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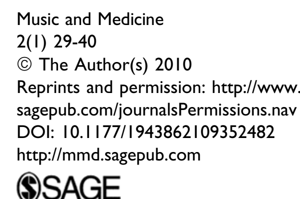

"Some Light at the End of the Tunnel": Exploring Users' Evidence for the Effectiveness of Music Therapy in Adult Mental Health Settings

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Abstract

This study responds to the current demand for evidence of the effectiveness of music therapy in adult psychiatric care and rehabilitation. The qualitative, idiographic, and user-based perspective of the study also responds to the growing requirement that "evidence-based practice" take into account patients' needs, experiences, and evaluations of services. The study is based on verbal data from 19 patients with chronic mental health problems who completed at least 10 individual sessions of professional music therapy in a London mental health unit. In-depth analysis of semistructured interviews using interpretive phenomenological analysis elicits patients' experiences of the process of music therapy and its varied benefits for them in relation to their symptoms, coping strategies, and overall quality of life. The data suggest how the approach to music therapy taken in this situation often works in relation to users' long-standing relationship to music, as expressed through their "music-health-illness narratives." Participation in music therapy has benefits in itself but can also help reestablish patients' ongoing use of music as a health-promoting resource and coping strategy in their lives.

Keywords

music therapy, music improvisation, adult psychiatry, rehabilitation, evidence

> *I don't feel this is just therapy, but this is participation in music. It gives me a sense of participation, fulfillment, of actively doing something good and useful. . . . When I come to these sessions I could be a bit depressed at the beginning . . . but usually during the therapy the mood lifts up, and it also helps me to concentrate on other things. Because when you're making music you really need to concentrate . . . you need to listen to the other person, what they are doing, what their sounds are. You have to put two heads together to make music together. . . . Music gives me a sense of a little light at the end of the tunnel. So planning what the next note's going to be would in a sense lead me to think about planning the next step in my life . . .*
>
> —*Edwin*

These words come from an interview with Edwin, a young professional man who had suffered an acute psychotic episode. During a subsequent depressive episode within his recovery phase, Edwin attended 12 individual music therapy sessions with a professional music therapist. The quotation above from his report on his experience of this course of therapy can serve as a summary of the findings of our study, which we will elaborate in this article.

The approach was Nordoff-Robbins Music Therapy (Nordoff & Robbins, 1977), which has been increasingly used with adult populations (Ansdell, 1995; Pavlicevic, 1999) including autism (Turry & Marcus, 2003) and psychiatry (Pavlicevic & Trevarthen, 1989; Procter, 2002). It is informed by musical, psychological, and sociocultural models, but it centers on the belief that creatively making music together is itself the prime agent of therapeutic change. The Nordoff-Robbins approach can be characterized as client-centered, interactive (i.e., making music, not just listening to it), semidirective, and experiential. Typically the therapist plays piano and sings, whilst the patient can play good-quality percussion instruments and can also use his or her voice. Much of the music-making is improvised, but known musical repertoire is also used with an "improvisational attitude." Patients need no formal prior experience of music-making, but those who are trained musicians can bring in their instruments. Making music together initiates and helps develop a musical/therapeutic relationship between

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client and therapist, which is the direct means for helping patients experience themselves as more active, communicative, social, creative, and spontaneous. This process mostly takes place nonverbally and is not usually directly interpretative or insight-oriented (though neither of these processes is proscribed). There are of course other approaches to music therapy, but in keeping with the idiographic focus of this study, we characterize here only the style of intervention used by the therapist.[1]

This research began its life during clinical supervision between a music therapist and a consultant psychiatrist—examining music therapy case material in relation to both process and perceived outcomes.[2] In the mental health unit in which we work, music therapy has found an acknowledged role for patients with long-term mental illness who are considered treatment-resistant, difficult to access therapeutically through verbal insight-oriented approaches, and often chronically isolated and socially and culturally excluded.

We began to ask why many such patients were willing and able to sustain their engagement in music therapy sessions, when their use of other therapeutic activities was very limited, or where they were resistive to these offers. Our patients were fortunately willing to tell us about their experience of music therapy, often in precise and illuminating detail. This study is based on their accounts as service-users and attempts to show that music therapy may be especially suitable for these particular patients and to explore the reasons *why* this may be so. The study was focused by the following research questions:

- What experiences of music therapy do service-users report, having completed at least 10 sessions?
- Do patients report benefits from the therapy, and if so, how are such benefits characterized?
- What is the role and status of service-users' experiential narrative accounts in demonstrating evidence of the effectiveness of music therapy within adult psychiatric care and rehabilitation?

We hope this study will stimulate discussion concerning not just the benefits of music therapy for this clinical area but how such benefit can be best evidenced: to the balance, that is, between experimental designs and narrative accounts from users and staff (Mental Health Foundation, 1999). This debate concerns both the appropriateness and the positioning of qualitative studies within an integrated research perspective (Weaver, Renton, Tyrer, & Ritchie, 1996). We agree with the following conclusion of a recent Editorial of *PLoS Medicine* titled "Qualitative Research: Understanding Patients' Needs & Experiences":

> When researchers investigate the experiences of people receiving or failing to receive health-care, identify themes in these subjective stories, and integrate these themes into the greater context of human life experience, the results are informative to care providers. The usefulness of these results lies precisely in their subjectivity; the subjects are telling us, or we are finding out through more subtle observation, what matters to them. (*PLoS Medicine*, 2007, p. 1283)

Our study addresses what mattered to 19 patients and what their evidence tells us about the potential of music therapy within mental health services.

Previous Studies

Music therapy[3] has been part of healing traditions for millennia (Horden, 2000) and a modern registered health profession in the United Kingdom working within mental health provision for more than 30 years. Recent demands for experimental evidence of clinical effectiveness as defined by an evidence-based practice framework have proved a challenge, though one successfully met with a recent Cochrane Review for music therapy with patients with schizophrenia (Gold, Heldal, Dahle, & Wigram, 2005) and also a randomized control trial (RCT) of music therapy with patients with acute psychosis (Talwar et al., 2006). The Cochrane Review concludes that "when added to standard care, music therapy helps people with schizophrenia improve their global state, mental state and social functioning" (Gold et al., 2005, p. 9). The RCT demonstrates an association of short-term reductions in general and negative symptoms of schizophrenia but also makes a concluding recommendation that quantitative and qualitative perspectives be combined in a future study "to examine the relationship between the process and outcomes of music therapy" (Talwar et al., 2006, p. 408).

Further outcome studies of music therapy are likely to continue to experience methodological difficulties, both in assembling appropriately sized cohorts for experimental designs and in providing formal evidence that links with patient and staff testimony. This situation has led to critiques of RCT-led demands for evidence in psychosocial treatment areas (DeNora, 2006) and to appeals that the "evidence base" be widened to admit other methods that can be sensitive to user perspectives and contextual needs and that can allow for effectiveness to be defined as more than targeted symptomatic change (Aldridge, 2004; Rolvsjord, Gold, & Stige, 2005). Music therapy has traditionally relied on other forms of evidence within the "hierarchy of evidence" such as expert opinion, case studies, and other qualitative process inquiry methods (Aldridge, 2005; Bruscia, 1991; Wosch & Wigram, 2007). This matches an increasing trend in other clinical areas to accept qualitative studies as part of broadening the evidence base for clinical practices unsuited to large-scale clinical trials (Barbour, 2000; Magee, 1999).

Our study connects with this ongoing debate, suggesting a way of linking the processes and reported outcomes of music therapy through a robust qualitative inquiry. It also suggests that an idiographic dimension is congruent with taking a service-user perspective seriously and with an increasing acknowledgement that, within the arts in health care, wide-ranging "qualitative outcomes" can be valid demonstrations of local effectiveness. This in turn is part of the broader strategy

in mental health of shifting the focus as far as possible away from just an illness formulation, and instead identifying people's strengths and potentials for rehabilitation. This means also attending to the potential social and cultural resources for helping people with this process. Our study gives ample evidence for the viability of such a view.

Design, Method, and Analysis

Our research questions were furthered through a qualitative, idiographic method, designed to elicit patients' subjective experiences and understandings of the processes and outcomes of individual music therapy sessions through verbal report. The study is based on a "purposive sample" (Denzin & Lincoln, 1998) of 19 positive cases—that is, patients who had informally reported benefiting from the therapy and were able to tell us about their experiences of sustained engagement in it, having completed at least 10 sessions. Whilst we acknowledge this as a select group in relation to the general patient population, we maintain that it is possible to learn from the 19 positive cases what features of music therapy could be experienced in similar ways by service users in similar contexts where music therapy may also be a suitable intervention. Patients ranged in age between 24 and 69 and came from varying socioeconomic and ethnic origins. Their specific psychiatric diagnoses were not central to sampling, but they meet the referral criteria of being people who were isolated, treatment-resistant, and difficult to access therapeutically through verbal insight-oriented approaches. Additional criteria were that such patients (a) could consent to the research and (b) were able and willing to speak about experiences that accorded with the focus of the study. Also, (c) the research procedure was not judged as unduly interfering with an ongoing therapeutic process. The only major ethical consideration concerns the guarantee of patient confidentiality. All identifying material has been disguised during data analysis, and there are no anticipated negative consequences for patients in this study following publication. The study was approved by the appropriate Local Research Ethics Committee and has been monitored by the Nordoff-Robbins Music Therapy Centre Research Ethics Governance procedure.

The idiographic stance attempts an in-depth understanding and comparison of a set of individual cases, not to establish causal relationships amongst treatment variables within a population that can be generalized automatically to another population. The sample of 19 patients is nevertheless substantial for this form of qualitative inquiry and was chosen to generate rich case variation for the purpose of strengthening idiographic analysis. Data was collected through short semistructured interviews with 19 patients who had completed at least 10 sessions of individual music therapy. The interviews were conducted in a known setting by the music therapist who had given the therapy. Careful thought was given to the advantages and disadvantages of this interviewing strategy. The disadvantage was naturally of interviewees saying "what the therapist/researcher wanted to hear" or withholding negative views. The advantage was that the music therapist had the patients' trust and a shared knowledge of the ongoing therapy process, allowing him more easily to elicit the level of reflection necessary for the study focus. It was decided that the advantage of the known music therapist outweighed the disadvantage for the research aims of this particular study—which claims only to draw conclusions from the positive views of a self-selected group. As a consequence of this decision, however, attention was given to careful interviewing and to co-monitoring of the research between the two researchers to ensure maximum reflexivity and trustworthiness in regard to this data-gathering choice. Interview technique and bias was carefully attended to—avoiding leading questions or interpretative suggestions, but preserving the flexibility to explore novel areas of response.

All interviews began with the simple question, "Why do you return to music therapy?" and subsequently followed an informal conversational pattern structured by the "spine" of the research questions—covering experience within the therapy process and the potential relationship between experienced processes and benefits. The relatively large sample for such a qualitative design gave sufficient opportunity for discrepancies, repetitions, or confirmations within the analytic process. We stopped adding cases to the cohort when we felt no substantially new perspectives were appearing within the data.

Interviews (which ranged from 5 to 20 minutes) were tape-recorded and transcribed verbatim by the music therapist. This verbal data was then analyzed from the perspective of interpretative phenomenological analysis (Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2003). According to Smith et al. (1999), this approach is phenomenological in that it is concerned "with an individual's personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself" (p. 218). It is also necessarily interpretative in that it aims "to develop an understanding of participants' *experiences*, with the themes that are identified considered to come from your *personal* interaction with, and interpretation of, the interview data, regardless of the particular strategy you choose to employ" (p. 230).

This perspective matches the research agenda in providing a rigorous procedure for approaching open-ended research questions such as ours and for formalizing researchers' interpretative engagement with complex verbal data (which had sometimes the added challenge of coming from patients in psychotic states, or those for whom English was a second or third language). The aim is to achieve an inductive, iterative analysis on a case-by-case basis, subsequently generating higher level theoretical statements synthesized from the total data set, which are nevertheless still true for most individual cases. For the complex process of coding and analytic reduction of the 19 interviews, the qualitative analysis software package QSR-NUD*IST Vivo was used. Trustworthiness of evolving coding and higher level analysis was strengthened by episodes of "random" independent coding by the two researchers. To test the consistency of our coding, we would select at random an interview, each code this independently, then compare and negotiate our mutual coding—with the aim of both regularizing and

checking our consequent data-analysis procedure. Additionally, continual cross-checking and negotiation was performed at each stage between the two researchers. We have decided that an exhaustive account of the complex analytical process from which the findings were inducted would overbalance the service-user focus of the current article. However, in the interests of demonstrating the *dependability* and *confirmability* of our research process (Robson, 1993), the appendix at the end of this article presents an outline of the logic of the data analysis in Tables A1 through A4. Table A1 outlines the 13 cumulative stages of the interpretative-phenomenological process: from verbatim transcription of the interviews through to coding, thematization, revision of themes, and the creation from the final 35 themes of a narrative sequence of 9 "headline theme statements" that communicate our summative interpretation of this data (presented in the Findings section below). This rigorous and progressive process of analysis enabled an accountable and logical construction of the final interpretation of the data as presented in this article.

Findings

This study generated complex and fascinating data. In this article we will present a summary of our findings under a set of "headline theme statements." These are not "ranked" in any quantitative sense but in the order of their presentation aim to characterize a progressive understanding of the data in a logical sequence. These theme statements, and our commentary on them, are annotated with illustrative direct quotations from the interviews—with the coded identifier of different interviewees in square brackets following the quotation. There is sometimes a characterful idiosyncrasy in the language of many of these quotations, both as the language of the interviews (English) was sometimes patients' second or third language, and with patients also being interviewed whilst in a variety of mental states.

Our interpretation of the accounts of the 19 service-users suggested the following:

1. Benefit From Music Therapy Is Broader Than Symptomatic Change

Music therapy is effective for these patients for broader reasons than symptomatic change or relief (though it may include this too). When asked why they returned to music therapy week after week two basic answers are given: "I enjoy it" and "it helps." The "help" is occasionally to do with something specific, and arguably symptomatic ("When you're drumming you just beat the devils out of your head!"). For most people it is, however, difficult to express "music's help" as a single, isolatable effect:

> I don't know... it's hard to explain... I found it... er... very helpful. It's quite calming to do... I enjoy music as well... and it was also a very good release for me when I was very upset... but the music, I really enjoy... I think it's healthy. [D]

> Has music therapy had anything to do with my illness? No, not really... except it takes my mind OFF my illness... [J]

The "enjoyment" or "help" is variously seen as to do with the sounds, the music, and with the process of music-making with the therapist. The benefit is often expressed simply as making patients "feel better". A question that will occupy much of the following discussion of the data is how the "musical aspects" (or processes) relate to the "therapeutic aspects" (or processes)—and what, if any, firm relationships can be found between these. To put it bluntly: Does it matter whether patients returned for the "music" or for the "therapy"? Is this a distinction that makes sense to patients (rather than to therapists)?

> I don't think this is just therapy, but this is my participation in music. [E]

2. Music Therapy Often Involves Reconnecting With a Previous Relationship to Music

Patients often seem to engage with the music therapy process because of an already-established relationship to music in their lives—although many would not conventionally define themselves as "musical" or "a musician." They do, however, communicate how music or music-making of many different kinds has been (or remains) a health-promoting resource for them. Often, however, their illness process has interfered with this natural resource, or has disrupted it entirely for them:

> You just forget music with this illness... I smashed my guitar to pieces when I was ill... [L]

> Music's always been a very important thing to me. But during this period of depression I found that I couldn't listen to any music for a long period of time—for like over a year. And it's been nice to feel that I can again here [in music therapy]. Because music's very emotion-provoking, and here you can really experience that, but in a safe environment. But because I always did enjoy music, it can make me feel better... it can put me back in touch here with how it could make me feel better... and when I was at school I was very musical... but you lose touch with all that... [J]

3. Music Therapy Elicits and Works With Patients' "Music-Health-Illness Narrative"

Patients often connect their relationship with music to their experience of both health and illness. We came to think of this as their *music-health-illness narrative* (see the Discussion section for more on this aspect). It seems that the music therapy process works within (and perhaps "on") this narrative. It generally has three stages: (a) An identified pre-illness relationship

to music, when it was used by the patient as a resource to orientate identity, shift mood, produce good associations and memories, connect to other people through playing or appreciating music; (b) illness ruptures this relationship with music, leading to patients' losing touch with "music's help" as a resource; and (c) music therapy helps reestablish or "heal" a patient's relationship to music—both what it *was* to them and what it *can be* for the future:

> I forgot about music . . . and coming to music therapy has rekindled the interest in music I had as a teenager. . . . In the old days it [music] always lifted my mood—and now sometimes it does again . . . [M]

The process (and outcome) of music therapy is often understood by patients in relation to this narrative. That they are participating again, through music therapy, in music-making, or reconnecting to music within the supportive relational context of music therapy (provided by the music therapist and the music therapy room):

> Well, I found I could do things here, whereas I felt in general like sitting down and doing nothing. At least here I could play the instruments. [P]

4. In Music Therapy the Qualities of the "Musical" and the "Therapeutic" Dimensions Are Often Experienced as a Unity

Against the background of this *music-health-illness narrative* patients often characterize their participation in music therapy in terms of their commitment to making music for its own sake, or else they elide the music/therapeutic when talking about the process:

> I would say it was therapy, yes. . . . But I wouldn't call it therapy . . . I'd just call it music . . . you don't really need the therapy bit . . . maybe it's just that all music is therapeutic . . . [I]

> Sometimes I come out of here feeling . . . just the fact that I've made some nice music, or sung something nicely, or whatever . . . that I didn't think I could do . . . I just feel good that I've come up with something that's a good thing . . . [O]

Patients talk of their commitment to their music-making, mostly not making conventional aesthetic judgments about it—though the sense of achievement many patients found when they were able to play fluently is key to the perceived benefits for them. Such "flow" in music is related to one of the central aspects of the musical process in this style of music therapy—improvisation. The descriptions of improvising in music therapy consequently take a double aspect: improvising as a *musical* practice/process (which is often a qualitatively different way of making music for service-users), but also improvising together as a significant *social/therapeutic* process). In this way, improvisational music-making can indeed be seen both as the means but also the therapeutic end of music therapy:

> I think it's having the freedom to play . . . whatever. What I've enjoyed the most is being able to improvise . . . there's no structure . . . you can just play freely and build up from there . . . which has been good fun . . . and the freedom of doing that's been great . . . not to feel restricted. [D]

> I have more of a feeling of enjoyment when I'm creating my song . . . it's a feeling of going on a wave. . . . And it doesn't really matter if you make any mistakes because there aren't really any mistakes to make! [B]

5. Aspects of the Musical Process in Music Therapy Are Experienced as Distinctive

Despite this experience of the unity or complementarity of the musical and the therapeutic, many interviewees focus also on distinctive features of musical practice within their music therapy—such as listening, playing, and performing. They often relate these to aspects of their music-health-illness narrative and compare them with other art forms and therapies they have also experienced. They make constant links between musical experience and personal experience, often describing the social-relational aspect of musical involvement as compensating for the isolating effects of their illness. Singing seems especially powerful for people living with mental illness:

> In adult life you don't sing any more . . . so to be able to enjoy music again is very important to me. . . . When I first came here I'd lost my voice completely, and all I could do was whistle the tunes . . . I said to people, he actually got me singing! [B]

> When you're feeling low, you can hardly talk, your voice doesn't hardly project, and you're silent. . . . And by making some sound come out, maybe it's letting some feelings out . . . because I'm actually making some noise in the world. . . . When I'm singing . . . I'm quite happy and relaxed . . . happy with my voice and myself . . . but I've also sung sometimes when I'm upset, because I find it very calming . . . [D]

6. The Therapist's Role Is Experienced as an Equal "Musical Companion"

The therapist's role is experienced as facilitating patients' musical participation and acting as a "companion," accompanying their music-therapeutic process. The qualities of togetherness, attunement, and relatedness afforded by joint music-making with the therapist are key to patients' positive experiences of the therapy. Again, such experiences of a close musical-personal relationship are often seen in contrast to the difficulties of an enduring mental illness. As one participant commented, "You can get very cut off from people . . . people who are mentally ill become introverted . . . they live rather

like hibernating hedgehogs!" In contrast, the experiences people describe in music therapy show different qualities of relationship based around companionship, comfort, and respect:

> Well, you forget about your personality, when you're playing with someone else. You just think of the music . . . and to be synchronizing with the other person. . . . I really don't think of myself. . . . I think it's good to work with someone else, you can develop a kind of rapport . . . it's almost as if I'd known you for years . . . with someone you've known for years you can be instantly relaxed, and that's what it's like when you're playing here . . . [G]

> It's to do with meeting each other on equal terms. As musicians you do meet on equal terms—whereas in "outer life" you don't always . . . but in music therapy there doesn't seem to be a role-play, it seems to be a meeting of equal minds . . . [E]

7. Music Therapy Is Experienced as Distinctive in Relation to Other Therapies

Some patients in the study were simultaneously receiving other forms of therapy (often verbal psychotherapy). They are mostly able to make a clear distinction between these and music therapy, in terms of both process and outcome for them (though there are often contradictory messages here):

> . . . different with the music [from his concurrent psychotherapy], and sometimes my problems easy to solve when relief in music. Sometimes I can't actually compare [psycho]therapy to this. Maybe they both work in the same line, but the effect is different. [R]

> Yes, it is very different [from psychotherapy]. The music's working on another level—a sort of emotional level maybe . . . tapping into things . . . whereas when you're in [psycho]therapy you're talking a lot, and you may be very emotional, but also you're thinking . . . [L]

For many patients the nonverbal nature of music therapy is particularly helpful. Their comments compare their experience of how music and words "work"—and how such differences affect both process and outcome for them:

> [In music therapy] it's like you can let some things out in a way . . . but in a different way from talking about it. . . . I can express what I feel in a more pure way [in music] . . . it's not limited by words . . . [L]

> It was positive that we didn't talk much . . . when you're playing music you don't need to talk—it's on a different level. [O]

> It's [music therapy] not really like a talking thing . . . like I'm talking to you about things, or sorting anything out. . . . I think maybe I'm sort of talking through the music or something . . . something's coming out, but it's in a musical way, and I don't know how or why . . . [L]

8. The Overall Benefits of Music Therapy Are Characterized as Compensatory or Alleviatory in Relation to Illness Experiences

Outcomes of music therapy are expressed in relation to patients' personal and contextual music-health-illness narratives, but not always related to symptoms or direct problems. Instead the effects of music therapy are often characterized as compensatory or alleviatory in relation to their *overall* experience of living with mental illness. Music therapy is perceived as being of help across the whole range of patients' experience: beginning with bodily and emotional states but also encompassing cognitive states of focusing, attending, concentrating, and thinking:

> [Music therapy] gets your heart going . . . gets your blood circulating . . . the heart's not used to that rhythm or whatever—so it's creative for the heart, and for the whole body. After hearing a pure sound go into your head, and trying different movements. It's like aerobics. [G]

> Yeah, I never feel worse coming out of here. I might feel the same, but usually I feel better. . . . At best I feel my mood has changed completely, and I'd feel a bit more relaxed and less isolated . . . [L]

> At the best it would increase my confidence—because I'd think, well I'm not totally rubbish at everything . . . I can make some nice sounds, sing a bit . . . and I'm not totally useless! [O]

Of equal importance to patients are the more global quality of life aspects such as relationships, social contact, and enjoyment and, beyond these, the existential dimensions of experiencing beauty, meaning, and transcendent moments of meaning or joy:

> I usually come out with a glow! It's being creative . . . I think mental illness is very destructive . . . so here's a wonderful way of instead being creative, without being destructive . . . [N]

> It makes it kind of like a circle rather than like a mish-mash of different interwoven cloth of whatever. . . . It makes it more a central thing for me. It's a bit like prayer . . . it has the same effect on me as prayer does for some people. It kind of centralizes things—brings out one whole aspect, pure essence and soul to the thing . . . [G]

9. A Key Benefit of Music Therapy Is Its Ability to Mobilize "Music's Hope"

Of all these benefits, "music's hope" is the profoundest help for people living with acute or chronic mental health problems. Many comments by interviewees can be interpreted as communicating how music and music-making give them both an image and an enactment of a "hopeful" relationship to their chronic illness and its existential impact on their lives. Music's temporal phenomenology—its dynamic interpenetration of

past/present/future—seems somehow able to model extramusical motivation, encouragement, and hope for some patients. Playing music together ("in time"—in both senses) somehow generates hope for the future, and through improvisation something *does* indeed emerge from nothing:

> It's some sort of hope . . . and something fresh is coming. I have to carry on . . . usually I felt that after the session . . . [C]

Discussion

We hope that this study will stimulate further discussion about how service-users experience music therapy, how they link therapeutic benefit to such experience, and how their personal and experiential narratives can provide a rationale and appropriate evidence for the provision of music therapy within adult psychiatric care and rehabilitation. As suggested by the authors of the recent British RCT study of music therapy in mental health (Talwar et al., 2006), qualitative studies are needed to more accurately focus the target for possible further experimental studies. For example, our study shows that whilst users experience a range of benefits from music therapy that are relevant to adult psychiatric care and rehabilitation, they do not necessarily experience (and value) such a therapy in the way therapists, referring clinicians, and researchers defining "outcomes" and "effectiveness" in this clinical area may perhaps anticipate. This should cause pause for thought. Little of what we heard patients report in terms of the benefits of music therapy related explicitly to changes in overt symptomatology—yet this is mostly what the current demand for adequate evidence focuses on. Across the range of benefits reported through users' narratives, most were instead related to broader quality of life, relational, or existential dimensions of experience, as users coped with a particular illness and its positive and negative symptoms. Perhaps we need to listen more closely to service users' evidence to focus further inquiry. Research designs surely need to match the identified areas of benefit patients report from particular therapeutic interventions.

This study's idiographic case-set design (and its interpretive phenomenological analysis method) claims only to study this particular therapeutic work, in this particular place, with these particular patients working with this particular therapist using his particular approach. Findings will consequently not automatically generalize to other populations, places, therapists, or approaches, though there is potential for "illuminating transfer" to comparable situations (Smith & Osborn, 2003). Many mental health settings, however, clearly experience the same challenges in finding appropriate therapeutic modalities that both address patients' needs during psychiatric rehabilitation and are accessible and engaging for users. Music therapy, as characterized in this study, suggests itself a viable option for such services.

An aspect of our study we would like to emphasize for discussion and hopefully further research attention is the role and significance of what we termed the "music-health-illness narrative." In one sense, this could be seen as a footnote to the long tradition of thinking about health and illness in relation to human narrative. This has been variously presented: by the pioneers of the "narrative turn" (Bruner, 2002; Ricoeur, 1987); by health psychologists working in narrative psychology (Murray, 1999, 2003); by counseling psychologists (Duffey, Lumadue, & Woods, 2001); by medical practitioners advocating a "narrative-based medicine" to balance an "evidence-based medicine" (Greenhalgh & Hurwitz, 1999; Williams & Garner, 2002); by music therapy researchers (Aldridge, 2004; Bonde, 2005); and by academics such as the philosopher Havi Carel (2008) with their own illness narrative to tell. For all these thinkers the key point is that our lives gain their meaning through the stories we tell others about them. The order and communication such stories afford become even more crucial when experience or identity is disrupted by acute or chronic illness. Patients want to tell doctors how their illness (and treatment) has changed the story of their life; doctors (so narrative-based medical practitioners say) need to understand such stories to understand patients' "lived experience" and to provide the best care and treatment for them.

To these traditional "illness narratives" we found that the interviewees in our research often added "music." At one level, these narratives were produced explicitly *through* the interviewing procedure. But they also brought into relief how the service users experienced music and music therapy and its relationship to their lives (if perhaps prereflectively in many cases). The "music-health-illness narratives" produced in relation to our interviews often had the classic three-part structure that narrative theorists have identified: (a) an identified pre-illness relationship to music, and its usually positive role in their lives; (b) how illness has disrupted their relationship with music, leading to patients' losing touch with "music's help" as a resource; and (c) how music therapy has helped them reestablish their relationship to music, such that it can be helpful again.

Both the form and the content of these narratives confirmed for us how music therapy with these patients was often experienced as "continuous" with their previous and ongoing relationship to/with music outside music therapy—rather than being thought of as a specialist and separate "clinical" form of therapy. Rather, users' "music-health-illness narratives" suggested how there is a link between the perceived value of music therapy and the ongoing relationship clients have to music. The music therapy process in our study is therefore chiefly characterized as an engagement with, and mobilization of, music as a health-promoting resource for people in times of illness. The therapy and the therapist are seen as reinitiating and facilitating this process, drawing on many of the "natural" modes of *musicking* (Small 1998) in our society.

This (re)formulation of music therapy is near to several recent models developed by music therapists: "resource-oriented music therapy" (Rolvsjord 2004), "community music therapy" (Pavlicevic & Ansdell, 2004; Stige, Ansdell, Elefant, & Pavlicevic, in press), "health musicking" (Stige 2002, 2003) and "music-centered music therapy" (Aigen, 2005). All of these identify less with a purely medical model, and more with a more sociocultural view of music, health, and illness. This is turn links to the developing "well-being perspective"

advocated by current rehabilitation policy and service initiatives in mental health (Future Vision Coalition, 2009). We encourage further discussion of "music-health-illness narratives" in relation to both formulating and evidencing music therapy practices in the area of mental health.

Coda

An idiographic research perspective can usefully suggest how single cases can function as exemplars or paradigms of relevance to comparable individuals, situations, and processes (Gomm, Hammersley, & Foster, 2000). There is a long history within music therapy and its research literature of attending closely to the single case and arguing for single-case designs as viable research methods for both developing practice and for providing evidentiary material (Aldridge, 2005). Whilst most cases in health care research are still told from the perspective of the therapist, increasingly service-users are asking that clinicians also take into account their own accounts of their experiences of illness and the unexpected health they often find within illness (Carel, 2008). This is an increasing trend in music therapy too, and as Aldridge (2005) writes, "We may argue that relevant outcomes are dependent on what the sufferer has to say" (p. 20).

One of the cases in our study, Edwin, was indeed exemplary in his ability to represent and communicate his experience of how music, illness, and health were interconnected for him and how music therapy was a way of exploring these interconnections during a key phase of his recovery. One of the criticisms of the form of qualitative analysis that we employed for this study overall is that it fragments individual narrative accounts in the service of synthesizing the data and obtaining composite findings (Murray, 2003). In contrast, a "narrative analysis" approach preserves the formal integrity of each narrative and reflects on how the narrative form of each individual account reflects both personal and social aspects (Murray, 1999). We will end this article by letting Edwin give his own "narrative evidence" about music therapy in full, preceded by some of our reflections on it.

Michael Murray (1999) in his chapter "The Storied Nature of Health and Illness," writes, "While health and illness exist outside narrative we can only begin to understand them through narrative.... Through narrative the sick person begins to bring order to time" (p. 59). We see in Edwin's narrative a classic ordering of this kind, on several levels. First, he casts his account in a temporal structure, organizing *past* ("when I was ill"), *present* ("I become focused, and I'm thinking only about music ... the music itself"), and *future* ("So planning what the next note's going to be would in a sense lead me to think about planning the next step in my life"). Second, Edwin is able to present aspects of the phenomenology of both his illness experience (its effects on his experience of time and the corresponding anxiety), and also of music, with its very different experience of "filled" and purposeful time. Third, he employs the metaphor "music is like a brush with some paint—it paints a picture in time" as a key device in his narrative. Through this trope he characterizes how he uses music (and his experience of *musicking*) as what the sociologist Tia DeNora (2003) calls a musical "template" to think reflexively about and around the complex relationships between the experiential and existential aspects of his situation. In short, Edwin is able to both think "through" his participation in music, and also to think reflexively *with* the idea of music as experienced within music therapy. Edwin's "music-health-illness narrative" in its very distinctness and eloquence advocates strongly that music therapy may be a useful intervention for others like him, but who are less able to report in a coherent narrative how and why music helps them:

> I don't feel this is just therapy, but this is participation in music. It gives me a sense of participation, fulfillment, of actively doing something good and useful.... When I come to these sessions I could be a bit depressed at the beginning ... but usually during the therapy the mood lifts up and it also helps me to concentrate on other things. Because when you're making music you really need to concentrate ... you need to listen to the other person, what they are doing, what their sounds are. You have to put two heads together to make music together ...
>
> I think basically music gives a person some insight into the past, the present and the future. My way of putting it is that you need time to make music, but music is not time; and time is not music. And if you just sit there, doing nothing ... time goes by, you just hear the clock tick. And usually nothing happens ... you can sit there for hours. And I think that by the end of such hours if you just sit there, you become very anxious about time passing by. But if you make music, or listen to music as the time goes by, you feel that the time that's gone is being utilized in a very useful way ...
>
> And so I think in a sense music is like a brush with some paint—it paints a picture in time.... It could be a picture of oneself, or a picture of music-making, of the musicians ... or a picture of the future.... It's very interesting ... when I'm playing music, the brain just goes completely blank ... except there is music! And I seem to have forgotten everything—everything else goes to the back of the brain—and I become focused, and I'm thinking only about music ... the music itself. When I play the drum or the cymbal or the metalophone, I need to think ahead ... of what the next note's going to be. So it gives me a sense of planning ... immediate planning ... what to do next.
>
> Because in the past, when I was very ill, I could not think about what to do next. I was so occupied by the present and the past.... But by playing music—particularly in this environment—gives me a chance to quiet-down.... and then concentrate on planning the next note ... it sort of gives me a sense of a little light at the end of the tunnel. So planning what the next note's going to be would in a sense lead me to think about planning the next step in my life.... I think basically I experience here the music painting a picture of the present and the future to me. And that picture basically is some light at the end of the tunnel!

Notes

1. For varying perspectives on music therapy in psychiatry, see Wigram and De Backer (1999); Odell-Miller, Hughes, and Westacott (2006); Gold, Heldal, Dahle, and Wigram (2005).

2. This article was written jointly. In terms of the distribution of the research work, the music therapist (GA) did the therapy sessions, interviews, and transcriptions. As outlined in the section below "Design, Method, and Analysis," the psychiatrist (JM) was involved with the research design and theoretical formulation of the study and the data analysis and interpretation.
3. Since 1999 music therapy in the United Kingdom has been a state registered profession regulated by the Health Professions Council. Music therapists are professionally trained on postgraduate programmes, and work according to codes of professional practice established by the Association of Professional Music Therapists.

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Appendix
Data Analysis Process

Table A1 gives an inventory of the progressive logic of the analytic treatment of the 19 interviews. Tables A2 through A4 show stages in the construction of the data interpretation.

Table A1. Data Analysis Sequence

1. Interviews recorded & transcribed verbatim (into QSR *NUDIST* software package for the management & analysis of qualitative data)
2. Interviews coded progressively through *NUDIST*—with the aim to get minimum number of codes with maximum descriptive flexibility
3. **1st Level Thematic Codes** created inductively in relation to early interviews
4. For subsequent interviews 1st level codes tested for relevance, and new codes created/modified for maximum relevance/flexibility in ongoing data coding
5. Provisional list of themes established ($n = 66$) (see Table A2)
6. Mapping of themes into clusters to identify overlaps and possible broader groupings
7. Reordering of themes according to numerical prevalence (as determined by *NUDIST*—which compiles the total number of units of the total text coded under each theme). This gives indication of *prevalence* of themes, indicating potential importance in the interpretation of the total text. This information was *not* used strictly quantitatively, but to inform the condensing of the themes and ongoing interpretation.
8. Each provisional theme printed out along with all chunked excerpts of total text coded by that theme
9. Each theme + excerpts read and reviewed for adequacy of each theme description (by checking against text of excerpt quotations)
10. Merging or trashing of unnecessary (= duplicating) themes—reducing 66 themes to 35 **2nd Level Themes** (see Table A4)
11. Making "analytic memos" for each 2nd level theme—reviewing the substantive content of each theme from the varying material of the excerpted quotations
12. Organizing 2nd level themes into 3 broad **Emerging Categories**—both continuing the induction of data into higher-level groupings, but also relating data back to evolving research questions.
13. Constructing a narrative sequence of **"Headline Theme Statements"** that convey the findings of the inductive data analysis in relation to the research questions. These were tested against previously established categories, themes and excerpted quotation, and used as subheadings for the report of findings.

Table A2. 1st Level Thematic Codes: Initial List of Themes Showing Reduction of Duplicates and Overlaps

~~1. Achievement~~
2. Aesthetics/beauty
3. Affect change
4. Affect state
~~5. Alleviation~~
6. ~~Appreciation~~
7. Musical associations/ memories
~~8. Attitude change~~
9. ~~Being heard~~
10. Somatic change
11. Catharsis/expressing
12. Character of music
13. Comfort
~~14. Commitment to musicking~~
15. ~~Communication~~
16. Concentration
~~17. Confidence~~
18. ~~Control~~
19. Creativity/serious fun
20. Displacement
21. Commitment to worthwhile playing
~~22. Encouragement~~
23. Engagement
~~24. Experience of music therapy~~
25. Pleasure/enjoyment/flow
26. Freedom
~~27. Health~~
28. ~~Hope~~
29. Illness
~~30. Improvisation~~
31. Improvising together
~~32. Learning~~
33. Listening
34. Confidence, motivation, achievement
35. Music therapy process
~~36. Music therapy's function/role~~
~~37. Music as narrative~~
38. ~~Music's importance~~
39. Music's work
40. Music/time
41. Music/words
42. Musical identity
~~43. Musical imagination~~
44. ~~Musical/personal~~
45. Other therapies/activities
~~46. Own musical material~~
47. Participation
48. Performance
~~49. Pleasure/enjoyment~~
50. Problems
51. Quickening
~~52. Recording/retaining~~
53. Recovery process
54. Relationship
~~55. Relaxation~~
56. Returning
~~57. Satisfaction~~
58. Sense of self
~~59. Serious/fun~~
60. Singing
~~61. Sites of therapy~~
62. ~~Space to think~~
63. Spirituality
64. Therapist qualities/function
~~65. Therapy?~~
~~66. Worthwhileness~~

Table A3. 2nd Level Themes

1. Aesthetics/beauty	19. Confidence, motivation, achievement
2. Affect change	20. Music therapy process
3. Affect state	21. Music's work
4. Musical associations/memories	22. Music/time
5. Somatic change	23. Music/words
6. Catharsis/expressing	24. Musical identity
7. Character of music	25. Other therapies/activities
8. Comfort	26. Participation
9. Concentration	27. Performance
10. Creativity/serious fun	28. Problems
11. Displacement	29. Quickening
12. Commitment to worthwhile playing	30. Recovery process
13. Engagement	31. Relationship
14. Pleasure/enjoyment/flow	32. Returning
15. Freedom	33. Sense of self
16. Illness/health	34. Singing
17. Improvising together	35. Spirituality
18. Listening	

Table A4. Emerging Categories

Category 1—BACKGROUNDS & CONTEXTS (links between users' previous and current experiences—both musical & illness/health related)
Category 2—EXPERIENCES (within music therapy)
Category 3—BENEFITS & OUTCOMES (of music therapy)