALTH BENEFITS EXPERIENCED BY PATIENTS AND STAFF WHEN SINGING IN A CHOIR

5.1 Introduction

This chapter will present the results with regard to the first research question:

What health benefits are experienced by patients and staff in a medium secure forensic setting when singing in a choir?

This will consider the findings from the Focus Group 2 meetings – including the written responses to the questions from meetings which certain people were unable to attend – and the responses from participants who expressed their views through a semi-structured interview. Following the procedure for analysis outlined in the previous chapter, three themes emerged which are relevant to this question.

Theme 1   Increased wellbeing.

Theme 2   Opportunities for learning.

Theme 3   Expression of empathy.

These themes are discussed in more detail below.

5.2 Theme 1: Increased wellbeing

There were clear similarities as to why people felt these rehearsals had been so positive. This theme, therefore, is drawn from category 1 'Rehearsal experiences'[14]. The highest selective code of 'Overall feelings of wellbeing' (28.1%) comprised general comments made by the participants[15]. These mainly alluded to experiencing a sense of enjoyment, warm-heartedness, excitement or fun. This sense of fun was frequently highlighted by staff and patients (whereas in the responses expressed in the Focus Group 1 meetings fun was alluded to by the staff members only). One member stated that it was:

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[14]The list of categories and open codes pertaining to the Focus Group 2 meetings can be found in appendix 12.

[15] A content analysis of the selective codes comprising this category can be found in appendix 13.

- "Totally like a little oasis and so different to anything else I ever do."

   S4: lines 143-144

The sense of belonging – and contributing – to a group was frequently mentioned by the patients and staff members (24.3%). The feeling of group camaraderie clearly meant a great deal for both populations. Two patients stated:

- "I think I found it a lot more fun than I thought it would be . . . em, and again, yeah, being in a group was really nice."

   P2: lines 100-108

- " . . . we had ourselves as a group and each one of us somehow, exactly, helped the other one. Em, it was kind of total concentration but not with straining oneself, not at all, it was natural as, as breathing . . . "

   P7: lines 232-234

I was careful not to lead the first question of the Focus Group 2 meetings towards a discussion of what it was like for patients and staff to be singing together; this would come later in the respective meetings. It may be inferred, therefore, that people did not simply value the opportunity of two 'sub-groups' becoming one 'main' group; rather, it was different individuals coming together for a common purpose. Indeed, a closer analysis reveals that within the staff discussion, people had welcomed the opportunity for a range of staff professions to be represented and sharing together in a way that seldom happened. The opportunity for an occupational therapist, a nurse, a social worker and an administrator to be collaborating together was warmly appreciated. Thus, it seems pertinent to reflect on the tendency to compartmentalise those who work in the clinic as 'staff' as this almost assumes a discrete group of people. The diversity of professionals may be more appropriately termed a disparity of individuals who will rarely be in the same room together. The choir afforded an occasion to be relieved from day-to-day responsibilities and to forge a new identity free from professional hierarchies.

The selective code of 'Benefits of singing in the choir have lasting impact' similarly comprised comments from both staff and patients. Yet the particular benefits felt by the

two populations were quite different. One patient, for example, made reference to the acquisition of a lasting feeling of strength while another spoke about her tendency to sing more on the ward. As she commented:

- "I have found that on the ward I just, I sing more. Yep. And sometimes I sing myself to sleep, and I, I'm singing the songs that . . . And I lie there hoping no-one can hear me . . . through the walls! But yes, so I've noticed that I have been singing more."

    P2: lines 176-190

The staff participants, however, referred to how they would return to work after the rehearsals feeling more relaxed and centred. One person indicated that he was more aware of how he was breathing; in particular, he felt an increased body awareness which assisted him when working for long periods at a computer:

- "I've certainly found that, em, the concentration on my breathing during the singing has got benefits to the rest of my, certainly initially afterwards I was feeling much more sort of centred and, and relaxed doing, doing my work, you know, cause of that, cause you're busy, computers, you're not really paying attention to your body and doing the singing gives you that sort of awareness of your body."

    S2: lines 88-93

The lasting impact of the rehearsals was also alluded to by two members of staff when they independently stated:

- "Forty-five minutes of doing something that you really like, certainly lasted for much longer than another forty-five minutes, it would last, you know, much of that the next few days I think, . . . carried that with you."

    S2: lines 167-169

- "I was always left with so much energy."

    S4: line 12

The only other selective code which comprised responses from both groups was 'Participation was safe and natural'; implying that people did not feel daunted or overwhelmed with the musical objectives that we sought to address in each of the songs. The feelings of insecurity about one's own singing voice potentially hindering participation in the choir – articulated as theme 3 from the Focus Group 1 meetings – were not apparent in these rehearsals. Such feelings, therefore, while genuinely felt may be sensitively alleviated through singing in an environment that is non-threatening.

It is interesting to note that of the 20 selective codes only 4 were shared by the staff and patients. The patients, however, spoke about increased feelings of confidence and self-pride as being significant when engaging in a project that was not based on verbal communication. It is pertinent to observe that it was the patients only who mentioned the promotion of attributes such as kindness and diplomacy as well as feeling an increased sense of empowerment, space and freedom. One might infer from this that these particular feelings and life experiences are less prominent in the lives of patients; that their everyday lives are, to an extent, a restriction of space and freedom while kindness and diplomacy may appear less apparent in a clinical and inevitably hierarchical environment.

5.3   Theme 2:   Opportunities for learning

The selective code of 'Opportunity to learn through the experience of music' from Category 1 'Rehearsal experiences' was referred to by the patients only (15 open codes). It is intriguing to note that mention was made on three occasions from the patients of my perceived role as a teacher. Notwithstanding my desire throughout the rehearsals to be open, democratic and a facilitator rather than a conductor, the participants appeared to welcome the opportunity to be taught, led and informed with clear instruction. People wanted to work and to learn. The patients did not seem to object to my change of approach from a therapist to one where I was viewed (temporarily at least) as a teacher. As one patient stated:

-     ". . . there was some kind of a, empowering, empowering and learning, every time I came here I learned something new. I, I, I discover something about

myself because I, I didn't think I would be able to sing that much but as the lady said we have had a very good teacher."

P7: lines 159-162

Upon reflecting on this comment it is perhaps helpful to consider that while I was not deliberately adopting the role of a teacher, some of the patients felt that this was a helpful learning experience. In addition, it is apparent that the learning was not exclusively about music; rather, the chance to learn about oneself, to discover and to be empowered were outcomes of the whole experience. Furthermore, the sense of personal regulation that may be fostered through learning was alluded to by one patient when he claimed:

- "We felt very strong because we learned something, we learned to sing, we learned the discipline."

P7: lines 91-92

Similarly, the comment made by another patient when she claimed that "I learned quite a bit about my voice" (P2, line 104) may have as much to do with a heightened self-esteem as it has about improvements to one's singing.

During the focus group meeting with the patients I had acknowledged my own learning as part of the whole experience. I was keen to emphasise that I had learned *from* the patients; indeed that I had been taught *by* them. This was a genuine feeling on my part rather than a verbal response that I had felt obliged to articulate. Thus, while I had adopted the role of a conductor (a position of authority) and held the responsibility of a therapist in this setting (a professional status) I was presenting myself as someone who had learned from those who would not normally be considered to afford an educational hierarchy over members of staff. This personal reflection was prompted by the comment made by one participant when he stated that "you helped us push the envelope" (P7, line 154). There is an implication here that, for this patient, the overall learning experience had required him to move out of his comfort zone. Yet it would be reasonable to suggest that that such 'moving out' is in itself a definition of learning which patients, staff and I had all experienced.

In conclusion, the ethos of a medium secure forensic unit is multi-faceted and complex; such complexities are also opportunities for learning. The definition that a medium secure unit is a setting "for people who are detained under mental health legislation and pose a serious danger to the public" (Mental Healthcare 2013) seems inadequate when considering some of the above responses. It is, amongst many things, a learning environment.

Similar observations were also made in the Professional Log thereby adding corroboration to these particular findings[16]. These are discussed more fully in chapter 7.

5.4   Theme 3:   Expression of empathy

This theme emerged as a result of careful reflection on the respective challenges felt by the two populations. Only one area of challenge (issues regarding vocal technique) was found to be common amongst the patients and staff; these were to do with the singing of scales and arpeggios, the high pitch range of certain songs or being able to sing some of the words in a sufficiently quick manner. As one patient said:

- "'Ob-La-Di Ob-La-Da', there was many words. I couldn't sing them. I couldn't keep up with the others . . . I gave it my best shot."

    P3: lines 330-339

Whilst other forms of challenge were articulated by the patients and staff, it did not appear that any individual person felt overwhelmed by the choral experiences or that he or she was unduly apprehensive. Indeed, the most frequently mentioned response affirmed that the challenges were realistic and empowering. There was a sense that once the rehearsals commenced people became more confident in their vocal technique and felt less anxious about participating in this way. The environment, therefore, was reassuring and safe.

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[16] Details of this can be obtained upon request.

The respective groups indicated quite different challenges; for some patients in the clinic the hourly smoking break can be very important and anxiety was often expressed in rehearsals if this occasion might be shortened or missed. For one member of staff the removal of barriers was highlighted as evoking a feeling of vulnerability; the sense that throughout rehearsals service-providers (staff) were also service-users (choir members).

It is poignant to note that within the patient and staff groups, an acknowledgement of the possible challenges that may affect the people of either population was made. One patient, for example, recognised that it was not easy for staff to find time to attend rehearsals. The staff, however, felt concerned that the emotional content of some of the songs could be overwhelming; it was the case that one patient in particular could become tearful with regard to the memory and association of certain songs and would occasionally request to leave the rehearsal early. As a member of staff indicated:

- "I think at the start the song lyrics of some of them, I just felt 'oh, you know, a wee bit like, ooh, how is this person in the room gonna react?' It was more about how other people were going to feel about some of the song lyrics and some of the emotions as well. I think it was more kind of a bit, bit scared of what it could bring out."

    S1: lines 130-133

Thus, the sense of care that was fostered between people in the choir appeared to promote new feelings of empathy in a tangible way.

5.5   Discussion

The results suggest that health benefits can indeed be experienced by patients and staff in a medium secure forensic setting when singing in a choir. In particular, people may experience overall feelings of wellbeing such as enjoyment, warm-heartedness, excitement and fun. A heightened sense of belonging and contributing to a group may also be felt. Singing, therefore, provides opportunities for collective performance which can be self-affirming.

For members of staff returning to their work after a rehearsal the opportunity may be provided to feel more relaxed, energised and centred as well as having an increased awareness of posture and breathing.

Patients may grow in self-confidence and develop a sense of pride as well as acquiring enhanced feelings of empowerment, space and freedom. The promotion of attributes such as kindness and diplomacy can also be observed.

The opportunity for learning through the musical experience in this study was clearly felt to be helpful by the patients. Furthermore, the process of learning may also afford a deeper insight into oneself. In turn this can lead to greater feelings of empathy towards others in acknowledgement of the respective challenges faced by different individuals.

Theme 1   Increased wellbeing

The comments made by the patients and staff in this study regarding health benefits resonate closely with the concept of social capital (Putnam 1995; Procter 2004; Halpern 2005). Indeed, Halpern's suggestion of a social network (relationships), social norms (values and expectations) and social sanctions (how the norms are maintained) are apparent in the findings relating to such benefits. More specifically, the actual enjoyment experienced by the participants links with Blaxter's (2010) view that being healthy will likely follow from being happy. This opinion is echoed by Matarasso (1997b), McQueen-Thompson and Miguras (2002) and Coveney and Bunton (2003).

The sense of passion for the experience of choral singing that was expressed by some participants may be compared to the views of Philippe et al. (2009) whereby passion can meaningfully contribute to wellbeing; this can be affirmed by the fact that those taking part were doing so due to a genuine desire to sing with others rather than an opportunity to further one's own status. Similarly, the findings of Clift and Hancox (2001) are generally consonant with this thesis in relation to the social, emotional and physical benefits that may be acquired through singing with other people; the exception to this is that spiritual benefits (as noted by these authors) were not specifically mentioned by either the patients or the staff. The emotional impact that was felt by those taking part was alluded to in the literature by, for example, Richmiller (1992),

Nelson (1997), Coleman (1999) Bailey and Davidson (2003), Cohen (2009) and Eyre (2011). Other pertinent similarities that can be made to the development of group camaraderie are those of empowerment (Strachan 2006; Tuastad and Finsås 2008; Balsnes 2012; Merrick and Maguire 2012) and belonging (Bailey and Davidson 2003; Barz 2006; Lortat-Jacob and Benamou 2006; Russell 2006; Livesey et al. 2011; Young 2014). Finally, the significance of belonging is emphasised by the World Health Organisation in their 'Mental Health Action Plan 2013-2020' (WHO 2013) regarding the desire for services to be more community-based.

The specific attribute of physical benefits felt by the staff members as a result of taking part in a choir rehearsal can also be observed in the literature. Two of these pertain to specific populations; Cohen (2006) in relation to a study with elderly people, and Young (2009, p.20) in her work with adults with cancer in which she noted changes with regard to "increased relaxation as well as heightened energy and motivation." While this thesis found that it was staff members rather than patients who commented specifically on feeling physically better as a result of singing, the study by Livesey et al. (2011) indicated that benefits such as improved breathing were similar to those who were considered to have high mental wellbeing as well as those who defined themselves as having low mental wellbeing. The unique finding from the study by Livesey et al. (2011) in which participants felt that choral singing could actually help to promote health-seeking behaviour was not replicated in this thesis.

Theme 2   Opportunities for learning
The significance of learning in relation to the choral experience – while being a likely outcome – is not generally considered to be an objective within the context of music therapy practice. Maydana and Brasil (2014), however, allude to a particular cognitive focus which included learning music theory and harmony when working with people within the age range of 52 to 90; not least for purposes of aiding memory retention. Likewise, Davidson and Faulkner (2010), when engaging with elderly people and their carers, incorporated optional harmony parts in choir rehearsals as a means of offering challenges considered proportionate to those involved. Yet the authors state, "There

was never a sense of failure, and all individuals and all vocal sounds were accepted" (p.168).

Observations may be made with regard to learning as a consequence of the devolution of responsibilities due, in part at least, to the nature of the relationship between the conductor and the choral participants. Talmage et al. (2013) discuss the importance of choice that may be apparent in tasks such as the selection of repertoire and the setting of goals which could facilitate a sense of ownership being experienced by the members of the choir.   Thus, the outcome might also be observed in other contexts and situations. Silber (2005), when working with an Israeli prison choir sought to transfer musical responsibilities to the members themselves. Similarly, Mellor (2013, p.191) discusses the reflections made by the participants of a choir with regard to its leader stating that this can "lead towards an understanding of a more inclusive pedagogy." Merrick and Maguire (2012), however, note that the devolving of responsibilities when establishing a choir at Broadmoor High Secure Hospital (through a "servant leadership" style) took time to be fully accepted. One might infer from this that the patients were unused to this form of autonomous learning and that a choir was a specific framework in which this might be implemented.

In this study participants commented on a heightened sense of freedom, space and kindness in relation to the experience of learning in a musical context. In the literature reviewed, however, no specific mention is made of kindness while freedom is alluded to only as an inevitable restriction experienced by "patients and inmates" (Stige and Aarø 2012, p.178). The concept of space appears to be something that is *provided* by the therapist rather than necessarily *experienced* by clients – e.g. Summers (1999) in the construction of a 'hello' space for elderly people. Similarly, Wilkerson and DiMaio (2013, p.89) refer to the offering of a "therapeutic space" for people attending the CarePartners Grief Choir.

Theme 3   Expression of empathy
The findings indicated that feelings of empathy may be felt and expressed in acknowledgement of the respective challenges faced by individuals when singing together in a choir.   In particular, this focused on how the different populations

perceived each other rather than how they related to each other. The study by Merkt (2012) which involved people with disabilities singing alongside students attending TU Dortmund University resulted in the latter group becoming more sensitive to the particular needs of the former. An inclusive choir, as suggested by comments made by the students, may lead to a more inclusive society. Furthermore, the project by Elefant (2010) – in which a choir comprising adults with physical disabilities sang alongside those with intellectual disabilities – is testament to how initial differences and tensions between two populations could be addressed and resolved through a flexible and client-centred approach demonstrated by the facilitator of the choir.

5.6   Conclusion

The three themes presented above do indeed bear close relation to the literature selected for review; thereby affirming the potential health benefits (within a psychosocial model of health) that may be acquired through choral singing in a medium secure forensic setting. As I reflect further on my own participation in this study throughout six months of choir rehearsals – and also on my work in this setting as a music therapist for several years – three concepts appear to be emerging which offer further robustness to these findings. Firstly, the significance of trust as a contributor towards health. This study has been based largely on the building of trust within individuals, between individuals and also between two groups of individuals. A sense of trust has been established as a result of each person involved moving out of their respective comfort zone. Risks taken by participants were eliminated, largely, due to the innate bonding and trust forged by the group as a whole. People have trusted themselves to satisfactorily cope with diverse demands; not least through *being* with each other in a new way. This has heightened the self-confidence of each participant which, in turn, has helped people to feel better. In addition, people have *felt* trusted which, as has been stated above, can have an empowering effect. Trust, therefore, is an outcome of feeling safe in the face of new challenges. The meeting of these challenges is a prerequisite of growth which can only assist in matters pertaining to health.

Secondly, notwithstanding the benefits acquired by individual people, a collective identity has been created between the two populations through *belonging* to a group

and *contributing* to a group. This is more than a temporary removal of barriers between staff and patients; rather, it is a manifestation of an inherent creativity that can literally find new voice through a shared musical experience. It is difficult to imagine another context in which such collectiveness can be expressed in this way. Such collectiveness is health-giving.

And thirdly, it is clear that significant autonomous learning has taken place. People have learned about music and also about themselves and others. The supportive environment has, I believe, allowed this to happen; not through being taught by myself but learning as a result of natural motivation and self-involvement. People have learned by doing and this in turn has encouraged each person to do more – and to want to do more. This has not been acquired through a need to further one's own status but a desire to achieve a level of fulfilment that is in itself growth-related and, consequently, health-promoting.

6.   ANALYSIS OF HOW SHARED PARTICIPATION IN CHORAL EXPERIENCES MIGHT INFLUENCE THE RELATIONSHIPS BETWEEN PATIENTS AND STAFF

6.1   Introduction

This chapter will present the results with regard to the second research question:

How does shared participation in choral experiences influence the relationships between patients and staff?

In keeping with chapter 5, this will also consider the findings from the Focus Group 2 meetings – including the written responses to the questions from meetings which certain people were unable to attend – and the responses from participants who expressed their views through a semi-structured interview. Following the procedure for analysis outlined in chapter 3, three themes emerged which are relevant to this question.

Theme 1   Feelings of benevolence.

Theme 2   Removal of barriers.

Theme 3   Being a person in one's own right.

These themes are discussed in more detail below.

6.2   Theme 1:   Feelings of benevolence

This theme comes from Category 3, 'Attitudes toward others'.   The combined responses of 17 open codes from patients (9) and staff (8) were arranged within 7 selective codes. The comments and codes from this category evolved naturally in the respective discussions and were not in response to specific questions asked by myself; more detailed comments in relation to what it felt like to be singing alongside patients (or staff) comprised a discrete part of the Focus Group 2 meetings. Yet a sense of context is required here in order to understand what has been said by the patients and staff members. Of the 9 open codes observed within the responses from patients, 8 of these came from one of the patients. Furthermore, this particular patient (P1) was not

able to attend the Focus Group 2 meeting due to being transferred to another hospital one week before the performance. We decided, therefore, to arrange a semi-structured interview prior to his transfer which would comprise the same questions asked in the Focus Group 2 meeting. It is likely that this afforded him an opportunity to be more open in his responses due to the intimate context of an interview. His comments, while still being candid, were always respectful. An example of how he adapted his singing voice to another patient's is given below:

- "So, but, if he, if whatever makes people happy then I think they've done it that way. But I've, I did, eh, rearrange my voice and I like to let his voice fit into the choir. And I've and I lowered my voice . . . no' to, em, make it sort of . . . a battle, a battlemerchant, like his was going, I mean I managed to meet him halfway and, eh, to make the song sound eh, eh, level, level itself out a bit. And eh, I enjoyed it really much."

  P1: lines 147-155

It is interesting to note that all of the comments pertain to the patients rather than the staff. In particular, the solo singing of one patient evoked an emotional response from several of the staff members. This patient had been unwell, indeed quite fragile, yet her commitment to singing a solo (beautifully) in the song 'You've Got A Friend' (King 1971) prompted the following comments from three participants:

- "Oh, I cannae get over it, how she was . . . " [SHE BREAKS OFF HERE, OBVIOUSLY MOVED BY THE MEMORY OF THIS EXPERIENCE].

  S3: line 253

- "It was, eh, hairs on the back of your neck."

  S2: line 259

- "I had a tear in my eye."

  S4: line 263

These comments were not spoken in a patronising manner; they were genuinely felt and warmly expressed. Members of staff had been emotionally affected by the artistic response of a patient. This patient, in fairness, had occasionally demonstrated a degree of resistiveness and confrontation in other contexts. Upon reflection of their subsequent reaction to her singing, it is interesting to consider whether this reaction was evoked by their changed feelings towards this patient in particular; or prompted by a deeper insight of their own assumptions that may have been unconsciously held towards those for whom beauty, warmth and gentleness are perhaps not normally anticipated. Furthermore, it is interesting to consider whether such feelings of benevolence would have been so apparent had this patient not sung with such expression.

6.3   Theme 2:   Removal of barriers

All of the comments regarding this theme were unanimous in their approval of staff having the opportunity of singing alongside patients. The staff members genuinely appreciated and enjoyed the chance of being with the patients in a different way. Notwithstanding this, one staff participant indicated that it took approximately two weeks in order to feel acquainted with this new context in which the two populations met and collaborated. One member stated initially that the experience was unlike other groups in which staff and patients would interact with each other. Later, however, she did make this comparison:

- "I have, have done other groups kind of like that, like football where you're very much kind of . . . very much part of the team and it's not about, you know, who you are, what profession you are or whatever. So it was, it was a kind of similar feeling to that. So it wasn't a totally new experience for me."

   S1: lines 255-259

The removal of barriers between staff and patients was frequently alluded to. This process seemed to occur naturally and allowed people to feel equal; negating, therefore, a sense of 'them and us'. Similar observations were also noted in my

Professional Log[17]. The participants were open and honest when reflecting on this issue; indeed there was a sense of a new realisation as to how relationships might be formed and developed in the clinic. One participant stated that, in general, barriers were created by the staff:

- "I think it breaks down those barriers that . . . in many ways they sort of, yeah, we, we form them ourselves. By doing something like this in a way we take them down and we choose, choose to do that, em. Em, yeah, it was, it was nice. I think it was really good."

    S2: lines 560-563

From this comment it may be inferred that if staff can create barriers they can also remove them. Another participant (S4) felt that it was during the performance when the sense of togetherness between staff and patients was most poignant:

- "I found the performance, particularly, a very unifying experience. And that was, that was quite powerful the way we were all supporting each other and congratulating each other. You know, we were just totally all in the same playing field."

    S4: lines 549-551

This feeling of support and security was voiced by one of the patients when she said:

- "Cause you come and you feel quite safe."

    P2: line 112

This same patient elaborated further on this when she later stated:

- ". . . the singing removed some of the boundaries that keep us separate, bit like what P7 was saying. Em, so it was nice we could identify with each other in a different way . . . as opposed to 'I'm a patient, you're the staff'. It just all became one group."

    P2: lines 544-550

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[17] This was noted in four themes from the Professional Log; in particular, theme 2 which states 'The setting of achievable and identical musical goals for patients and staff may help to establish a community spirit underpinned by warmth and mutual support'.

Similarly, another patient indicated his comfort at this new form of closeness with members of staff:

- "Well, I thought we got really familiar with everybody and every time we turned up we got smiley faces, recognised everybody pretty well."

    P1: lines 270-272

This might suggest that such openness should not be restricted to choir rehearsals and thus be adopted as a way of being with each other in general; reflecting, perhaps, the notion of a common humanity to pervade the clinical setting in a more transparent manner.

6.4   Theme 3:   Being a person in one's own right

As with the previous theme all comments pertaining to singing with a distinct yet different group of people (in this instance, members of staff) prompted only positive responses. There were several reasons for this including the promotion of a sense of belonging, the opportunity for people to talk together, the chance to identify with each other in a different way and to facilitate group dynamics. Likewise, the patients felt that singing together enhanced a sense of choral membership and that in so doing allowed everyone to feel that something new was taking place. A link may be observed here with theme 2 from the Focus Group 1 responses in which the opportunity to express oneself in a new way through a creative experience such as singing was highlighted as an aspiration for the patients.

Some comments suggested that singing alongside staff members was not an issue and that each person was simply a co-participant working within one group. This might explain that the issue of a removal of barriers was referred to specifically by patients only on two occasions (8%)[18] whereas staff mentioned this on twelve occasions (57.1%)[19]. It is interesting to reflect, therefore, that the actual concept of a barrier, boundary or distinction between two populations appeared to be a staff rather than a

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[18] This was exemplified in Category 7: Singing alongside staff (patients only).
[19] This was exemplified in Category 6: Singing alongside patients (staff only).

patient construct. Indeed this was stated by S2 in the previous theme when he commented that "we form them ourselves."

For one patient, however, the feeling that a label rather than a barrier had been removed was particularly significant. In so doing, whilst remaining a patient in a hospital her identity as a person in her own right was respected, at least for a time being. As she stated:

- "They were just like us . . . instead, instead of looking at us as mental health problem. Just getting away from that for a little while. Some sense of normality."

    P3: lines 564-575

Similarly, this allowed patients to experience a sense of freedom which, within a medium secure setting, has poignant significance. Singing offered an opportunity to be fully in the moment of what was taking place. As one patient exhorted:

- "I looked forward to, to our rehearsal because, eh, then I would be free just to sing, sing and think about nothing else and, eh, I felt I was no longer in, in the [NAME OF SETTING] but I felt I was somewhere else and totally free and totally strong."

    P7: lines 85-88

This patient later claimed that:

- "I felt, eh, assertive. Not aggressive but assertive and it was kind of like, eh, climbing a, a mountain or climbing up on a tree, kind of eh, I knew it would, it would require many rehearsals and some efforts from myself but I did this eh, as P2 said, willingly and I chose to do it. And it was, and this was a kind of freedom. Not at all 'you must do this, you must do that' but kind of like volunteering."

    P7: lines 310-315

Another patient felt that this freedom was affirmed due to the experience of singing with other people rather than speaking with other people:

- ". . . the group effort, being in the group and, like you say, without verbally communicating, it is a different way to communicate and a different way to

spend time with people. And I, I think that I enjoyed that, spending time with people and singing as opposed to having to speak or . . ."

P2: lines 239-246

It is interesting to reflect, therefore, on a particular affordance of choral singing; that is, that singing with others allows people to express themselves simultaneously. There is an element of paradox, perhaps, that the sense of being a person in one's own right may be most keenly felt when the respective experience is shared rather than solitary. One's uniqueness and individuality can be heightened through *community*.

6.5   Discussion

The results suggest that shared participation in choral experiences can positively influence the relationships between patients and staff. Within this context the labels of 'patient' and 'staff member' are temporarily removed. Status becomes insignificant; for a choir to truly sing it should be non-hierarchical. Unity can therefore be attained.

Such unity, however, must be accompanied by a sense of benevolence that is manifest between each person. A choir provides a framework within which compassion may be expressed throughout the rehearsal as a whole as well as in the moment of singing together. Thus, the way in which the conductor might sensitively nurture the musical responses and abilities of each person may transfer to the interrelationships between the participants themselves.

It is suggested that barriers are a staff rather than a patient construct and that while members of staff might initially find the removal of such barriers to be challenging, a new way of relating may begin to be formed. The implementation of a democratic ethos from the outset allows decision-making, commenting and questioning to pervade the duration of the respective activity. This may foster a feeling of creativity and of working together – literally and metaphorically – in harmony. It would appear that this may be partly due to the non-differentiation of expectations between the two populations. When the musical objectives for patients and staff are not only achievable but identical the removal of barriers can be a natural consequence.

Finally, a song affords opportunities for structure and improvisation; for predictability and uncertainty. When patients and staff participate in a shared musical experience such as a choir there can be a level of mutual support which may compel one person to help another through the creative act. In turn this can enable each member to feel a person in one's own right. A choir, therefore, may be a template for other contexts in which *relatedness* is promoted; or at least considered. This is neatly encapsulated by one of the patients as he stated towards the end of the focus group meeting:

- "[There was a] nice feeling of belonging. Then we were like, eh, members of a choir. And no longer eh, a carer and patient . . . people making music together; which is quite another perspective."

    P7: lines 518-520

Theme 1   Feelings of benevolence

This theme evolved as a result of staff members being deeply moved at the vocal response demonstrated by a particular patient. Indeed this appeared to represent a significant moment in this project as it suggested the possibility of a heightened sensitivity *in general* towards the patients from members of staff. The lyrical content of the song 'You've Got A Friend' (King 1971) and the "reminiscence bump" that was likely felt by the staff members (Janssen et al. 2011, p.1), seemed to evoke genuine benevolence towards this patient; more poignant and purposeful, perhaps, than empathy. Bailey and Davidson (2003) note the cathartic potential of certain songs to arouse difficult and possibly traumatic emotions held by some people; alluding, therefore, to the potent associative content that words and music can have. Lortat-Jacob and Benamou (2006, p.92) discuss the possibility of shared singing as "a lightning rod for the emotions"; thereby cautioning the facilitator of the choir to be cognisant of this issue when selecting repertoire. The lyrical content of songs and choral music is also highlighted by Young (2009). Such feelings may be an outcome of "musical fellowship" (Balsnes 2012, p.256) and a consequence of being with each other in this specific way. The experience of collaborative singing provides a unique context in which caring may be facilitated through the literal sharing of a musical moment and its accompanying memories and associations.

Theme 2   Removal of barriers

The findings suggest that the removal of barriers which can occur when staff and patients sing with each other might act as a template for other groups comprising the two populations. In so doing, it might compel us to think more about how we relate. Inevitably, at the end of a choir rehearsal patients return to their respective wards and staff resume their working responsibilities; the normal hierarchical structures and boundaries are once again respected. Yet this theme invites consideration of this accepted arrangement. Notwithstanding the requirements of security which permeate forensic settings, it is interesting to reflect on the 'Mental Health Action Plan 2013-2020' (WHO 2013, p.14) in which emphasis is placed on "listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care." A choir requires people to listen and respond to each other; albeit in a different way. Yet need this particular concept of relating be exclusive to a choral context? Cohen (2009, p.60) notes that when a choir comprising prisoners and volunteers met to share a meal immediately following a performance, the "social experiences contrasted dramatically with daily interactions between inmates and staff at the correctional facility." With regard to this thesis, this sense of warmth and companionship was precisely the dynamic observed at the barbeque attended by patients and staff immediately following the choir's performance. Writing within a different context, Davidson and Faulkner (2010) state that when elderly people and their carers sang together in a choir, the form of social interaction at times was akin to a role reversal of the two populations; creating, therefore, a sense of mutual dependency that would likely not exist outside the choral setting. Maguire and Merrick (2013, p.118), however, admit that a music therapy group in a high secure hospital may not immediately evince a natural welcoming with regard to the removal of barriers; they write "These parallel shifts in the power dynamic, a mutual relinquishing of control, left all involved initially uncomfortable, but ultimately with a feeling of success." This suggests, therefore, an element of risk being taken yet one that can eventually yield a pronounced change in how staff and patients may then relate with each other. The findings from this thesis indicate that collaboration through choral singing can indeed act as a catalyst for such change through a reconsideration of boundaries.

The implementation of this project required me to constantly reflect on my own relationships with patients. The frequent shifts from a clinical to a community stance caused me to consider the potential confusion this may evoke within certain clients. In so doing, might my professional stance be compromised if barriers were felt to have been removed? This point is considered by Stige et al. (2010, p.304) when the authors suggest the concept of "re-professionalisation" (rather than de-professionalisation) which would encourage the exploration of closer partnerships between professionals and participants; it is interesting to reflect on the implications of the words 'partnerships' and 'participants' when referring to patients in a forensic setting. This issue is also alluded to by Wood, Verney and Atkinson (2004) when they suggest how Community Music Therapy affords participants the chance to make choices and decisions that may not so easily occur in more traditional clinical settings; likewise, this emphasis on negotiation is discussed by Rolvsjord (2007).

The specific instance of working as a music therapist with clients in a conventional manner *as well as* attending to these same clients within a choir rehearsal is considered by Elefant (2010) to be an appropriate framework for enabling clients to make transitions more generally. My personal view concerning this issue seems to concur with Elefant as I was not aware that patients attending both contexts found this to be uncomfortable or problematic. Thus, the observation made by one of the staff participants in the Focus Group 2 meeting that with regard to boundaries or barriers – "we form them ourselves" – may be worth further consideration in relation to different healthcare contexts. Indeed, such reflection on the potential hindrance of boundaries echoes the views of Totton (2011, p.243) when he questions their therapeutic value and encourages therapists to "dance outside the frame" in order to positively affect change and promote health.

Finally, the potential complexity of this issue is highlighted by Young (2009, p.21). Her recommendation that the facilitator of a choir for people with cancer should, ideally, be a music therapist seems intriguing in tandem with her advice that the therapist should not have "any hidden therapeutic agendas." One might infer from Young that the personal values of the therapist are helpful while the professional boundaries normally held in more clinical contexts may be less so. There may be parallels to draw here with

my own consideration that while the *abilities* of a music therapist may be deployed the *responsibilities* are perhaps less appropriate.

Theme 3   Being a person in one's own right

The data suggest that the opportunity to feel a person in one's own right rather than a patient with a corresponding label can be an outcome of singing alongside members of staff. The literature reports several examples in which choral participation appeared to have significant influence on members' self-perception or sense of identity. Nelson (1997), for example, noted the positive changes in self-perception felt by high-risk adolescent males as a result of their choral singing experiences. Coleman (1999) states that a particular objective of Gay and Lesbian Association Choruses (GALA) in America was the nurturing of self-esteem which in turn could help to establish closer links with society in general. Thus, there is a sense of affording communities which would have likely felt a considerable degree of discrimination the opportunity to care for each other whilst also performing on the public platform. Similarly, Bailey and Davidson (2003) consider positive changes in identity to have been experienced by homeless men as a result of choral participation. The individual case study presented by Balsnes (2011, p.249) found that singing in a choir offered the possibility of "a way to provide meaning and coherence in life." It may be reasonably inferred from this that the acquisition of meaning and coherence in one's life can assist in the affirmation of a positive identity. The issue of identity – within the context of social identity theory – is highlighted by Dingle et al. (2012) in relation to benefits that may be accrued by disadvantaged adults as a result of choral participation. Finally, Wilkerson and DiMaio (2013) noted how the members of the CarePartners Grief Choir experienced a new sense of identity through choral singing whilst also being able to have their grief acknowledged in a supportive environment.

6.6   Conclusion

The three themes presented above once again bear close relation to the literature selected for review and affirm how shared participation in choral experiences might positively influence the relationships between patients and staff. A deeper reflection as to why this is so suggests that more consideration should be given to the actual concept

of a barrier within a medium secure forensic setting. There are two reasons for this. Firstly, a barrier is a temporary rather than a permanent construct. It is rare that a patient will remain in such an environment indefinitely. Yet (in my own experience) it is not uncommon for patients who have been discharged from this unit to return at a later date due, for example, to a decline or change in their mental health. It may be, that for certain patients at least, the abrupt removal of a barrier has proved overwhelming due to the need to assume (or reassume) certain responsibilities. While a degree of *phasing* this transition to the community for the respective patient is normally required, it can be argued that more opportunities for the devolution of responsibilities to patients could be expanded; not least within contexts in which identical challenges and expectations are to be met by patients *and* staff. Barriers may then be eliminated as appropriate. This thesis has proved that a choir is an ideal template for such mutual expectations.

And secondly, a barrier is not simply a locked door, a security procedure or a time restriction; it is not only a punitive measure. A barrier can be a tendency to be too helpful, to be over-supportive. A medium secure forensic unit is not a microcosm of society yet it has a responsibility to prepare people for society. Such a setting has a duty of care; yet, conversely, it may care too much. A choir, therefore, is an example of a group of people who, when performing, will ultimately be responsible for the sound that is created. A conductor can nurture their abilities but not negate their individuality. A degree of risk-taking and exposure is required. A barrier, therefore, is an attitude which can be too helpful; which itself can be harmful.

## 7.	ANALYSIS OF MY IDENTITY AS A MUSIC THERAPIST USING A COMMUNITY-BASED APPROACH

### 7.1	Introduction

This chapter will present the results with regard to the third research question:

How – and to what extent – is my identity as a music therapist altered as a result of including a community-based approach to my work in addition to a clinically-oriented model?

In chapters 5 and 6 the findings were based on the reflections of others – i.e. the participants – as the results from the Focus Group 2 meetings and the semi-structured interviews were analysed. In this chapter the findings are partly based on my own reflections that were collated through the Professional Log. From these findings the following three themes were established.[20]

Theme 1	The tendency to adopt a more didactic approach.

Theme 2	Conscious working towards musical outcomes.

Theme 3	Heightened sensitivity towards the needs and abilities of service-providers.

These themes are then corroborated with some of the reflective comments pertaining to the implementation of Participatory Action Research as outlined in section 3.2.7. I reflected further on each statement in this section and deliberated its relevance to this third research question. By considering this question as a category the process of constant comparative analysis in grounded theory is being applied through the identification of similarities and differences of statements (or codes) relating to this category.

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[20] The full list of theoretical codes from the Professional Log which led to the refinement of these three themes can be found in appendix 14.

These themes are now discussed in more detail within the context of the Professional Log and Participatory Action Research. Following this, comparisons with the review of literature in chapter 2 are also made.

7.2 Theme 1: The tendency to adopt a more didactic approach

As therapists we may find ourselves adopting a more didactic approach when working with larger numbers of people.[21]

The following reflection is taken from the Professional Log to provide a rationale for theme 1.[22]

"I was aware that I was now less nervous than I had been when the rehearsals commenced. While I was still seeking an appropriate level of challenge through, for example, the choice of repertoire or singing more frequently in harmony, I felt more secure within myself in the facilitating of rehearsals. I was finding ways of offering constructive criticism while also acknowledging to the choir my own errors and weaknesses. This tendency for self-deprecation seemed liberating rather than embarrassing and, I believe, strengthened my own position as a member of this community.

I became conscious that if attendance at a particular rehearsal was relatively low I would adopt a gentler approach. My notes pertaining to the 8th rehearsal include the following statement: "Only four participants make it feel almost like a group music therapy session; I sense more of a caring attitude from myself." Conversely, when working with perhaps twice as many people I became aware when listening back to the recording of the rehearsal that I would ask questions more frequently and sensed a similarity with a method more akin to teaching."

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[21] Theoretical code 4: Professional Log – Reflections on myself (rehearsals 7-12).
[22] Each reflection from the Placement Log is presented in inverted commas.

As the needs and attributes of the respective musical group become more apparent, the therapist may feel compelled to assume a more directive approach.[23]

The following reflection is taken from the Professional Log to provide a rationale for theme 1.

"There is a degree of contradiction implicit in the codes comprising these particular reflections. Such differences may be more likely to occur when a large number of codes (60.8%) have been allocated to this category. On the one hand the democratic ethos underpinning our work is conducive to a positive relationship being maintained; on the other hand the rehearsals, I feel, are becoming slightly 'stuck' and the quality of sound could be better. There are ways in which I seek to move us forward as a choir; the sensitive use of humour, for example, the element of surprise or the incorporating of more challenges. My notes include the following specific musical points: "New warm-ups good, next week incorporate changes of dynamics as well as tempo with sol-fah; we are still singing descending semitones a little flat, work on this; 'Ob-La-Di Ob-La-Da' – make sure people are clear of starting note prior to commencing, also make sure the tempo is not too fast; think more carefully about the effect of changing keys in order to help people with pitching." It may be suggested, therefore, that 'Reflections on myself' are becoming more entwined with 'Reflections on rehearsals'. I am sensing a growing need and desire to conduct in a more conventional manner and to gently exert more musical control as the rehearsals continue. It is interesting to observe that this is in contrast to what was expressed in the Focus Group 1 meetings (theme 5) where people indicated that as the rehearsals progressed my own leadership of the choir would become less apparent."[24]

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[23] Theoretical code 9: Professional Log – Reflections on rehearsals (rehearsals 13-18).
[24] This theme is 'A gradual transition from a conductor-led to a choir-influenced style is generally felt to be appropriate'.

It is unlikely in my clinical work that I would seek to inform patients as to how improvements might be made in relation to their musical responses. My role as a conductor, however, required me to be informative. No matter how open and democratic I intended these rehearsals to be, I had a responsibility to provide constructive feedback.[25]

Some similarities may be observed between this statement and the second reflection above. The emphasis here is not simply on how I *listen* but on what (and how) I *say*. There is a delicate balance between informing people what could be improved and how improvements might be made. In a community-based context such as this it is likely that the therapist will be talking more frequently. Such talking may be more didactic than discursive. Yet the opportunity for balance can be afforded by asking the participants themselves how improvements to the sound we are producing as a choir could be made. This concurs with the views of Elefant (2010) in relation to her work with the *Renanim* choir in Israel; this required careful listening to the opinions of all the participants in order to facilitate a smooth and transparent running of the choir. It is reasonable to suggest that in a more conventional choral setting the opinions of the members would not normally be invited. In taking this step the sense of community may be further enhanced; the *removal* of a barrier between patients and staff can be modelled to an extent on the *lowering* of a barrier between the conductor and the choir members. A feeling of mutual respect can thereby be expressed and enjoyed.

7.3   Theme 2:   Conscious working towards musical outcomes

Achievement is felt most keenly when it is earned.[26]

The following reflection is taken from the Professional Log to provide a rationale for theme 2.

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[25] Statement 1 from 3.2.7 'Participation and facilitation of choir rehearsals' (*Musical responsibilities*).
[26] Theoretical code 6: Professional Log – Reflections on rehearsals (rehearsals 7-12).

"A consideration of the codes which evolved suggests that the degree of formality that is required when committing oneself to a group such as a choir was being appreciated. This could be observed in procedural issues such as each participant having a choir folder as well as the sense of doggedness that was needed in order to make improvements in our singing. Thus, while there were occasions of lightheartedness and humour in our rehearsals, there was also the need for hard, concentrated work. We would spend considerable time working on short sections of music which required focus and perseverance from all parties. Yet the participants did not did resist this or shun the effort that was involved. The attention to detail could be painstaking yet still motivating in itself. Following the 11th rehearsal I made the following note to myself: "It was a good rehearsal though perhaps didn't have quite the same buzz as last week." I felt comfortable with this realisation and that it would not be appropriate to attempt to 'dilute' the work ethic in order to make the experience less demanding. People could sense the improvements that were taking place with regard to pitching, for example, and this affirmed for each person clear evidence of musical progress."

The encouraging of participants to attain higher levels of musicianship may require us as therapists to allocate more time to our own musical preparation.[27]

The following reflection is taken from the Professional Log to provide a rationale for theme 2.

"This third block of rehearsals represents the commencement of the second half of the project. It is interesting to observe, therefore, a distinct change of emphasis in the number of codes applied to each of the three areas for analysis. There has been a marked decline in the allocation of codes to 'Reflections on myself' from 31.8% to 21.4% and now to 8.6%. Conversely, 'Reflections on rehearsals' which also began with an allocation of codes at 31.8% remained approximately the same at 28.5% then increased considerably to 60.8%. The number of codes applied to 'Reflections on participants' has fluctuated from 36.3% to 50% and then to 30.4%. A closer analysis

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[27] Theoretical code 7: Professional Log – Reflections on myself (rehearsals 13-18).

reveals that in the first block of rehearsals the majority of codes were allocated to myself, in the second block they were assigned to the participants and in this third block they are weighted heavily to the actual rehearsal process. Similarly, the number of codes overall has declined from 44, to 28 and now to 23."

"Only two selective codes were allocated to 'Reflections on myself'; yet they are significant as they apply to the need for me to be more prepared for the musical demands of each rehearsal (e.g. improvements in my piano playing and to be more 'on top' of the music) and that I now might be more musically demanding of the participants. Indeed, following the 13th rehearsal I made the following comment to myself: "I came away from this rehearsal feeling slightly annoyed that I had not prepared more fully. Even though I am trying to be as democratic as possible there is still a need for me to be ready with the songs that we may do (perhaps a community model requires us to musically prepare more thoroughly)"."

An important objective in the opening rehearsals was to consider the most helpful way in which we might aspire to a certain musical standard or vocal accuracy in relation to the sound being presented. To put this more simply, how demanding should I be as a conductor?[28]

Musical aims such as these would not normally constitute therapeutic objectives when working with a client or group of clients. My use of the word "helpful", however, and my self-questioning with regard to the degree of demand I should apply indicate a necessary caution that I need to retain. While people have voluntarily agreed to take part in this project there is still an element of risk in doing so. I am aware of the need to *musically compromise* whilst taking care not to *musically patronise*. The opportunity to audio record and listen back to the rehearsals allows me to keep 'in check' this delicate balance. The quality of listening that is fundamental to how a music therapist interacts moment by moment is equally applicable here and serves as a reminder to be person-

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[28] Statement 2 from 3.2.7 'Participation and facilitation of choir rehearsals' (*Musical responsibilities*).

centred even when musically-focused. When working towards a certain musical standard it is important to preserve this absolute concern for the individual person within the collective group. This resonates with the notion of "servant leadership" as defined by Merrick and Maguire (2012) when engaged in choral singing with patients and staff at Broadmoor High Secure Hospital in England.

The opening rehearsals allowed me to gauge individual responses and abilities which in turn helped to affirm an appropriate level of musical challenge to which we might aspire. . . . Specific musical objectives were gradually formulated.[29]

When working in a more clinically-oriented manner there is arguably less of a tendency to focus on a person's musical abilities; or at least on the development of these abilities as clinical aims. The inherent musical responses of a person may be considered more central to the therapeutic relationship and interaction than musical abilities. We work unconditionally with what a person offers *through* music rather than overtly focusing on their abilities *in* music. Within a community frame, however, this distinction is less obvious. Indeed the therapist may consider the development of musical abilities to be of notable therapeutic value in itself. Upon reflecting on this it would appear necessary and helpful for the *concept* of abilities to be retained within the *context* of responses. These responses may then manifest abilities which in turn can lead to the formulation of objectives. This would appear to allow the needs of the person to remain at the heart of all that we do. Yet it may be suggested that a community-based approach to music therapy would have a more predominant focus on the promotion of abilities. This links closely with the comments of Stige and Aarø (2012, p.21) when they discuss "the personal strengths of participants, such as musical talents and interests" as being central to the notion of Community Music Therapy.

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[29] Statement 3 from 3.2.7 'Participation and facilitation of choir rehearsals' (*Musical responsibilities*).

*As the rehearsals progressed I began to review my initial concerns about being perceived as a 'conventional' conductor. I reflected that this may have more to do with my own perceptions of this role rather than the members of the choir. The commitment demonstrated by each person was indicative of a genuine desire to **work**.*[30]

In considering the different roles that a music therapist might deploy I am aware that I may have appeared apologetic in this thesis for giving these roles due consideration rather than respecting them as aspirations to work towards. In so doing I have conceivably presented a value judgement as to what music therapy 'ought' to be. Yet I have also felt that the adoption of a community-centred approach has been liberating; indeed it has compelled me to think about the therapeutic benefits that may be acquired when participating in a project such as this. There can be a tendency, perhaps, to be motivated towards fulfilling one's own objectives rather than considering the needs of those with whom we work. Yet such aims need not be incompatible. Indeed the enthusiasm that we as 'musician therapists' may hold for music itself will likely be felt and subsequently expressed by our clients. The music was inspiring us and indeed requiring us to *want* to do the best that we *could* do. The work became motivational in itself regardless of whether it was offered within a clinical or community context.

7.4 Theme 3: Heightened sensitivity towards the needs and abilities of service-providers

The musical interests and abilities of a person attending a performance-based musical activity may be further expanded in his or her own time.[31]

The following reflection is taken from the Professional Log to provide a rationale for theme 3.

"The selective codes pertaining to 'Reflections on participants' once again indicate an appreciation of the attention to musical detail that is being applied. The participants are

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[30] Statement 4 from 3.2.7 'Participation and facilitation of choir rehearsals' (*Musical objectives*).

[31] Theoretical code 8: Professional Log – Reflections on participants (rehearsals 13-18).

also grateful that I frequently ask them how our singing might be improved; thus, their voices are heard in speech as well as in song.

The quality of our vocal performance was being acknowledged collectively. This was manifest in different ways such as verbal comments or the breaking out of spontaneous applause after we had carefully rehearsed and performed a song. The notion of self-congratulation or applause may seldom feature in a group music therapy session but in this context it seemed appropriate and genuinely motivating.

What was increasingly evident was how the positive musical experience being acquired by each person was being taken out of the rehearsal space and into the everyday lives of the patients and staff members. One patient, for example, was keen to return to his room in order to play his guitar while another patient wanted to purchase a keyboard so that he might practise the songs himself in between the weekly rehearsals. A staff participant indicated that his desire to listen to music had been heightened by this experience."

To an extent, therefore, although the choir rehearsals were not music therapy sessions, the notion of an underlying therapeutic relationship that might permeate these choral experiences would likely be helpful.[32]

This statement is framed within the context of the need for participants to feel safe and respected within the rehearsals. Such dynamics are essential for clients attending music therapy sessions. While a choir rehearsal is not a music therapy session it seems reasonable to suggest that my *abilities* as a therapist will be of value even though my *responsibilities* may not necessarily apply in the same way. The notion of therapeutic sensing through the maintaining of a respectful relationship with all of the participants (i.e. staff as well as patients) is relevant. A parallel may be observed here with the significance Stige attaches to a "culture of care" that needs to be sensitively nurtured when conducting choir rehearsals for elderly participants (2010, p.269). Thus,

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[32] Statement 5 from 3.2.7 'Participation and facilitation of choir rehearsals' (*Introduction*).

the transition from a music therapy session to a choir rehearsal will still require me to retain a therapeutic instinct in all that I say and do.

Yet it also required sensitivity with regard to the feelings of the staff. To an extent service-providers were now service-users. Thus, it was necessary for me to contemplate the vulnerability that might be experienced by staff members at the removal of a metaphorical barrier between themselves and the patients.[33]

It is not uncommon for music therapists to work alongside members of staff when facilitating clinical sessions. In such contexts the staff member may adopt an assistant or co-therapist role. A degree of hierarchy is therefore still evident between the respective member of staff and the client (or group of clients). This was not the case in these rehearsals. The active musical involvement of all participants towards a shared musical outcome required the removal of a barrier between patients and staff. Music therapy sessions are often defined and framed within the context of there being no 'right' or 'wrong' and that musical skills are not required. This was no longer the case and in moving towards a more product- or performance-based ethos a feeling of vulnerability – from patients and staff – would likely arise. Such feelings, arguably, may be more keenly felt by staff and therefore heighten my need to offer a safe space to all concerned. The choir comprised one unified group rather than two sub-groups.

. . . it is interesting to observe an underlying theme of hope in several of the song titles which may have significance in relation to the aspirations (conscious or otherwise) of the patients.[34]

One might infer from the above that the choir affords the opportunity for patients to use music as a means of making a political statement; within this environment a song of hope may potentially be considered a song of protest. Certainly, the titles and lyrics of

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[33] Statement 6 from 3.2.7 'Participation and facilitation of choir rehearsals' (*Musical responsibilities*).
[34] Statement 7 from 3.2.7 'Participation and facilitation of choir rehearsals' (*Musical choices*).

several of the songs implied the possibility of a brighter future. The rehearsals, however, were not a vehicle for anger or criticism; while the overall mood was enthusiastic this was presented in a contained and respectful manner. Upon reflection I am intrigued as to why in this statement I have referred only to patients. It may be that at the time I became over-enthused with the significance of hope and what it might mean to patients in a setting such as a medium secure unit. Yet hope is of no less significance to members of staff. Working in a more community-oriented way provides scope for acknowledging the aspirations of each person within that community. A reminder, perhaps, of the common humanity we share and that the opportunity for sharing is embedded in the activity of choral singing.

The notion of therapeutic sensing was once again helpful as the possibility existed of patients becoming over-anxious prior to the performance and, potentially, not taking part. It was also important for me to be sensitive to the feelings of members of staff in the choir. I therefore adopted a strategy of deliberately presenting myself as 'low-key' in the moments prior to the performance.[35]

The decision whether to perform has been discussed on earlier occasions in this thesis. Upon reflecting on this statement relating to the final performance I am aware that I am concerned of appearing too prominent. I seem to be investing much thought and effort in trying not to be conspicuous. This is not easy – neither is it necessarily advisable – for a conductor to do when responsible for a performance. It may be suggested, therefore, that as a music therapist working within a community-centred approach I am also a member of that community. Just as a music therapist works *with* and *alongside* his/her patients when the interaction has a predominantly clinical emphasis, so too is the need to be alongside staff apparent in a community context. Arguably, this is more difficult to achieve when the need to provide clear leadership in a performance setting is required. Thus, a paradox may be observed due to the need to be simultaneously obvious yet unobtrusive. Ultimately the therapist is part of the community.

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[35] Statement 8 from 3.2.7 'Participation and facilitation of choir rehearsals' (*Performance perspectives*).

7.5   Discussion

The results suggest that my identity as a music therapist is adapted in three ways as a result of including a community-based approach to my work in addition to a clinically-oriented model.   Firstly, I have frequently presented a more didactic approach. Notwithstanding the open, relaxed and democratic attitude which has been prevalent in these rehearsals, a conductor is still a leader. Leading this particular choir has required me to teach as well as to learn. It is interesting to reflect that in the Focus Group 2 meeting with the patients I was occasionally referred to as a "teacher." I am aware, for example, that during the rehearsals I tended to talk more than I would normally do so in a music therapy session. This talking has often been instructive and informative in nature.

Secondly, I have been more purposefully involved in the promotion of the musical abilities of the participants. Whilst not negating the needs of the participants there is now a greater emphasis on the fulfilment of musical objectives. Such objectives are inevitably heightened when working towards a performance. In turn this has also required me to work more deliberately on my own musical development in preparation for the rehearsals.

Thirdly, I have been cognisant of a need to maintain a therapeutic instinct in my interactions with patients *and* staff. Choir rehearsals are not music therapy sessions. Yet the vulnerability that may be felt by all participants suggests that certain qualities of a therapeutic relationship – compassion, empathy and unconditional positive regard – are similarly helpful in this context. Thus, while my *responsibilities* as a music therapist regarding issues such as confidentiality and boundaries may not necessarily apply, my *abilities* that I have developed as a therapist working with people in music are still relevant.

One outcome of this project is that I have become increasingly visible and pervasive in this setting. In particular, with regard to members of staff I am more familiar with people than I perhaps had been before the commencement of the project. I am a more prominent member of this community. It may be argued that my practical skills as a musician which are demonstrated through conducting, piano playing, singing and arranging represent how I am perceived more so than my clinical interactions.

One final reflection: when a music therapist takes a step out of the clinical room (s)he is taking a step into the unknown. The requirement to lead, to teach and to present a more public persona may evoke a sense of vulnerability within the therapist. Certain aspects or aspirations may go 'wrong' and these could have consequences for the participants as well as the therapist. For patients in a medium secure forensic setting it is often the case that something has gone 'wrong' in their lives. An event, perhaps, has been life-changing which can easily lead to feelings of insecurity and vulnerability. The witnessing, however, of the therapist feeling vulnerable may be a helpful reminder to the patients of our shared insecurities, our fears and our common humanity.

Theme 1   The tendency to adopt a more didactic approach

The notion of being perceived as a teacher when conducting choir rehearsals was one which I was personally aware of in addition to being literally described as a teacher by the patients in the Focus Group 2 meeting. The opportunity to listen back to each rehearsal heightened an awareness of my tendency to adopt a teaching stance through speaking – at times – in a didactic manner. Indeed this seemed to increase as the performance drew closer and I became more demanding with regard to the quality of the choral sound. The need for a music therapist to deploy a range of skills and approaches such as teaching has been referred to by Pavlicevic (2010) and Stige et al. (2010). Furthermore, McGuire (2006) comments on the didactic qualities of the Tonic Sol-fa approach to singing (which formed the basis of our warm-up exercises) as these in turn may foster greater discipline and a stronger moral foundation; attributes, therefore, which go beyond the development of musical skills.

In relation to this theme it is helpful to revisit the three components of social capital as presented by Halpern (2005) in which he outlines the significance of a social network, social norms and social sanctions. Throughout this study there was a clear sense that the choir itself represented a social network, social norms were expressed through the democratic ethos of the rehearsal process while social sanctions were manifest by my affirming of decisions regarding the quality of sound, how improvements could be made and also issues pertaining to whether we might perform. Within the literature, for example, the issue of who might choose which repertoire to sing appears to be an

example of a social norm generally afforded to each participant (Silber 2005; Young 2009; Talmage et al. 2013) while Merkt (2012, p.97) felt otherwise by stating "this choir is meant to provide new musical experiences for everybody, and not to repeat well-known pieces." Thus, there would appear to be a range of views in relation to the didactic/authoritative emphasis that a music therapist may choose (or not) to adopt. The specific context and environment in which the work is taking place, the personal nature and overall philosophy held by the respective therapist, and his or her relationship with the participants are all significant variables to consider.

Theme 2   Conscious working towards musical outcomes

I had noted in the Professional Log that as the performance featuring the choir drew nearer I appeared to exert more control as a conductor. The performance represented a tangible musical outcome. The significance of public performance as a possible outcome of Community Music Therapy has been well-documented – e.g. Logis and Turry (1999), Turry (2005) and Elefant (2008). The possible risks of performing in front of others comprised a considerable amount of my own thinking and reflection due to the range of opinions expressed by the participants. Yet the ultimate reaction of the choir members and audience following the singing of three songs at the clinic's barbeque appeared to validate the decision we made to perform; this sense of working towards a performance and the achievement felt at its conclusion is alluded to by the above authors. In addition, a parallel may be made regarding the desire for some of the participants to continue developing their performance skills outside the choir rehearsal time with the study of Tuastad and Finsås (2008) in which people moving from a custodial setting to the community could continue to engage in rock band activities.

This thesis has required me to carefully consider aims that one might normally work towards in music therapy practice. It may be argued from the above that Community Music Therapy affords a wider range of aims than might be contemplated in more clinical contexts; such as the development of musical skills and working towards a performance. It was noted earlier that the songs people were requesting to sing frequently had an underlying theme of hope. It may be said that hope represented an unintentional outcome of this work rather than a specific objective from the outset; yet

this had come to light as a result of devolving musical choices to the participants. While it may appear an imprecise, almost nebulous aim to work towards, in retrospect it seems potent and appropriately personal to those involved. This, I believe, goes beyond nostalgia or the "reminiscence bump" as suggested by Janssen et al. (2011, p.1). Arguably, the opportunity to re-engage with songs that were deeply meaningful reminded people of the joy of music – of life, perhaps – that might be attained once more. While little direct reference appears to have been made to hope in the Community Music Therapy literature, it was mentioned by Zanini and Leao (2006) as an objective when working with a therapeutic choir for elderly people. The sense of achievement felt by participants following a successful performance may also be considered a realisation of hope. Arguably, the *process* of the musical experience can be validated by the *product* of the musical outcome; not least when it has been affirmed in the *presence* of others.

The shift from a predominantly clinical stance to one that is more community-oriented requires the therapist to prepare for increased public recognition within the respective setting. Through opportunities for performance, for example, the therapist will likely be more visible and, potentially, more audible through public music-making. Thus, he or she will be seen and heard more frequently. My frequent feelings of vulnerability were testament to this. It may be that the potential insecurities experienced by music therapists when working in this way warrant further investigation.

Theme 3   Heightened sensitivity towards the needs and abilities of service-providers

In the concluding section of the opening chapter to this thesis (section 1.3) I stated that a particular focus of this study was the perception of relationships between different groups of people. My own relationships with the patients and also with the staff members have been alluded to earlier. The need for patients and staff to work together in a non-hierarchical context, however, did arouse a degree of vulnerability with some of the staff members; initially at least. I acknowledge that my concern of facilitating choir rehearsals for patients and staff by emphasising that these were *not* music therapy sessions may have seemed confusing; contradictory, perhaps. I could not be the staff

members' therapist yet my tendency towards what I have termed as therapeutic sensing seemed to satisfy my own questioning with regard to my identity. I could continue to be cognisant of the vulnerabilities that people may hold while not necessarily addressing them with deliberate therapeutic intent. As noted earlier, Ansdell and Denora (2012, p.103) consider the need to "attend to and accompany people musically; to be sensitive to people's own relationships to music; to foster musical communication and musical community" as overarching professional competences. Yet it would appear that the specific aspect of being sensitive to the needs of service-providers has not been particularly highlighted in the literature. The exposure of one's musical abilities when collaborating alongside others may be unsettling. The therapist needs to be mindful of this potential reaction and respond accordingly. An aspect of this work, perhaps, which is more likely to be perceptible in community contexts and which may benefit from deeper reflection in future studies.

7.6   Conclusion

For a music therapist the duration of their training programme will probably represent a small period of time within the context of their music therapy career. Yet it is likely that what we experience as a student will remain with us for a considerable period. Indeed, there may be a tendency for us to almost unconditionally accept what we learned in those years as being foundational to our subsequent thinking and practice. The requirement, however, for students to adopt a critically reflective approach will hopefully broaden their understanding and awareness. Therefore, a music therapist implementing a community-based approach is not relinquishing his or her clinical roots or traditions. I would argue that the clinical focus which continues to feature as a strong foundation of music therapy training programmes will still be utilised regardless of the approach one chooses to apply as a therapist; community or otherwise. The particular ways in which a music therapist listens, observes and reflects will, I believe, always inform the respective work one is undertaking. That this approach might diversify considerably according to the context and population concerned should be welcomed. A realisation such as this can be liberating for the therapist and also health-promoting for the client.

8. CONCLUSIONS AND RECOMMENDATIONS

"But, but I know it will take some, much time, much effort, much work. But I am willing to do it because I, I love singing. I live to sing, I hope to sing to live."

(P7, Focus Group 2 Meeting, lines 597-598)

8.1 Conclusions to the study

The findings of this thesis suggest that health benefits can be experienced by patients and staff when singing in a choir in a medium secure forensic setting. These include an enhanced sense of wellbeing and enjoyment, a heightened awareness of belonging and contributing to a group, and more attentiveness towards posture and breathing. The findings also suggest that relationships between patients and staff may indeed be enriched as a result of singing together in a choir due to the removal of labels and boundaries and the acknowledgement of each individual as a person in one's own right. Finally, the findings indicate that my identity as a music therapist is altered in certain ways when implementing a community-based approach in addition to a clinically-oriented model. This is due to the adoption of a more didactic stance, a deliberate working towards musical outcomes and greater sensitivity towards the needs and abilities of service-providers – i.e. staff – as well as service-users.

Such conclusions invite deeper reflection on the central issues that have arisen from this study. It may be argued, for example, that the concept of Community Music Therapy and the context of a medium secure forensic psychiatry unit are not natural bedfellows. The former is concerned with a potential realignment of boundaries, careful consideration as how best to address individual needs *and* abilities, and a closer collaboration between patients and professionals. The latter, however, is based on stringent protocols, security and a graded structure regarding management procedures and working practices. Yet while an appropriate level of security is paramount, it may be of value to investigate whether the more secure one desires an environment to be, the more insecure it becomes. The need to eliminate risk and fear, therefore, may continually lead to higher security measures being adopted. In such cases it is

conceivable that the relationships between staff and patients would become increasingly marked which could make the development of relationships for patients upon returning to the community more challenging.

The notion of "re-professionalisation" as suggested by Stige et al. (2010, p.304) may help to create a new way of thinking for professionals by promoting a different way of relating with those in a range of healthcare environments. Singing with others, as this study has demonstrated, offers unique opportunities for meaningful and creative relating which depend almost entirely upon the value and support of others. It requires, too, the respect of the art form of music and all its inherent mysteries, discoveries and risks. The risks and the insecurities of the forensic setting, however, may find security in the musical experience. Likewise, the concern of Totton (2011, p.237) regarding the "re-medicalisation of therapy" complements the idea of the re-professionalisation of therapists as posited by Stige.   Indeed, one might present the concept of 'de-medicalisation' in which less emphasis is given to the conventional medical model in mental health while more weight is placed on the consideration of health from a psychosocial perspective. This would encourage music therapists to work confidently and more creatively with clients. A framework such as this should be sufficiently flexible to allow therapists to respect professional boundaries yet also to dance around them when required. This is the ideal to which we should aspire for our profession and for those whom the profession seeks to serve.

The potential realisation of such an aspiration should not seek to ignore or dismiss the limitations of our mortality. As Gawande (2014) eloquently states, wellbeing can still be experienced within such limitations:

> If to be human is to be limited, then the role of caring professions and institutions – from surgeons to nursing homes – ought to be aiding people in their struggle with those limits. Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it the good we do can be breathtaking. (Gawande 2014, p.260)

The statement from P7 which opens this chapter – "I live to sing, I hope to sing to live" – is an example of how choral singing can serve the larger aims of a person's life. Furthermore, the findings which were made in relation to the first research question of this thesis similarly reflect these aims. Ironically, perhaps, there is such simplicity to this. Singing in a choir promotes community. And as we have seen community – a common unity – promotes health.

8.2   Reflections on the study

Upon reflecting on this study it is important to acknowledge the limitations of the research and to therefore consider ways in which certain aspects of the process might have been undertaken differently. These include the following areas:

- The six-month duration of the project was relatively brief in order to make generalisations. Whilst this duration was not necessarily a limitation within the context of the requirements for this thesis, a longer period of time (in a subsequent study) may add further robustness to these findings.

- The moderation of the focus groups by myself perhaps restricted the opportunity for participants to be as candid as they might otherwise have been with regard to criticisms of the project.

- It may be argued that too many songs were rehearsed throughout the six-month period and that they were restricted to the genre of popular music. The opportunity to explore and rehearse less familiar styles of music yet in greater depth might have brought new experiences to those involved.

- It may have been helpful to prepare and offer particular resources to the participants that they could have utilised between rehearsals. These include the words of songs, copies of the music, guidelines for music notation or audio files of the actual parts to be sung. This might have promoted an overall musical confidence and saved time during the actual rehearsals.

A further reflection is concerned with the prevalence of grounded theory as a methodological approach in music therapy. Within the research literature pertaining to

this discipline, most studies which have used grounded theory are presented within an abbreviated (or modified) form rather than a full version.   Amir (2005) notes the comparative absence of grounded theory studies within music therapy practice generally. She believes that this is due to the relative infancy of the profession and also that music therapists who choose to engage in research will be unlikely to have the required knowledge and experience to conduct grounded theory studies using the full implementation of the approach[36]. Amir herself was the first person to publish a study in music therapy using grounded theory (1992). This explored meaningful moments in music therapy as felt and articulated by four experienced therapists and four individual clients; in this instance the coding sequence devised by Glaser and Strauss (1967) was used.

More recently, O'Callaghan (2012) looked specifically at research projects in music therapy which were based on grounded theory. Between 1993 and 2012 the author noted thirty articles in refereed journals and monographs; the majority of which were based on the approach by Strauss and Corbin (1990).

Notwithstanding the points raised above by Amir (2005) regarding the relative lack of studies, the actual range of topics chosen for research in music therapy based on grounded theory is diverse. These have included Nagler's (1993) study regarding the use of music therapy interventions and digital music technology in order to benefit children in crisis; an investigation by Ruud (1997) of sixty music therapy students and how their identities were constructed using musical and verbal forms of autobiography, and the work of Moe (2002) which featured nine patients diagnosed with schizophrenic disorders participating in Guided Imagery and Music (GIM)[37]. Studies which have featured modified versions of grounded theory include O'Callaghan's (1996) investigation of lyrical themes in songs written by palliative care patients and Edwards' (2000) study which focused on techniques used by music therapists working with children in a hospital-based rehabilitation service.

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[36] In the decade since this chapter was published, however, it is fair to say that research methods in general are taught more widely on music therapy programmes due to their requirement, in the UK at least, to be offered only at Masters level.
[37] Guided Imagery and Music is a recognised international model of music therapy.

It will be interesting to observe in future years if the number of studies which use grounded theory as a qualitative approach will reflect the increasing number of music therapy graduates required to undertake modules in research methods as part of their Master's training. Should respective studies continue to reveal a leaning towards an abbreviated version of grounded theory it will be important, as O'Callaghan (2012) claims, for researchers to "clarify what and who inspired their design, why partial grounded theory methods were used (when relevant), and their ontology" (p.236).

8.3   Recommendations for further research

With regard to the first research question, it is clear that more research requires to be undertaken to further substantiate these findings. While a qualitative methodological stance has been appropriate for this study, it may be helpful – as suggested by Clark and Harding (2012) – to incorporate a mix of quantitative and qualitative methodologies to increase the potential significance of subsequent findings. This could include a consideration of changes observed when measuring physiological reactions as well as those more commonly associated with psychosocial outcomes. The design of a validated measurement tool specific to this focus of investigation would be highly desirable. This may be based, for example, on the CORE questionnaire (CORE IMS 2014) or the Oxford Happiness Scale (Hills and Argyle 1998a; 1998b). Quantitative tools such as these, however, should not be exclusive and it is essential that such personal experiences of creativity and relationship-forming though choral participation are afforded sufficient qualitative enquiry. Yet the incorporating of both methodologies may help to further promote the effectiveness of music as a valid therapeutic intervention within an organisation such as the National Health Service. Furthermore, the engagement of a larger group of participants and for a longer period of time would hopefully yield more robust findings.

With regard to the second research question, further research might be undertaken to investigate more thoroughly the longer term impact of such enhanced relationships. Might these be observed in other contexts within a medium secure unit? It may be interesting to consider an ethnographic study in which service-providers adopt more generally a role akin to a service-user and to then reflect on a potentially changed ethos. Might a removing or lessening of boundaries facilitate improvements in health

for patients? Conversely, might this different kind of relationship sit uneasily within what is inevitably a hierarchical environment?

With regard to the third question, within the limitations of this study it has not been possible to confirm the views of those patients who sang in the choir while also attending music therapy on either an individual or group basis. It would be helpful to know from the patient perspective if this helped or hindered the therapeutic relationship that had been established prior to the commencement of choir rehearsals. Furthermore, for patients in the choir who are then discharged into the community it would be interesting to consider if their potential involvement in subsequent musical ensembles was influenced by their earlier participation in the choir. In relation to the education of music therapists, it may be of value to investigate how future practitioners are being taught to adopt working practices which require an increased emphasis on roles which are more pervasive, public and performance-based; as mentioned above this might include a heightened sensitivity towards the needs and abilities of service-providers as well as service-users.

Notwithstanding the rationale for the three questions which underpinned this thesis, it may be interesting to consider in more detail the relationships between them by partly reforming them as one question. An example of this could be: *Might a community-based model of music therapy in a forensic setting afford more opportunities for staff and patient collaboration which in turn may lead to an increase in health benefits?*

Finally, it is interesting to note that within the literature concerning Community Music Therapy there are studies which sit appropriately within the general forensic domain (Tuastad and Finsås 2008; Pavlicevic 2010). The literature pertaining to music therapy in forensic settings, however, is almost void of references to Community Music Therapy. Yet the recent study by Maguire and Merrick (2013) in a high secure setting suggests that this may change and it would be intriguing for this to be further explored in a medium secure setting; indeed studies undertaken in the latter environment may be easier to implement which, if successful, could attract the attention of forensic units more generally. This might also include the significance of therapeutic interventions in a community framework within the prison services.

8.4   Coda and vignette

In this final section I wish to present a personal afterthought. As such, it should not be considered part of the findings as the evolution of this reflection occurred after the data collection process was completed; yet it is an opinion that I wish to express and to share.

An outcome of this investigation has been the continuation of the choir. New members joined and new music was rehearsed. A performance was planned at Christmas and the choir was to be accompanied by a string quartet of musicians external to the setting. I was, unfortunately, unable to be there on the day of the performance. Yet the choir sang and for part of the performance the singers were conducted by one of the male patients who sang with the choir and also accompanied by playing acoustic guitar. Thus, the devolution of the ultimate responsibility had been given to a patient; this young man was responsible for the musical accompaniment and leadership of a choir comprising patients and staff in a public context. The circle was complete. In addition, the welcoming of a string quartet to a forensic unit challenged the notion of an environment that was not part of the community. Such shifts in thinking – patients assuming roles of leadership over staff and a secure setting literally opening its doors to members of the public – can lead to the creation and celebration of community. This is the psychosocial model of health in action.

Having worked as a music therapist in a forensic setting for approximately nine years I take the view that the system – as it currently stands – is not working. The structures and procedures required by the National Health Service are, I believe, hindering rather than helping those for whom the system is intended. Notwithstanding the significance of medication in a healthcare setting, the emphasis on the medical model within mental health disempowers the individuality of the patients in the respective environment. It can also disempower the individuality of members of staff. While certain boundaries and barriers are necessary it is to the benefit of no-one if such boundary-insistence leads to a blockage of human potential. This occurs when boundaries become an internalised concept; when we feel we 'can't do' or 'shouldn't do'. The hierarchical structures that appear a given in forensic settings affirm such limitations; over-security breeds insecurity. Thus, creativity and the living of life itself are stifled. A choir is a

place where – for a time being – people are completely dependent on the responses rather than the restrictions of others. Arguably, this begs the question: is it necessary for the restrictions to resume when the singing stops?

In conclusion, this thesis has sought to respectfully consider three distinct yet related questions which are pertinent to contemporary debates within the broad discourse of music therapy. Ultimately, it has led to the formulation of more questions than conclusions. One conclusion, however, may be that to facilitate increased wellbeing, to provide opportunities for belonging and to offer a sense of hope it is indeed important to hear the people sing.

Yet it is no less important to listen – with compassion – to what they have to say.

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APPENDIX 1   LETTER CONFIRMING APPROVAL FROM NHS RESEARCH ETHICS COMMITTEE (Page 1)

▬▬▬▬▬▬▬▬▬▬

▬▬▬▬▬▬▬ Research
Ethics Committee 01

NHS

Date   12 December 2012
Your Ref
Our Ref

Mr James W Robertson
Lecturer in Music Therapy
Queen Maragret University, Edinburgh
Queen Maragret University Drive
Musselburgh
East Lothian
EH21 6UU

Enquiries to: ▬▬▬▬▬
Extension: ▬▬▬▬▬
Direct Line: ▬▬▬▬▬
Email: ▬▬▬▬▬▬▬▬

Dear Mr Robertson

Study title: **The choir as therapeutic context: a service evaluation of responses from patients and staff in a medium secure forensic unit following their participation in a series of choral experiences.**

REC reference: **12/SS/0218**
IRAS project ID: **115269**

Thank you for your letter of 12 December 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator ▬▬▬▬▬▬▬
▬▬▬▬▬▬▬

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

INVESTORS IN PEOPLE   **Healthy Working Lives**   Headquarters ▬▬▬▬▬▬▬
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APPENDIX 2   **LETTER CONFIRMING APPROVAL FROM NHS RESEARCH & DEVELOPMENT COMMITTEE**

University Hospitals Division

NHS Lothian

DEN/LM/approval

17 December 2012

Research & Development
Room E1.12

Email: ████████████████

Director: ████████████████

Dear ████████

████████ **R&D Project No:** 2012/P/PSY/39

Title of Research: The choir as therapeutic context: a service evaluation of responses from patients and staff in a medium secure forensic unit following their participation in a series of choral experiences

REC No: 12/SS/0218

Participant Information Sheet: Version 2   **Consent Form:** Version 1 dated 21 November 2012 dated 11 December 2012

Protocol: Version 1 dated 14 August 2012

I am pleased to inform you that this study has been approved for NHS ████ and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS ████

We note that an Honorary Contract is required for **James Robertson**, who will have direct contact with patients but does not have an NHS ████ contract. Please ensure this is in place before the Project commences.

Please note that the NHS ████ R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS ████. This includes any changes made subsequent to management approval and prior to favourable opinion from the REC.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study

Yours sincerely

R&D Director

cc: James Robertson, Chief Investigator

APPENDIX 3   PARTICIPANT INFORMATION SHEET

Date   11 December 2012
Your Ref
Our Ref   JR Participant Information Sheet

Enquiries to   James Robertson, Music Therapist
Telephone
Fax
E-mail

Participant Information Sheet
The Therapeutic Choir

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
As well as working one day each week as a music therapist in the ███████████, I am also a postgraduate student from the School of Health Sciences at Queen Margaret University, Edinburgh. As part of the Professional Doctorate programme at this university, I am undertaking a research project for my thesis. The title of the thesis is:

The choir as therapeutic context: a service evaluation of responses from patients and staff in a medium secure forensic unit following their participation in a series of choral experiences.

The study will comprise weekly choir rehearsals for patients and staff on a Wednesday morning in the ███████████. The rehearsals will last for 45 minutes. I will coordinate and lead the choir rehearsals but everyone involved will be encouraged to decide on what we sing and how we rehearse. I envisage us singing songs that we like – e.g. songs from musicals, pop songs or traditional songs from our respective cultures. I will write a simple arrangement of these songs that I feel will be accessible yet enjoyable for all to rehearse.

Why have I been asked to take part?
I am looking for volunteers to become members of the choir. There are no criteria restrictions with regard to age, gender or musical ability. It does not matter if you do not read music or have never sung in a choir before. All staff members are welcome to attend. Likewise, all patients are welcome to participate with the exception of those who are not permitted to leave the ward area. Any students in the ███████████ are also warmly invited.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect the healthcare that you receive.

What will happen if I take part?
If you agree to take part in this study you will be invited to attend choir rehearsals once a week for six months. You will also be asked to attend a focus group discussion before the first choir rehearsal and after the final rehearsal. If you have to leave the ███████████ before the project has been completed you will be invited to complete a short sentence completion test.

It is important for you to be aware that by agreeing to take part in these rehearsals you are not participating in music therapy sessions. For those patients, however, who currently attend – or who have previously attended – music therapy sessions, they will be assured that such work will remain confidential and no reference will made to these sessions during the choir rehearsals or the focus group discussions.

What are the possible benefits of taking part?

You may/may not get a direct benefit from taking part in this study. It is hoped, however, that you will enjoy the process of singing and taking part with a group of people in a satisfying musical experience.

I hope that this study will be useful in determining how the general health of patients might be improved through engaging in a series of choir rehearsals. Likewise, potential developments in relationships between patents and staff may lead to a stronger sense of community in the ███████████. In turn, the role of myself as a music therapist

might be expanded to accommodate the needs, abilities and preferences of a larger number of people.

What are the possible disadvantages and risks of taking part?
I am not aware of any physical risks associated with taking part in this project. It may be that there could be some psychological reaction to the emotional content of some songs or the memories they may evoke for you.

It may be that a participant could become ill during the study and lose the capacity to consent or continue in the study. In such instances the person would likely cease to attend choir rehearsals or engage in the second focus group discussion; similarly, he/she might not undertake the sentence completion test. I would intend, however, to retain previously collected data - e.g. audio recordings of the participant taking part in choir rehearsals and also audio recordings of the first focus group discussion that took place prior to the first choir rehearsal. If you are a patient I will inform the GP at the ███████████ of your participation. Disclosure of information of a criminal nature or involving children will be passed on to staff.

What happens when the study is finished?
Once this project has been completed I will be very happy to share the results with you as a form of feedback. I intend to do this by discussing the findings with you either individually or on a group basis. I can also provide you with a written summary of the main findings.

Will my taking part in the study be kept confidential?
All the information I collect during the course of the research will be kept confidential and there are strict laws which safeguard your privacy at every stage. Your name will be replaced with a participant number and it will not be possible for you to be identified in any reporting of the data gathered. The case histories of patients will not feature in any way in this study; the only background information I require will be your gender and whether you are a patient or a member of staff. With regard to staff, I will refer to participants only as 'clinical staff' or 'non-clinical staff' ensuring, therefore, that no particular staff member could be identified. Students would not be identified by their respective course of study.

I would like to audio record the choir rehearsals and focus group discussions. The only extracts from recordings that may leave the ███████████ would be examples of choral singing to be used for purposes of teaching or presentation at conferences. All data will be anonymised as much as possible and it is highly unlikely that you would be identifiable from audio recordings of your voice.

What will happen to the results of the study?
The study will be written up as a thesis as part of the Queen Margaret University Professional Doctorate programme. The results may be published and the findings presented at a conference.

Who is organising the research and why?
As part of the Professional Doctorate programme at Queen Margaret University, I am organising and undertaking this study for my thesis.

Who has reviewed the study?

The study proposal has been reviewed by Queen Margaret University. A favourable ethical opinion has been obtained from ███████████████ REC. NHS management approval from the ██████████ has also been obtained.

If you have any further questions about the study please contact James Robertson when you see him in the ██████████ each week. Alternatively please leave a message with ██████████████ Head Occupational Therapist.

If you would like to discuss this study with someone independent of the study please contact:
Dr Shona Cameron,
Programme Leader,
Professional Doctorate Programme,
School of Health Sciences,
Queen Margaret University, Edinburgh,
Queen Margaret University Drive,
Musselburgh,
East Lothian
EH21 6UU.

Email / Telephone: scameron@qmu.ac.uk / 0131 474 0000

If you wish to make a complaint about the study please contact NHS ██████ :

Thank you for taking the time to read this information sheet.

James Robertson.

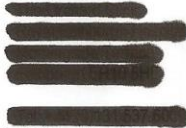<u>Music Therapist</u>

APPENDIX 4   PARTICIPANT CONSENT FORM

REFERENCE NO. 12/SS/0218

NHS

Participant Consent Form

Project Title: The Therapeutic Choir

Name of Researcher: James Robertson

Thank you for reading the information about my research project. If you would like to take part, please read and sign this form.

Participant's name:_____   Date of Birth_____

Hospital_____

Please initial box

1. I have read and understand the information sheet dated 11 December 2012, (Version 1) and have had the opportunity to ask questions.

2. I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. (For patients only): I understand that sections of my medical notes and data from the study may be examined by the researcher where it is relevant to my taking part in the research. I give permission to this person to have access to my data and records.

4. I give permission for my data to be kept for use in future ethically approved research.

5. I give permission for my GP to be informed of my participation and given any relevant information.

6. I agree to take part in the above study

_____   _____   _____
Name of Participant   Signature   Date

                                   _____   _____

Version 1 date: 21 November 2012

APPENDIX 5   **FORM TO GAUGE OPINION REGARDING POSSIBILITY OF PERFORMANCE**

Since we have been taking part in the ███████████, we have sung the following songs:

Bridge Over Troubled Water

Annie's Song

Do You Hear The People Sing?

Knowing Me, Knowing You

You've Got A Friend

Skye Boat Song

Top Of The World

Ob-la-di Ob-la-da

Here Comes The Sun

Could you possibly let me know if you would like to take part in a short informal performance that would be held in the ███████████? If you would like to take part, please indicate (in order of preference) which three songs you would like us to do.

Yes, I would like us to take part in a short performance [ ]

No, I would not like us to take part in a short performance [ ]

The three songs which I would like us to sing are:

1

2

3

James Robertson

APPENDIX 6   **CD RECORDING OF 'DO YOU HEAR THE PEOPLE SING?'
TAKEN FROM THE PERFORMANCE**

APPENDIX 7   **EXAMPLE OF INDEX SHEET FROM REHEARSAL**

REHEARSAL 1   **35 min.13 sec.**

WEDNESDAY 20 FEBRUARY 2013 (11.30-12.15)

IN ATTENDANCE   **P1, P2, P3, P6 & P7**
                      S3, S4 & S5

Rehearsed: 'Bridge Over Troubled Water'

General Points: 1) I was aware that I was nervous prior to this rehearsal commencing – would anyone turn up, for example? Might my own nerves transfer to the choir, were they actually aware of my anxiety, or might this actually help them to feel more at ease?

2) 'Bridge Over Troubled Water' is an inappropriate choice of song due to its very wide vocal range. Why did this not occur to me beforehand?

3) Be careful about discussing aspects of musical terminology.

4) Be sensitive to the lyrical and emotional content of songs – this clearly had an impact on P3.

5) Notwithstanding the above points, I felt this was a positive first rehearsal. The importance of the relationship in this context is, I believe, equally significant as it would be in a 'conventional' music therapy session.

TIME	MUSICAL CONTENT	MUSICAL RESPONSES	VERBAL RESPONSES
00.13			I welcome people to the first choir rehearsal (seven are there at start).
00.35			I state "I'm not quite sure what we'll do – but I have a rough idea."
00.41			I refer to one of the focus group meetings when it was suggested that we might do something by Simon & Garfunkel.
0.51			I suggest 'Bridge Over Troubled Water'.
01.57			I give out copies of the words.
02.14	We listen to the 'Unplugged' version of the song on CD.		
06.43			There is a general appreciation of this version of the song.
08.04	I begin to play some chords on the piano to introduce a simple warm-up activity; the chord sequence of C, F, G and C.		
08.22	I vocalize on "ah" E, F, D, E, E, F, D and C in order to demonstrate what we might do.		

08.29		We gradually begin to sing these notes as a group.	
09.23	I now demonstrate singing G, A, G and E over the same sequence.		
09.36		We now all sing this new melody (lovely sound).	
10.03	I suggest front row of singers sing first melody and the second row sing the second melody; I demonstrate this but make a mistake with the second melody.		
10.38		We begin to sing the two parts.	
11.17		As above but to "oo."	
11.25			P3 comes into the room.
11.42		As above but humming.	
12.00	We end the warm-up and I welcome P3.		
12.10			I talk generally about singing in harmony. P7 mentions "canon" and

			"Pachelbel."
12.39			I now ask us to look at 'Bridge Over Troubled Water'.
12.50			I explain to people that it might feel slightly high to sing but that I can change this for next week if necessary.
13.24	I begin to play the introduction for verse 1.		
13.47		We begin to sing verse 1. I sense quite quickly that it is proving too high (even in the transposed key of C). I am aware of P3 beginning to cry.	
14.58			We reflect on this first verse. There is a general session that it is too high although I tell them "That was absolutely wonderful." There is laughter. I then suggest that when it is felt to be too high that we can sing it at a lower octave and I briefly demonstrate this.
15.44			P3 says that she is not feeling too well and asks to go back to the

			ward. I reassure her that this is okay and someone takes her back. I thank her for coming.
16.05	I play introduction again.		
16.27		We sing again.	
17.55		We move into verse 2. There are times when people – e.g. P7 naturally takes this an octave lower.	
19.33		We move into verse 3.	
21.00			There is a combined sense of fun, relief and achievement that we have reached the end of the song. I then ask people for their views on this choice of song. P7 says "I'm very optimistic, I like it." P6 says "Room for improvement"; there is some laughter in response to this comment. P1 says "There's lots of versions, it's like singing in a bath"; again there is some laughter. P2 says "The high was a bit high and the low was a bit low"; S5 agrees, this seems to be the general view and that it is quite a hard song to sing. I make some suggestions – e.g. taking it into a lower key,

			providing a harmony part for those who found the tune too high.
23.53	I demonstrate the possibility of a harmony part to 'oos' and 'ahs'.		
24.26			I also suggest that if we found this song "a bit tough" we could sing a less demanding song. I ask people which songs they might like to sing. P7 says that we should stick with this song. P1 mentions "Anthony Woodward" but I think he was actually meaning Howard Goodall.
25.42			I suggest we sing the first verse again and I talk about one of the features of this song being the need to wait.
25.55	I demonstrate/highlight the silences between the lines of the song. I mention the significance of rests.		
26.28		We work in more detail with the separate phrases of verse 1. I play the melody rather than the piano accompaniment. We decide which phrases we might take one octave lower.	

30.24			I suggest we stand up to sing and imagine that we are performing in a concert hall.
31.09	I play the introduction for the song.		
31.32		We perform verse 1 and people make a very good effort.	
32.55		We finish the song.	
33.06			I complement everyone on the good sound that we made. I suggest that I feel the song is "a bit demanding" but that we can come back to it to sing some verses from it in the future. I ask P6 if there any particular songs that she would like us to sing and she says "Annie's Song". S3 agrees with this choice. P6 also mentions "Greensleeves". P7 suggests "For unto us a child is born" from Handel's 'Messiah'.
35.10			I thank people and bring the rehearsal to a close.

APPENDIX 8   LIST OF QUESTIONS USED IN FOCUS GROUP 1 MEETINGS

The list of questions for the meetings prior to the rehearsals commencing (along with a rationale and probe for each one) is given below:

1   Can you indicate any experiences you have had with regard to taking part in a choir or a singing group?

Rationale: *This was essentially a warm-up question to allow people to indicate the nature of any previous choral experiences they have had.*

Probe: *Do you remember singing in a choir when you were at school?*

2   What would you say has motivated you to be part of a choir in this unit?

Rationale: *To find out people's motivations for attending choral rehearsals.*

Probe: *What would you like to get out from being here?*

3   What kind of music would you like us to sing?

Rationale: *To allow people to feel immediately involved in the process of choosing repertoire.*

Probe: *If there was one song that you would really like us to sing, what would it be?*

4   How would you like rehearsals to be organised?

Rationale: *To assist people in the reflection of a conventional choir rehearsal in which the conductor would normally take a predominantly authoritative role; to ascertain whether participants might prefer a more open and flexible approach.*

Probe: *How much do you want me to be in charge?*

5 Might we wish to perform to other people in the unit or do we prefer to sing only for our own pleasure?

Rationale: *To consider the potential continuum between private rehearsals and public performances.*

Probe: *How do you feel about putting on a concert?*

6 Is there anything else you would like to say?

Rationale: *To provide the opportunity for anyone who wished to make a final comment or ask a question.*

APPENDIX 9   LIST OF QUESTIONS USED IN FOCUS GROUP 2 MEETINGS

The list of questions for the meetings following the conclusion of the rehearsals (along with a rationale and probe for each one) is given below:

    1   How would you describe your overall experience in taking part in these weekly rehearsals?

Rationale: *To acquire a general perspective of those who attended.*

Probe: *Have you enjoyed coming?*

    2   How has the experience impacted upon wellbeing?

Rationale: *To reflect on the benefits and positive outcomes that have been felt by different people.*

Probe: *Have you felt better within yourselves in any way?*

    3   What, for you, has been the most satisfying part of the whole process?

Rationale: *To consider what it was that seemed to engage people most meaningfully.*

Probe: *What did you look forward to most each week?*

    4   What, for you, has been particularly challenging or disappointing?

Rationale: *To reflect on the reasons why some people may have found the experience to be less than fulfilling.*

Probe: *Did anything make you feel uncomfortable?*

5   Are there songs we did not do that with hindsight we might have done?

Rationale: *To give people the opportunity within their own respective groups to consider songs that we may do in the future.*

Probe: *If we were rehearsing tomorrow which new song would you most like us to sing?*

6   Would you like the rehearsals to continue and, if so, how might they be organised?

Rationale: *To gauge opinion about resuming rehearsals and the form they might take if we do.*

Probe: *If we were to change one thing, what would it be?*

7   How did it feel singing alongside patients/staff?

Rationale: To allow each group to comment openly on how they felt interacting with the other group in this way.

Probe: Did it feel awkward in any way?

8   Is there anything else you would like to say?

Rationale: *To provide the opportunity for anyone who wished to make a final comment or ask a question.*

APPENDIX 10 **PRESENTATION OF THEMES FOLLOWING ANALYSIS OF DATA FROM FOCUS GROUP 1 MEETINGS**

1   Singing provides opportunities for collective performance as well as learning through clear guidance.

2   A sense of camaraderie through teamwork may be fostered through singing in a choir which for staff members may promote fun and enjoyment while for patients the opportunity is afforded to engage in re-creative experiences.

3   People appear inclined to favour songs that may now be considered as 'standards' written by established singer-songwriters.

4   Feelings of insecurity about one's own singing voice might hinder participation in a choir.

5   A gradual transition from a conductor-led to a choir-influenced rehearsal style is generally felt to be appropriate.

6   The option of performing in front of others requires ongoing and sensitive consideration from a therapeutic perspective.

APPENDIX 11   **PRESENTATION OF THEORETICAL CODES FOLLOWING ANALYSIS OF DATA FROM FOCUS GROUP 2 MEETINGS**

1   Participation in choir rehearsals can foster an overall sense of wellbeing as well as the development of group camaraderie between individuals.

2   Members of staff may experience an enhanced feeling of relaxation and increased body awareness when returning to their work responsibilities following rehearsals.

3   Patients may acquire an increase in confidence and self-pride through learning in music as well as a deeper appreciation of freedom, space and kindness.

4   While the opportunity to perform in front of others can be a positive experience for all concerned, the actual occasion of performance may hold greater significance for members of staff than it does for patients.

5   Singing in a choir may evoke feelings of benevolence towards those perceived as particularly vulnerable.

6   Participating in a choir affords opportunities for learning about oneself as well as the acquisition of musical skills, understanding and knowledge through purposeful work.

7   A newly formed choir will likely prefer to choose repertoire comprising 'standard' or well-known songs prior to embarking on music that is more contemporary and perhaps less familiar to the wider population.

8   The removal of barriers that can occur when staff and patients sing with each other might act as a template for other groups comprising the two populations. Furthermore, it might compel us to *think* more about how we *relate*.

9   The opportunity to feel a person in one's own right rather than a patient with a corresponding label may be an outcome of singing alongside members of staff.

10   Through choir rehearsals the understandably restrictive environment of a medium secure unit may be expanded by welcoming patients and staff from other wards throughout the wider hospital. A more inclusive community might therefore be fostered.

11   Feelings of empathy may be felt and expressed in acknowledgement of the respective challenges faced by individuals when singing together in a choir.

APPENDIX 12   LIST OF CATEGORIES AND OPEN CODES PERTAINING TO FOCUS GROUP 2 MEETINGS

Rehearsal Experiences
Period of time for rehearsals went very quickly
Excitement at taking part in rehearsals
Rehearsals promoted feeling of space
Rehearsals promoted feeling of freedom
Rehearsals promoted sense of community
Warm-hearted mood of rehearsals
Comforting mood of rehearsals
Sense of anticipation in advance of each rehearsal
Sense of freedom felt when singing
Opportunity to think only of singing
Opportunity to forget you were in a medium-secure unit
Rehearsals promoted feeling of strength
Opportunity to learn how to sing
Opportunity to learn about musical expression
Opportunity to improve diction
Sense of being given a gift
Sense of empowerment
Sense of achievement through learning
Sense of discipline through learning
Wonderful experience
Appreciation of warm-up exercises.
A beautiful experience.
Sense of excitement
Rehearsals promoted a sense of discovery
Rehearsals facilitated development of abilities
Rehearsals were more fun than had been anticipated
Feeling of enjoyment when rehearsals commenced
Opportunity to learn about one's own voice
Satisfaction of participating in a group
Feeling safe in being part of a group
Sense of fun experienced during the rehearsals
Sense of excitement felt at having taken part
Sense of self-pride at having taken part
Sense of feeling different during the rehearsals has had some lasting impact
Appreciation of being challenged
Element of surprise at realisation of hidden potential
Comparison with yoga with regard to focus on breathing
Lasting feeling of strength
Sense of empowerment
Opportunity to learn something new at every rehearsal
Element of surprise at one's own vocal ability
Experience of team work
Increased confidence as a result of being in a group
Tendency to sing on the ward more
Using the songs to sing oneself to sleep
Singing has helped develop confidence
Confidence has improved as a result of attending
Increased confidence when well enough to attend rehearsals
Determination to make the best effort possible
Awareness of one's state of mind when participating

Sense of dedication towards the choir
Experience of concentration
Experience similar to taking part in Japanese martial arts
Sense of going with the flow
Participation did not require strain
Participation did not require effort
Participation was a natural process
Comparison with Buddhism
Opportunity to see difficulties in advance and therefore overcome them
Sense of total concentration
Process was as natural as breathing
The effort of being in a group is satisfying
Verbal communication not necessary
Rehearsals represented a different form of communication
Rehearsals represented a different way of spending time with people
More enjoyment felt when singing with people rather than having to speak with people
Awareness of the group dynamic
Significance of non-verbal communication
The opportunity for the group to bond
Infrequent attendance of some people did not detract from the overall sense of a bonded group
Feeling of being assertive rather than aggressive
Sense of nostalgia regarding happier times in the 1960s
The experience was lovely
I enjoyed the rehearsals
I adapted well to the rehearsals
The rehearsals were quite easy
Some voices sounded better than others
Even if some people did not have good voices they still enjoyed it
I can take the confidence I have gained from singing at school and in the clinic with me into the future
Singing in the choir here will help me adapt to a choir in the hospital I am going to next
Singing in the choir helped me with my guitar playing
I would remember the words of the songs each time I came to a rehearsal
The most satisfying part was knowing how to react to other people
It has helped me to interact with other people my age
It has helped me to be kind
It has helped me to be diplomatic
Each helped the other in the group
I enjoyed the overall experience
It sounded like a choir
Sometimes in the morning of rehearsals I would feel lazy and have to force myself to go
Wednesday is a good day for the choir to meet
The nurses stayed and kept their eye on us
I think I came to twenty rehearsals
Everyone became familiar with each other
People smiled each time we turned up
Everybody recognised each other
We were able to sing louder without losing a contemptuous quality to the sound
Rehearsals were loved
Did not want rehearsals to stop
Rehearsals were great
Amazing sound considering choir is small in number
Recording sounds as if there are many more people singing
Rehearsals were enjoyed
Rehearsals have been fantastic
A really good experience
Everything was enjoyable

Practising was enjoyable
Focus on breathing had benefits after the rehearsal
Felt more centred after the rehearsal
Felt more relaxed doing work after rehearsal
Increased body awareness when working at a computer
Felt a lull whenever rehearsals were missed
Real energy felt upon returning to rehearsals
Great to be part of a group with people from the clinic
Overall experience of the choir was increased energy afterwards
Sense of fun and laughter
Rehearsals were not long in duration
Rehearsals were too short in duration
Rehearsals were like an oasis
Affirmation that rehearsals were like an oasis
Rehearsals were unlike anything else
Would return to office singing
Would return to office full of joy
Restlessness felt when unable to attend a rehearsal
Felt something was missing when unable to attend a rehearsal
Enhanced feeling of happiness
Enhanced feeling of cheerfulness
Feeling of relaxation
The positive impact of the rehearsal stayed with you for several days
Looking forward to having fun each week with the same people
The closed group meant that people were not coming and going
It was good getting to know people
It was good being able to spend more time with people
We quickly felt that we could sing in front of each other
People were supportive of each other
People were encouraging towards each other
There was a sense of togetherness
Doing different songs each week was really good
Even if we had not performed we would still have enjoyed the overall experience
There were lots of fun moments
The scales and arpeggios were fun
Staff participant felt self-conscious about how his voice was so dominant in the first recording we did
Supporting each other was a powerful experience
Congratulating each other was a powerful experience
The mix of different staff members provided an added dimension
Rehearsals were loved
Looked forward to the rehearsals
Unable to attend all the rehearsals
Frustration felt at not being able to attend all the rehearsals
Missed rehearsals when unable to attend
Rehearsals were an enjoyable experience
Felt that we gradually improved
We became more confident as a group
We became more confident in our singing
A therapeutic experience
It was a good way in which to release emotions
I have been singing more since taking part in the choir
Singing since the choir has ended has resulted in an ongoing release of emotions
The music in general has been helpful
Singing in the choir has represented music becoming part of my life again
Singing has helped me feel more confident
Connecting to people on an emotional level has been satisfying

Patients and staff bonded as a result of the whole experience
The human connection that evolved between people was the most satisfying element
Everyone had different musical tastes
Rehearsals were well-organised
Unable to think of anything that did not work
The mix of people was the reason it worked so well
It was good that different professions were represented
It was good that it wasn't only AHPs attending
It was good that whoever wanted to come was welcome
It was good that there was not a clear division of roles
Relationships between the different professions were strengthened
It was good seeing people in different roles
It was good fun
Everyone got a lot out of it
I felt positive when I sang in the choir
The best thing has been having the opportunity to sing in a group
The choir encouraged positive social interaction
I enjoyed attending the choir
The choir was structured in a manageable way for everyone
The choir was structured in such a way as to prevent anxiety people might feel about singing
I enjoyed every minute of the rehearsals
The rehearsals were very satisfying
The experience has made me feel happy
The experience gave me something to look forward to
I acquired a sense of achievement
The songs improved with practice

Performance Experiences
Enjoyment at taking part in performance
Sense of surprise at being able to perform in front of an audience
The cementing of the group bond through the performance
Realisation of how bonded the group was as a result of doing the performance
The performance was great
Feeling of nerves regarding performance
Affirmation of feeling nerves regarding performance
People were brave to stand up and sing in front of colleagues
The option to perform was not an initial priority
Initial feeling of real discomfort at the thought of performing
Sense of regret at ticking the 'yes' box to performing when the feeling was really 'no'
Knowing we were to perform helped to focus our minds
Feeling of nerves on lead-up to performance
Unsure if it was good or bad to have been off during the weeks leading up to the performance
Felt uncomfortable on the day of the performance
Sense of disbelief at how much I enjoyed the performance afterwards despite feeling so uncomfortable before it
It was a challenge to perform but it was best to simply get on with it
Sense of shock at how people attending the performance were watching us so intently
BBQ has never been so well-attended
BBQ has never been so well-attended by staff
Several administrative staff came to the BBQ
Staff participant had cajoled colleagues to be there
Audience members really respected the sense of performance
Absence of inhibition during the performance
The performance was a unifying experience
Audience members had commented on the mix of staff in the choir
An audience member had commented on how amazing it was to see the mix of staff in the choir
Even though there were only 8 performing there was such diversity amongst staff and patients

I was aware that myself and a patient were feeling similarly nervous about the performance
The group members were able to share the feeling of being nervous
The reaction from everyone to the performance was positive
The performance allowed people to demonstrate how worthwhile it all had been
The performance allowed people to demonstrate how much we had all learned
The audience comprised people from different professional backgrounds
It is rare to have so many different people in the clinic together at one time
People really wanted to see us perform
The coming together of everyone at the performance was really satisfying
Admiration expressed from others but also an insecurity about taking part

Possibility Of Future Rehearsals
Enquiry regarding continuation of rehearsals
All patients affirm desire for continuation of rehearsals
All patients affirm desire for rehearsals to be organised in the same manner
Enquiry of rehearsals continuing until Christmas
Discussion regarding resumption of rehearsals
Approval of the idea of having new members
Affirmation of approval of the idea of having new members
Approval of the idea of singing something at Christmas
Affirmation of approval of the idea of singing something at Christmas
Request to sing 'We'll Meet Again' when we resume rehearsals
It would be good if I could stay until Christmas and sing songs with the choir
Would like the choir to continue
If I was able to stay in the clinic I would keep coming to the choir
It might be good to add percussion instruments
Percussion instruments would give it a Christmas sound
The music therapy group might work with the choir
Patients with learning disabilities outwith the clinic would also benefit
Query of potential to expand the clientele who might attend
Desire for rehearsals to continue
Affirmation of desire for rehearsals to continue
Further affirmation of desire for rehearsals to continue
Suggestion for Christmas performance
Timing of the rehearsals is convenient
45 minutes is appropriate length of time for patients to attend rehearsals
Not aware of any changes that might be made re organisation of rehearsals
Would love rehearsals to continue
Would not want rehearsals to continue if I (i.e. the participant) cannot attend. (element of humour)
Choir members might now take more ownership of responsibilities
Possible contribution at Christmas party
Other people are already suggesting a performance at Christmas
If[other people did attend they would surprise themselves
Happy to help with general organisation as well as singing
I would recommend it to anybody
I hope that we have inspired other people to join
Rehearsals could be improved with increased attendance
I would like the rehearsals to continue

Attitudes Towards Conductor
Appreciation of conductor as teacher
Appreciation of conductor as teacher
Conductor helped in the process of overcoming difficulties
Expression of gratitude for the whole experience
Affirmation of expression of gratitude for the whole experience
Further affirmation of expression of gratitude for the whole experience

Conductor worked diplomatically with the patient who had a loud temperament
Conductor was a good listener
Appreciation of conductor
Appreciation expressed to JR
Affirmation of appreciation expressed to JR
Appreciation towards conductor for the experience

Attitudes Towards Others

Appreciation of how another participant has been positively affected by the whole experience
Patient with a loud temperament seemed to improve
Patient with a loud temperament was also very self-confident
I adapted my voice to accommodate the voice of the person with the loud temperament
By adapting my voice to accommodate the voice of the person with the loud temperament helped to level out the overall sound
The ladies in the choir sang very well
The ladies in the choir sounded very sweet
The person with the loud temperament was able to push the sound further
Admiration at how one patient overcame her nerves
Admiration at how one patient performed so well
Sense of surprise at how one patient managed to overcome her nerves
Regret that one patient was unable to take part in performance due to transfer to another hospital
Emotional recall at suddenly hearing a particular patient sing solo
Affirmation of emotional recall at suddenly hearing a particular patient sing solo
Further affirmation of emotional recall at suddenly hearing a particular patient sing solo
Hearing a particular patient suddenly sing solo was quite spiritual

Attitudes Towards Certain Songs

Beatles' songs revive memories of swinging 60s
Desire to sing Abba songs
Preference for 'Knowing Me, Knowing You' rather than 'Ob-La-Di Ob-La-Da'
Desire to sing 'Bridge Over Troubled Water'
Affirmation of another participant's desire to sing 'Bridge Over Troubled Water'
Initial forgetting of the fact that 'Bridge Over Troubled Water' was the first song we had sung
Indication of the difficulty in singing 'Bridge Over Troubled Water' with regard to its high pitching
Indication of the difficulty in singing 'Bridge Over Troubled Water' with regard to its high pitching
It was good to have opportunities to make songs different
I sent the words of two of the songs to my grandmother at her request
We might have sung 'Mistletoe and Wine'
Some songs I heard on the TV might be good for us to do
Looked forward to trying out different songs
Enjoyment of singing songs that were personal favourites
Sense of anticipation regarding what songs will be sung next
Desire expressed to have sung something more modern
Recognition of the fact that the songs were from the 60s, 70s and 80s
Desire expressed to have sung something from the 21st century
Suggestion made of the songs of Goyte
Suggestion made of a particular song by Goyte
Acknowledgement made that the suggested song by Goyte may be challenging
Discussion of Goyte
Affirmation that it would have been nice to have sung something more contemporary
Difficulty of not choosing songs that come from your own youth
Suggestion of a Van Halen song that has been adapted by Tony Bennett
Suggestion of songs by Michael Bublé
Affirmation of idea of taking an old song and adapting it
Acknowledgement of recent slow version of 'Power of Love'
Reworking old songs is fashionable
John Lewis adverts are an example of reworking old songs

Reworking old songs can take audiences by surprise
Suggestion of singing something acappella
Suggestion of The Flying Pickets with reference to acappella
Further appreciation of The Flying Pickets
Poignancy of the lyrics
Feeling of release when singing the defiant song
We chose very different songs to perform
We chose a defiant song, a love song and a happy song
I would have liked to have done some soul songs
I would have liked to have sung 'California Dreaming'
It would have been good to have sung a modern song in a choral style that would have shocked people
Songs chosen were at least familiar to those taking part
For a first block of songs it was good that people were familiar with them
The fact that the songs were familiar meant that they were not threatening
Offering completely new songs at the start would have been too much
It may be good to do completely new songs in the future
I enjoyed singing 'Bridge Over Troubled Water' most of all

Comments About Singing
Singing is a natural process in itself
Realisation that singing on one's own was not a requirement
Sense of being able to refuse not to sing on one's own
To an extent you can hide your voice in the group which is helpful
Desire to become a professional singer in the future
Realisation of time and effort involved in order to become a professional singer
Expression of a love of singing
Moment of spontaneous singing
Memories of singing solo in front of others at primary school
Memories of singing in front of relatives at primary school
Relatives still recall me singing in front of others at primary school
I like singing
I was impressed with the choir that came to the clinic prior to last Christmas
The choir that came before last Christmas were more experienced than ourselves
The choir that came before last Christmas had probably been singing round the local churches
The choir that came before last Christmas motivated me to join the choir in the clinic
I think I can also sing louder
I had not sung since leaving school
I am not good enough to sing in a choir in which auditions are required
I have always been keen to join a choir

Comments About Music
Music can be difficult to decipher on your own
It is easier to weave the sounds of different instruments together
The music would not be interesting if you only had drums
I like the background effect of sounding bowls
I like metal instruments
I've grown an interest in music
I've grown an interest in music therapy

Challenges
Being nervous provides adrenalin
The thought of singing on one's own was challenging
Apart from the initial feeling of having to sing on one's own there were no negative aspects to the experience
Challenge akin to climbing a mountain
Challenge akin to climbing a tree
Necessary to attend many rehearsals in order to meet the challenges

Effort from oneself required in order to meet challenges
Challenges were welcomed
Sense of autonomy in deciding to meet challenges
Meeting challenges promoted a feeling of freedom
Challenges were not unfairly imposed
Meeting challenges was akin to volunteering
Meeting challenges was brave
Meeting challenges was important
Meeting challenges was akin to building
'Ob-La-Di Ob-La-Da' was challenging due to the number of words
The number of words in 'Ob-La-Di Ob-La-Da' meant that it was difficult to keep up with the others
Challenge did not deter effort to do one's best
Experience of disappointment in oneself at not being able to sing all of the words in 'Ob-La-Da Ob-La-Da'
It can be hard to rehearse tunes and notes
The smoking break interfered with attendance
Most people stayed despite the smoking break
Staff came to rehearsals despite not having much time
Occasionally a patient would leave the choir
The rest of the choir singing a little louder would compensate for the loss of a patient
Initial inhibitions soon vanished
Scales and arpeggios could be quite challenging
Scales and arpeggios were particularly challenging when words and numbers were incorporated
It was fun having the challenge of singing scales and arpeggios to words and numbers
Initial concern felt at how people might react to some of the song lyrics
Initial concern felt at how people might react to some of the emotional content of the songs
Initial anxiety felt at what the song content could bring out for some people
Initial concern felt at the unpredictability of what might happen
The newness of the experience was slightly disconcerting at the beginning
What I felt people might find uncomfortable with turned out to have the opposite effect
My own expectations were wrong with regard to what I thought people might find upsetting
After the first two rehearsals I realised that my concerns of how people might react were unfounded
Initial feeling of self-conscious regarding the possibility of singing out of tune
Slight sense of vulnerability in terms of letting your barriers down
Dual role of escorting unwell patients back to ward was slightly uncomfortable
I have found it difficult to reach some of the notes
Learning new songs was challenging

Singing Alongside Members Of Staff
Acceptance of singing alongside members of staff
Singing alongside members of staff was not an issue
Members of staff were simply co-participants of the choir
Singing alongside members of staff promoted a sense of belonging
Singing alongside staff promoted a sense of choral membership
The distinction between carer and patient was removed due to musical collaboration
Musical collaboration between staff and patients offers a new perspective
Musical collaboration between staff and patients led to discovery of each other doing something completely different
Musical collaboration between staff and patients created a nice feeling
Musical collaboration between staff and patients led to more communication
Musical collaboration between staff and patients led to more talking together
Musical collaboration between staff and patients facilitated teamwork
Musical collaboration between staff and patients facilitated group dynamics
Musical collaboration between staff and patients was very nice
Some of the boundaries between staff and patients were removed due to musical collaboration
Musical collaboration between staff and patients helped us to identify with each other in a different way
Sense of one group was affirmed
The fact that some participants were staff and some were patients did not matter

Staff members were just the same as us
When singing alongside us staff members did not perceive us as people with mental health problems
Singing alongside members of staff allowed us to not feel that we had mental health problems
Singing alongside members of staff allowed us to feel a sense of normality
The choir comprised 50% staff and 50% patients
It was very good singing alongside staff
The staff are good singers
I liked the staff members

Singing Alongside Patients
Appreciated working with patients as most work is done outwith clinic
Actually doing something with the patients was good as I do not normally do this
Staff participant interest in what patients said re singing alongside members of staff
Distinction between staff and patients disappeared once the rehearsals started
Staff and patients were just one group
Staff and patients were on a level playing field
Barriers were broken down as a result of singing together.
It is staff who form the barriers
By singing together we choose to remove the barriers
It was nice to sing with the patients
It was good to sing with the patients
Being together in this way is how it should be anyway
Unanimous agreement that it would be nonsensical for the choir to be for staff members only
It would be nonsensical for the choir to be for patients only
Sense of being on an even keel in the room
Unlike other groups in which I am facilitating several patients
Sense of equality in the group
No difference between singing alongside patients in comparison to anyone else
Similar to my facilitation of football groups in which everyone is part of a team
It took a couple of weeks to get used to the dynamics of patients and staff being together in this way
Staff and patients shared the enjoyment of attending the choir
Sharing the experience with patients has been very satisfying
It was very nice to be part of the same group
There was no feeling of 'them and us'

Miscellaneous
The most satisfying part was knowing how to react to other people
It was difficult being in prison
Prison taught me that people can do rotten things to other people
People can still get on well with each other
People can still be human beings to each other
People can still be nice to each other
People don't have to struggle to get along with each other
It can be hard to pay for crimes you have committed
It is hard to talk about crimes you have committed
It is fine for people to be who they really are
I've learned a lot since being in the clinic
I've grown an interest in cooking
I've grown an interest in going to the gym
Since I have been here time has gone very quickly
I am now about to leave the clinic
When I leave here I will miss the different activities
I am familiar with this place
I am familiar with the people in this place
I cannot stay here forever

I sometimes wonder why I am moving to the new place
Unsure if I am trying to find a quick route to get my freedom back
You have to earn your freedom
If you have not earned your freedom you go back downhill
I have still a bit to go in order to earn my freedom
Appreciation of OT Assistant
OT Assistant was a fun-giving person
Appreciation of the Link-Up group
Connecting to people on an emotional level has been satisfying

TOTAL - 484

APPENDIX 13   CONTENT ANALYSIS OF SELECTIVE CODES FROM PATIENTS AND STAFF PERTAINING TO CATEGORY 1 'REHEARSAL EXPERIENCES' (FOCUS GROUP 2 MEETINGS)

RESPONSES FROM PATIENTS	No.	%
Overall feelings of wellbeing	21	23%
Strong sense of group camaraderie	19	20.8%
Opportunity to learn through the experience of music	15	16.4%
Participation was safe and natural	6	6.5%
Benefits of singing in the choir have lasting impact	5	5.4%
Increased feelings of confidence and self-pride	5	5.4%
Significance of non-verbal communication	4	4.3%
Promoted feelings of space and freedom	4	4.3%
Promoted feelings of strength and empowerment	4	4.3%
Similarities with oriental practices	3	3.2%
Enhanced concentration	2	2.1%
Promoted a feeling of kindness	1	1%
Promoted a sense of diplomacy	1	1%
Provided opportunities for nostalgia	1	1%

RESPONSES FROM STAFF	No.	%
Overall feelings of wellbeing	30	33.3%
Strong sense of group camaraderie	25	27.7%
Benefits of singing in the choir have lasting impact	15	16.6%
Sense of pride in the quality of choral singing	5	5.5%
Feelings of restlessness when unable to attend rehearsals	5	5.5%
Participation was safe and natural	3	3.3%
Desire for rehearsals to continue	3	3.3%
Range of musical tastes was helpful	2	2.2%
Self-conscious regarding dominance of one's own voice	1	1.1%
Unable to think of anything that was not positive	1	1.1%

RESPONSES FROM PATIENTS AND STAFF	No.	%
Overall feelings of wellbeing	51	28.1%
Strong sense of group camaraderie	44	24.3%
Benefits of singing in the choir have lasting impact	20	11%
Opportunity to learn through the experience of music	15	8.2%
Participation was safe and natural	9	4.9%
Increased feelings of confidence and self-pride	5	2.7%
Feelings of restlessness when unable to attend rehearsals	5	2.7%
Sense of pride in the quality of choral singing	5	2.7%
Significance of non-verbal communication	4	2.2%
Promoted feelings of space and freedom	4	2.2%
Promoted feelings of strength and empowerment	4	2.2%
Similarities with oriental practices	3	1.6%
Desire for rehearsals to continue	3	1.6%
Enhanced concentration	2	1.1%
Range of musical tastes was helpful	2	1.1%
Self-conscious regarding dominance of one's own voice	1	0.5%
Unable to think of anything that was not positive	1	0.5%
Promoted a feeling of kindness	1	0.5%
Promoted a sense of diplomacy	1	0.5%
Provided opportunities for nostalgia	1	0.5%

Those in italics represent selective codes comprising responses from patients only while those in bold represent selective codes comprising responses from the staff. The selective codes in plain text were contributed to by patients and staff.

APPENDIX 14   **PRESENTATION OF THEORETICAL CODES FROM THE PROFESSIONAL LOG**

1   The openness and vulnerability that a music therapist may reveal when adopting a role of leadership may lessen the anxiety felt by participants and thereby help to affirm a trusting relationship in the early stages of work.

2   The setting of achievable and identical musical goals for patients and staff may help to establish a community spirit underpinned by warmth and mutual support.

3   Meaningful learning occurs in an environment where new challenges are felt to be motivating in themselves. In so doing, *getting better* with regard to the quality of musical sound may lead to *feeling better* as a result of the musical experience.

4   As therapists we may find ourselves adopting a more didactic approach when working with larger numbers of people.

5   The lyrical content of a song – and the opportunities for vocal improvisation within a familiar structure of a song – can consolidate relationships between different patients as well as removing barriers between staff and patients.

6   Achievement is felt most keenly when it is earned.

7   The encouraging of participants to attain higher levels of musicianship may require us as therapists to allocate more time to our own musical preparation.

8   The musical interests and abilities of a person attending a performance-based musical activity may be further expanded in his or her own time.

9   As the needs and attributes of the respective musical group become more apparent, the therapist may feel compelled to assume a more directive approach.

10   When preparing patients and staff for a situation which will involve a degree of public exposure, the therapeutic attributes of compassion and care may helpfully be demonstrated towards both populations.

11   A democratic ethos which is carefully nurtured from the outset will allow people to feel similarly involved in decision-making in the latter stages of a project.

12   A community which makes the transition from a private to a public presence will be a changed community as its inner ways and workings have been revealed.