Group Vocal Improvisation as a Music Therapy Technique in Community Mental Health Services: A Comparative Case Study Using Convergent Mixed Methods

Irene Pujol Torras

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Guildhall School of Music and Drama

Research Department

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ABSTRACT

BACKGROUND: The use of voice in music therapy is considered a powerful resource for engaging clients and facilitating change. Group improvisation is identified as one of the main techniques for working with mental health service users, particularly from a psychodynamic perspective, yet there is little evidence about the practice of group vocal improvisation (GVI) in music therapy. An exploration of the use of GVI as a specific music therapy technique may provide some insights into its clinical affordances and challenges.

METHODS: 10 mental health service users with heterogeneous diagnoses accessing secondary mental health outpatient services were recruited and allocated based on clinical assessment and preference to one of two closed groups. Both groups focused on group improvisation but one used instruments (GMT group, n=5) and the other used the voice (GVI group, n=5). Participants attended weekly group music therapy sessions for 6 months. Audio recordings of the sessions identified specific features of each modality through interaction analysis. Questionnaires measuring therapeutic alliance were compiled at the end of each session to analyse evolving therapeutic processes. End of therapy interviews explored participants' experiences from the sessions and narratives around the engagement in music making.

RESULTS: Musical activities showed important differences in timing, distribution and format between the two groups, whilst verbal negotiation of tasks in the group provided similar group dynamics. The musical analysis indicated greater variety within musical activities for the GMT group whilst the GVI showed more musical variety across different activities. Scores of therapeutic alliance showed similar trends for both groups but the GVI showed a slower increase. Participants from the GMT group reported a greater emphasis on narrative reflection on their musical experience, whereas GVI participants described a greater impact on experiential bodily awareness and accessing new experiences.

CONCLUSION: The use of GVI was feasible clinically and showed both similarities as well as differences in interactions, therapeutic processes and change mechanisms in comparison to the GMT group. An emphasis on the physicality of singing, a greater need for structure within improvisations and a shift towards a more active therapeutic stance were the main distinct features of GVI. Further research should look into the combination of both techniques and explore the links between voice work and body work further.

1. INTRODUCTION

1.1 Introduction to the study

This is a qualitative comparative case study with a mixed methods component. It outlines the process of devising and informing a new theoretical framework for researching a novel music therapy technique. This thesis includes a thorough systematic literature review, a detailed consideration of methodological issues related to the enquiry and a design for a clinical study devised to investigate and provide answers to the research questions. The present document then provides the findings from the clinical study and presents a discussion of the results in relation to the original questions and to wider music therapy debates.

1.2 Personal motivation

The interest in group vocal improvisation (GVI) comes from the author's composite background as a singer, musicologist and music therapist. The experience of these separate but overlapping fields inspired a reflection around the social, musical and psychological experience of improvising with others through singing.

This interpersonal, intersubjective and intimate experience of singing in a choir and using improvisation led the author to pursue a degree in Musicology in an attempt to learn more about the intricate workings of music within history and society. During this training process a growing interest towards the psychological implications of music making motivated a specialisation in music therapy.

The realisation that some of the core elements of music therapy (especially in the UK) related to the similar aspects that had originally imprinted a fascination towards the influence of music, such as improvisation, group work and singing, was reassuring. However, despite the centrality of these elements the literature, research, case studies and practice did not seem to bring them together in music therapy.

Although there were generic comments and vague allusions to the use of improvisation in group singing in some of the literature, this did not seem to be a technique that was specifically used, researched or theorised about. This surprise motivated the author to engage in enquiring further about this question in her master's research project. A survey

was sent to all the music therapists (who had publicly provided their details in the British Association for Music Therapy) in order to find out whether anyone was making use of GVI.

From the scarce answers received, three interviews with those respondents who seemed to have a most directly related practice to GVI were conducted. However, still none of the interviewees was using GVI recurrently or as a distinct element in their practice.

This preliminary investigation into the subject provided two main conclusions. On one hand, there is a tendency to associate singing with pre-composed material and instruments with free improvisation. Secondly, it was perceived that introducing GVI into a music therapy session was a challenging idea that required a very robust context and boundaries in order to contain and support the levels of exposure and intimacy that were associated with the use of improvised singing in a group situation.

In light of these findings, a larger project was envisaged in the form of doctoral studies in order to look more in depth at these questions and find out about what GVI can offer to music therapy.

1.3. Vision for the project

One of the preliminary considerations for creating the appropriate framework for GVI was to investigate it with a client group that had the cognitive capacity to understand and reflect on this very specific technique. Adult mental health seemed to be the client group that better corresponded to this description and that was accessible through the author's experience and clinical work.

Within this context, GVI appeared as an alternative to standard practice of group music therapy in metal health settings, which typically involves the use of improvisation with instruments. Therefore, the element under investigation is the introduction of the voice in general music therapy (GMT).

At this point in the formation of the project it became necessary to ask the question of whether GVI should in the first place be considered as separate intervention or as just a form of GMT. Whilst the position of this project is to consider GVI as a specific technique of GMT – maintaining the similar overall aims and global functioning – it was considered

that it could potentially imply different dynamics and modes of operation due to the uniqueness of the voice that were worth investigating, as will be described in the following section.

For this reason, in this study GVI will be isolated and compared with a generic practice of music therapy (GMT) which will focus on the use of instruments instead. It is apparent that this clear separation of the use of instruments and use of voice does not reflect accurately the practice of group music therapy, where both media might be used in a session or in a group. However, for the purposes of the research, which will focus on the nature, processes and therapeutic affordances of group music therapy improvisation using instruments and voice, it will be useful to make the two practices more or less mutually exclusive. In this way, it will be able to look in depth at each of the practices, GVI and GMT, and to compare them from different perspectives.

However, it can also be argued that, in fact, the 'consensus' model (Ansdell, 2002) of group music therapy, particularly with a psychodynamic focus, tends to suggest in the literature a primacy of the use of instruments when improvising. Ansdell (2002) uses the construct of the 'consensus model' to talk about the way that music therapy as practiced in the UK has been portrayed in the literature and to argue a wider understanding of music therapy and Community Music Therapy. Although the use of the voice is not excluded from this consensus model and it is sometimes mentioned as one of the musical resources, at the same time it tends to not feature in clinical cases, or if it does it is in the use of pre-composed songs. This will be described in the literature review and explored further in the discussion within a reflection on the theoretical and clinical implications of the use of GVI. Here the term 'consensus' model is used similarly to Ansdell (2002), namely in an abstract way and not implying that individual music therapists adhere to it as a model, but rather as it having an overall influence on how they think about their work.

The study will therefore focus on the analysis and comparison of two specific group music therapy practices:

- GMT (General Music Therapy): this will represent the 'consensus' model of psychodynamic group music therapy. The techniques used in this group will revolve around group improvisation through the use of instruments. Although the use of voice will not be restricted it will not be encouraged either.

- GVI (Group Vocal Improvisation): this will consist of a similar approach to group music therapy as the GMT but the techniques here will make use of the voice instead of the instruments. Some instruments will however be available mainly for the therapist to support the group harmonically.

This exercise will allow an exploration of the features, challenges and possibilities afforded by each of these practices.

There are a number of considerations around the power dynamics of the therapeutic relationship in regards to the fact that the therapist will be the only member of the group accessing instruments to accompany the group harmonically. This, as well as the rationale for considering the need to bring in harmonic accompaniment, will be thoroughly explored at various points in the thesis.

1.4 The voice in music therapy

According to some music therapy authors, the use of the voice seems to be considered as being particularly powerful in music therapy. In this section several considerations around the particularities of the use of voice in music therapy are briefly explored.

1.4.1 Powerful experiences

Diane Austin, who notably wrote about her Vocal Psychotherapy method (2008) states that: "Throughout the years I have noticed that whenever I attend a music therapy conference, supervise a student or listen to a colleague's work, the most compelling clinical examples involve the client and therapist singing. In my own practice, I have also noticed that the most climactic moments occur when clients begin singing." (p.19).

In a similar line, Ansdell (in the foreword to Uhlig, 2006) reflects on a similar notion of the use of the voice being a climactic experience:

> *"Singing is often the goal to which music therapy is aiming. Or, to put it another way, what our clients really want and need to do is to sing. Even this is not quite right perhaps, since this "falling into singing" hardly seems a voluntary choice but something which just has to happen. I've seen this repeatedly in my own clinical sessions with adults or children, but also when supervising other music therapist's work, or when researching colleague's work. I've also noticed that when music therapists present case narratives of*

the therapeutic process with a client often the climax of their story is when the client sings. This is really the moment when music therapy happens."

Pedersen (in Baker and Uhligh, 2011) also comments on the importance of the use of voice, particularly in psychiatry and specifically in regards to certain psychological processes: "From my extensive clinical experience, I have noted that [the voice] is one of the instruments that has the strongest impact on development of the self on self-awareness, and on self-regulation. Therefore, it can have a strong impact on the mental health integration processes for the population I am working with in psychiatry." (p.288)

It seems clear that the value of the use of voice is well recognized within music therapy. However, most of these remarks, as is implied above, tend to refer to individual settings, although they might be intended in more generic terms. In fact, there is a canon of case studies addressing vocal improvisation in individual music therapy as will be described later. However, once more when looking at the use of voice in group settings, often the improvisation turns into use of pre-composed songs. It is not argued here that the use of songs is problematic, in fact later in this document different important functions that the use of songs might have in a group format will be discussed. However, what this research questions is why the improvisation element slips away so easily and almost imperceptibly.

1.4.2 Particularities of the voice

We also have some evidence in the music therapy literature that the use of voice is not only powerful but also might involve slightly different dynamics than the use of instruments. Bruscia (1987) provides a clear description of this (p. 516):

"In vocal media, one's body is the sound-producing object. The body creates the vibration, resonates, and gives sensory feedback itself. Unlike other media, the voice requires using the invisible parts of the self. The body mobilizes the unseen physical self – to sound its inner self – according to feedback from the observing self. As the individual instrument of the body, the voice extends the physical self and projects a sound identity of the inner self."

Here Bruscia highlights the body's involvement, invisibility and sense of identify linked with the use of voice. These aspects will be explored further in the discussion of the clinical work from the present research. The embodied nature of the use of voice will be

of particular relevance. Below are some further considerations on these and other aspects around the particularities of the voice.

The voice is in the body

The voice is the only instrument that is 'inside' the performer, the body is the instrument. It is intimately connected to the breath (Austin, 2008; Baker and Uhlig, 2011) and depends on the mobilisation of the 'core' of the singer. In this sense, it requires a more embodied engagement. In fact, the voice is the sonic representation and physical resonance of the body, the only object which we know from the outside as well as from the inside. We hear our voice from the inside and from the outside. Therefore, it constitutes a good vehicle for mediating, communicating, negotiating and establishing a dialogue between our internal world and external environment from a very sensory point of view.

The voice is crucial in early development

The important role of early life dyadic vocalisations between infants and their caregivers is well documented (Malloch and Trevarthen, 2009). Most verbal adults have communicated with and related to the world around them through non-verbal and pre-verbal vocalisations as infants. This suggests that the emotional attachment with one's own voice is an important – and at times complex – one and that the voice can be experienced as a very intimate part of one's identity.

The voice is invisible

The mechanisms of sound production for singing are invisible, which means that exploring its possibilities is less obvious than with instruments, where the different sound options are often intuitive, even for someone who has lacks technical skills. However, at the same time, the voice is an instrument that most verbal adults are experts in using. The level of intricacy in modulating the voice for speech implies that although the mechanisms are not visible the general population is technically able to use the voice in a nuanced and refined way. In fact, the act of singing is a very natural one in most cultures, but it does require a different breathing technique and certain practice of sustaining the sound, which is different from using the speaking voice.

The voice is cultural and political

This links very importantly with the fact that the voice is cultural. In this sense, Western cultures have generated a view of singing as a perfectionist professional activity that has generated a notion of people either having a good voice, associated with a relatively rare

talent, or not (Austin, 2008; Uhligh, 2006; Newham, 1999). The contexts where singing and group singing practices occur tend to be very well defined and group vocal improvisation is a rare phenomenon. For this reason, many individuals might feel quite exposed and self-conscious in singing in front of others and this is particularly relevant in a clinical situation, where people might already feel in a vulnerable position.

In a similar way, using the voice can be associated with narratives around 'having a voice' in society or being heard in a more generic sense. This links with other sociological and political critique around vocality. Two of the major authors to have engaged with the voice from these perspectives are Cavarero (2005) and Barthes (1977). Cavarero 'is critical of the way the logo-centric tradition of Western philosophy uncritically disregards sounding and privileges semantics over sound – mind over body' (Bruun, 2015, p. 5). In a similar way, Barthes distinguishes the 'phenosong' and the 'genosong', to which he refers to as the 'grain' of the voice. As described by Bard-Schwarz (2018) Barthes proposes that "singing in the realm of the phenosong subordinates the body to the clarity of perfection of execution and an evacuation of signification, articulation, and expression […] singing (or playing an instrument) in the realm of the genosong lets the body as the source of signification sound in all its visceral and irreducible immediacy." (p.29). These considerations are relevant for music therapy, particularly in non-verbal improvisation, where the 'sound' (rather than semantics) and the genosong (rather than phenosong) come at the forefront of vocal expression.

The voice can use words

However, as pointed out by Bard-Schwarz (2018) in the quotation above, playing instruments is also part of the realm of phenosong, but what instruments cannot play with are words. Therefore, despite the importance of the physicality and grain of the voice, singing also allows improvisations or musical activities in general to incorporate the use of words, which can be significant in music therapy. It also means that both production (improvisation) and reproduction (pre-composed) techniques can be used in a fluid way: an improvisation can lead to writing a song or singing a precomposed song can lead to an improvisation. Instead in the use of instruments, unless clients are particularly skilful in their use of instruments it is difficult to use reproduction techniques. This affordance opens up new possibilities when using the voice, such as incorporating songs in various ways, which can be very useful in certain clinical situations (Bruscia, 1998; Leite, 2014).

Given these considerations around aspects that are unique to the use of voice as opposed to the use of instruments, it is reasonable to argue that some of the aspects of therapeutic work when using the voice might be different. Crucially, most of these aspects have potentially important implications in a psychodynamic music therapy approach given the links with embodiment, sense of self, early psychological development and cultural associations. These features might enable and or challenge different aspects of the therapeutic process and it will be the object of the present study to explore these possibilities.

1.4.3 Lack of literature

Some of the authors cited so far often accompany their appraisal of the clinical importance of the voice in music therapy with comments on the lack of attention it has received in the literature and in research. For example, Pedersen states that (in Baker and Uhlig, 2011) "I do consider it [the voice] a very strong therapeutic instrument which deserves more attention in music therapy in literature and practice." (p.287). This is echoed by Austin (2008): "there is an obvious lack of literature addressing the physical, emotional, psychological and spiritual benefits of using the voice and singing in therapy and the effectiveness of vocal interventions in music therapy" (p.19).

Ansdell (in the foreword to Uhlig, 2006) highlights the fact that singing is a 'complex phenomenon' that required further reflection: "within the current music therapy literature, however, you will have found surprisingly little sustained and systematic thinking about this complex phenomenon of singing in relation to music therapy practice."

More recently, Carr (2014) highlighted that, although singing has been researched in other related fields such as music and health, "little attention has been paid to the possible role and function of singing, particularly improvised, within music therapy groups" (p.247). This is something that will be addressed in the following chapter, where neighbouring areas of research will be explored in order to provide a more complete picture of the research available on the use of voice.

To illustrate this gap in the literature, the presence of group vocal improvisation in the main relevant texts in the music therapy literature is now reviewed. This will allow a consideration of the implicit 'consensus' model of music psychotherapy referred to earlier. The literature review in the next chapter will provide a more detailed analysis

from the findings from empirical studies, but it feels important to also cover here the theoretical writings of the discipline. For this reason, a range of books that address music formats that either target the use of voice, group formats or the client group of mental health or group formats has been selected.

Starting with the important text by Baker and Uhlig (2011) on voicework in music therapy, this book divides the different case studies of music therapy focusing on the use of voice into 'structured approaches' and 'free approaches'. From the nine presented structured approaches only three address group formats, none of which target adult mental health. This client group only features in one of these structured approaches and is in an individual format. In regards to the 'free' approaches, which refer to less manualised models, none describe group work and only one is a case study of adult mental health.

Another book by one the same authors, this time looking specifically at songwriting techniques (Baker and Wigram, 2005), only features two group case studies out of the eleven presented. Mental health also features in two of the case studies, but not in the group chapters. Interestingly, although the entire book provides clinical reflections on the use of songwriting, and therefore vocal activities, none of the cases presented explore the implications on the act of singing the songs itself. The focus is instead put on the creation and analysis of lyrics and structures for songs, but the singing or other vocal considerations are almost absent from the book.

The other two books focusing on the use of voice in music therapy reviewed here, Austin (2008) and Uhlig (2006) only offer examples of individual work in all case examples and clinical vignettes. Austin, in the concluding thoughts of the book addresses the fact that "the majority of the vocal interventions in this book are described as they occurred with individual clients but many of them can be adapted to group work" (p.213). The book does not provide recommendations for such adaptation or considerations around what aspects of the techniques presented might need to be approached differently in a group situation.

We now look at two books on music therapy group work to review the presence of the voice there. The book by Davies and Richards (2002) only includes one case study that addresses the use of the voice out of the eight cases with adults presented (another briefly mentions the use of opening songs, but singing does not feature in the clinical reflections). In the more recent book by Davies, Richards and Barwick (2015), which

focuses specifically on psychodynamic approaches, only two of the eight clinical vignettes presented at the end of the book include the use of the voice. Both of these clearly refer to the use of pre-composed songs.

Also included here is a review of the case studies presented in Clinical Applications of Music Therapy in Psychiatry, by Wigram and De Backer (1999). Here, only one of the thirteen cases is from a group format, where the use of the voice is not present. Singing is referred to as an intervention in four of the cases but only specifically addressed in two of them. In the more recent book by De Backer and Sutton (2014) focusing on Psychodynamic Music Therapy in Europe, where again the client group of adult mental health features largely (eight out of the thirteen cases), only two cases address group work (in both cases in dementia). One of these mentions the use of singing, as does another case of individual work in autism; however, these do not explore singing in particular. The only case where vocal work is specifically discussed is the study by Leite, who presents her individual work with a young woman, with whom she started working as a verbal psychotherapist.

Finally, three books on the use of improvisation in music therapy are reviewed, although they do not present case studies. The first one, by Gardstrom (2007) specifically addresses work in groups. In this volume, the introduction to the chapter on 'instruments of improvisation' mentions in parenthesis that "the human voice, a powerful tool in clinical improvisation, is not specifically addressed in this text" (p.25) without offering further explanation as to why.

In his key volume Improvisational Models of Music Therapy (1987) Bruscia describes most of the models as affording the use of voice (p.513-514). Wigram's text on Improvisation (2004) also seems to address the voice as another instrument that can be used in most of the techniques proposed, although singing is only directly specified in techniques for group warm-ups.

This contrast between the presence of singing in the theory (as shown in the last two books from this review) and its absence in most case studies as has been shown is one of the main phenomena that have inspired the present research.

To summarise, from all the cases reviewed here from various music therapy texts, and focusing only on the variables of group and use of voice, it can be seen that:

- Only 4 of the 33 case studies from books focusing on the use of voice referred to group work.
- Only 1 of the 16 case studies from books focusing on group music therapy work referred to the use of voice specifically, and 3 others mentioned using songs.
- Only 1 of the 26 case studies presented in the reviewed books on music therapy in psychiatry or psychodynamic music therapy combines both group work and use of voice.

This gives a total figure of only 6 case studies out of the 75 reviewed (8%) that combine group work and voice work. Moreover, this is before looking at whether there is any element of improvisation and regardless of client group. The gap in the literature on the use of voice in groups in the practice of music therapy appears clear. As the following chapter will present, this is also the case when examining the empirical research. This is not to say that GVI does not feature in mental health music therapy groups and even anecdotally in case studies. However, the purpose of the present study will be to explore how to bring GVI into a group when or if a clinician felt it would be a valuable intervention for a particular group.

Neighbouring fields such as community music have in recent years identified a number of wellbeing benefits of group singing activities and interest in this area appears to be increasing as will be presented in the following chapter. Such benefits point towards increase in motivation, positive affect and social connectedness as well as a decrease in anxiety as highlighted in the systematic review by Clift *et. al* (2008). These are all relevant clinical aspects for the chosen client group of adult mental health.

Subsequent studies have continued to increase the evidence for the wellbeing benefits of group singing in reducing mental distress for people experiencing mental health issues (Clift, Manship & Stephens, 2015; Morrison & Clift, 2011) as well as for older people (Coulton et al, 2015), carers (Fancourt et al, 2019) and women diagnosed with postnatal depression (Fancourt & Perkins, 2018).

1.5 Development of GVI

Interventions

A number of vocal music therapy techniques, which will be discussed in the following sections and chapters, inform the interventions that will be facilitated in the GVI group, such as: vocal warm-ups (Wigram, 2004), vocal holding techniques (Austin, 2008), songwriting Grocke *et al.* (2014), reproductions of pre-composed songs (Mössler, 2012) or call-and-response (Bradt, 2016). These will be detailed further in Chapter 5.

It is not the aim of this study to design specific new activities for GVI but rather to make use of existing techniques and interventions and adapt them for this particular setting and group. The choice of musical activities will be based on the requests, preferences and needs of the groups. As a general guide, the pool of possible technique to use in the GVI group will include using:

- Pre-composed songs as material for improvisations
- Various songwriting techniques
- Non-verbal sounds and vocalisations
- Referential and free improvisation techniques
- Call-and-response activities

Aims

As well as a theoretical exploration of the absence of voicework in group improvisation within music therapy, the question of this study is also aimed at clinically informed goals. The previous section on the particularities of the voice began to describe aspects of voice work that might be relevant for mental health interventions given its inherent particularities.

As has been mentioned before, a previous preliminary research into this topic revealed that the reasons that GVI might not feature often or easily spontaneously in this setting could be related to the degree of exposure and intimacy that such practice tends to involve. A greater emphasis on structure and directiveness from the therapist might be

needed in order to counter this identified challenge. Cultural associations to singing might be another obstacle, which will be explored in the discussion.

Despite these challenges identified in current practice, there seems to be enough potential – as will be argued in the literature review and as has already been highlighted when exploring the particularities of the voice in this initial chapter – for GVI to be a valuable music intervention in music therapy groups in adult mental health. The use of voice offers the potential to work more directly with embodiment and sense of self and identity whilst it also allows the use of words within the music making and facilitates a more flexible movement along the continuum between pre-composed and improvised music making, which can offer useful flexibility as a therapeutic technique to meet the different coexisting needs in a group. A consultation with patient groups for a music therapy study conducted by Carr et. al. (2007) showed that singing was perceived as a more accessible way of music making and a strong sense of structure was seen as desirable.

Further implications for therapeutic aims or processes will be addressed later on in the findings and discussion sections.

Model

The following model (Figure 1.1) presents the hypothesised musical and therapeutic processes involved in the use of GVI as well as those for GMT as a comparison. This model has taken Carr's (2018) proposed model of processes in arts therapies groups as a starting point and has been adapted to the present study's modalities. Carr's model is particularly relevant since it refers to the same client group: secondary mental health community service users.

This proposed model suggests that there are common factors between the two groups relating to the similarity in the format and the fact that both modalities are forms of group music therapy: engagement with others and different ways of interacting and relating. At the same time, the differences in the musical activities might involve slightly different processes and highlight different aspects of the work. Bearing in mind the overall overlap in aims and general similar characteristics of both instrumental and vocal musical interventions, the model attempts to highlight the possible differences and in this

sense artificially polarise these elements of the intervention. However, it is crucially important to highlight that by doing this the author does not imply that these processes are mutually exclusive or intrinsically only pertaining to one modality or the other.

In this sense, for example, in the detail of the processes involved with the engagement with the music making, the GVI has been characterised as emphasising new sensory experiences, imagination and play, whilst in for the GMT the focus has been put on self-expression, new modes of communication and creativity. This does not mean that play is not important in GMT or that self-expression is not a feature of GVI. Below is a table (Table 1.1) detailing this further.

This model will be used throughout this document and referred to at the end of each main section of the study to portray the evolution from the initial proposed model through to the insights gained at the end of the discussion. In each version of the model the same categories or 'boxes' are kept but the bullet points within them reflect the most salient findings from each of the sections.

Overall therapeutic approach

This study will adopt a flexible psychodynamic approach to music therapy. This will be characterised by taking into account the role of the unconscious and of dynamics of transference and countertransference in the sessions (Pavlicevic, 1997; Davies & Richards, 2002; Davies, Richards & Barwick, 2015). Concepts from object relations theory (Klein, 1984), attachment theory (Bowlby, 1969), holding (Winnicott, 1971) containment (Bion, 1967), as well as theories of affect attunement (Stern, 2010), vitality affects (Stern, 2010) and communicative musicality (Malloch & Trevarthen, 2009) will be used to think about and make sense of the clinical sessions.

Adopting Edwards' proposed definition of music therapy approaches and models (Edwards', 2017), the present study will adopt a psychodynamic 'approach' and will propose GVI as a model within it, similarly to Austin's Vocal Psychotherapy (Edwards', 2017). In this definition, an approach is characterised by "an established tradition of therapeutic practice or theory outside of music therapy" that "has been integrated within music therapy techniques and methods" (Edwards', 2017, p. 418). In contrast to this, a model "can be considered unique to music therapy" (ibid). Edwards adds that "the

coherence of an approach or model is not particularly evident from descriptions of its techniques and methods […] but rather can be seen in the way the approach or model explains the role of music, the role of the therapist, and the processes in the work" (ibid).

Therefore, the present study will aim to explain the link between the techniques, interventions and methods involved in the practice of GVI with the overall therapeutic approach. The terms 'technique', 'intervention', 'activity' or 'practice' will be used flexibly throughout the text.

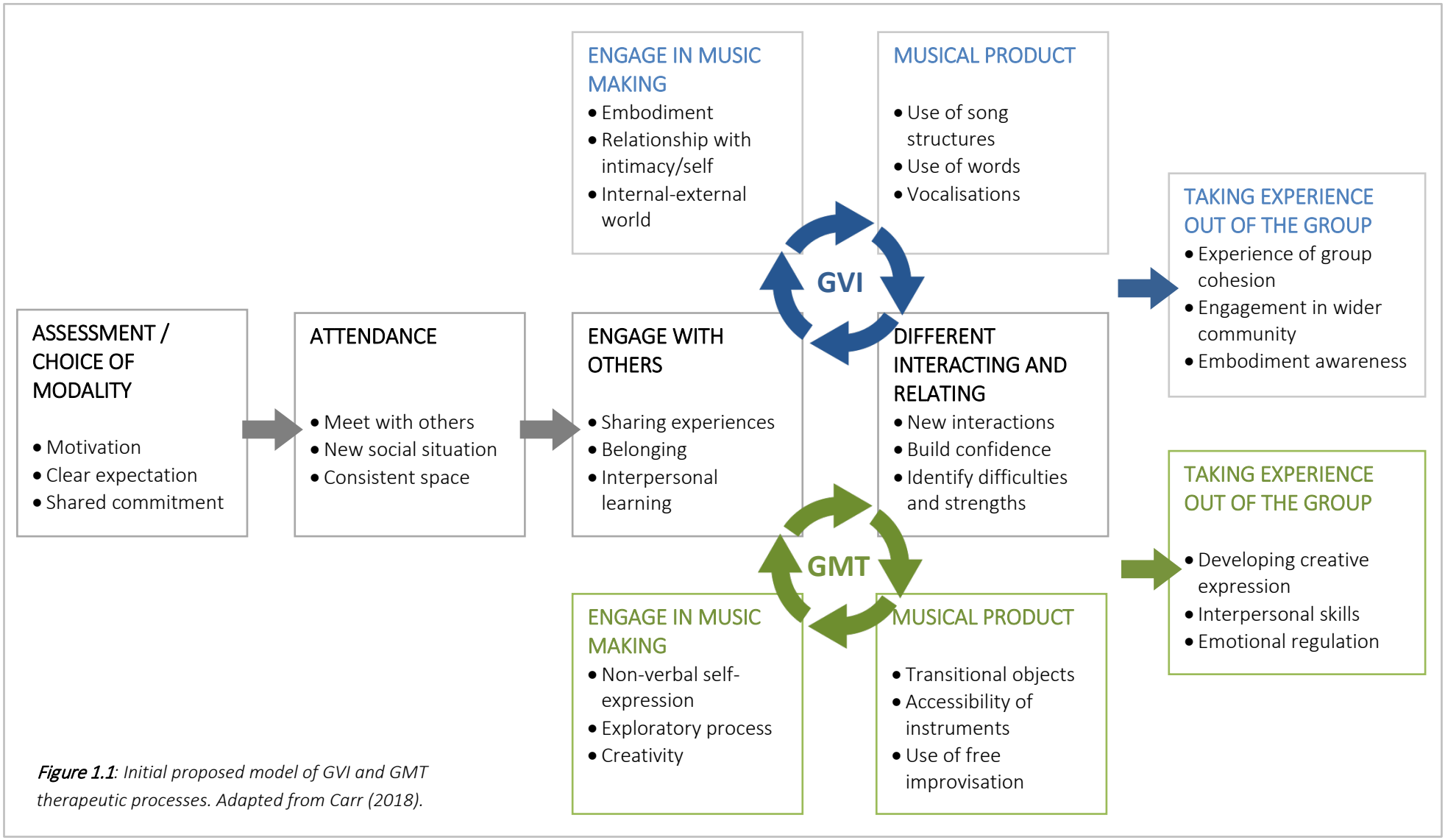


***Figure 1.1**: Initial proposed model of GVI and GMT therapeutic processes. Adapted from Carr (2018).*

Table 1.1: Description from Initial GVI/GMT model or therapeutic processes

GVI		GMT	
ENGAGEMENT IN MUSIC MAKING			
Embodiment	Bodily connection of singing	**Non-verbal self-expression**	Processes contained non-verbally
Relationship with intimacy / self	Link between personal identity and use of voice	**Exploratory process**	Instinctive curiosity about exploring instruments
Internal-external work	Mediation of inner-outer experiences through the dual experience of singing	**Creativity**	Combinations of different sound possibilities
MUSICAL PRODUCT			
Use of song structures	Structured improvisation	**Transitional Objects**	Use of instruments as objects for projections
Use of words	Creative possibilities of using words in music	**Accessibility of instruments**	Simplicity of engagement
Vocalisations	Modulation of expressive sounds.	**Use of free improvisation**	Ease of generating free improvisation
TAKING EXPERIENCE OUT OF THE GROUP			
Experience of group cohesion	Awareness of own bodily states and body-mind links	**Developing creative expression**	Experience of resources for self-expression
Engagement in wider community	Possibility of joining a community choir as a step down	**Interpersonal skills**	Practice of different ways of relating
Embodiment awareness	Development of relationship with one's voice.	**Emotional regulation**	Awareness of own capacity to self-regulate

2. SYSTEMATIC LITERATURE SEARCH

2.1 Introduction: Narrative Synthesis Systematic Review

This literature review aims to identify and map the research that has been done around the topic of this research project: the use of group vocal improvisation as a music therapy technique in a mental health setting. Describing the types of interventions that have been evaluated in previous research and the types of research designs used in these evaluations will help to refine the research questions and inform the methodology of this research project. This review of the literature will also serve to assess the volume of potential relevant literature on the subject.

This literature review will follow a narrative synthesis systematic review model, which consists of the use of words and text to summarise and explain the findings from multiple studies (Popay *et al.* 2006). This review will follow the Popay *et al.* guide on conducting a narrative synthesis of the findings of a systematic search of the literature.

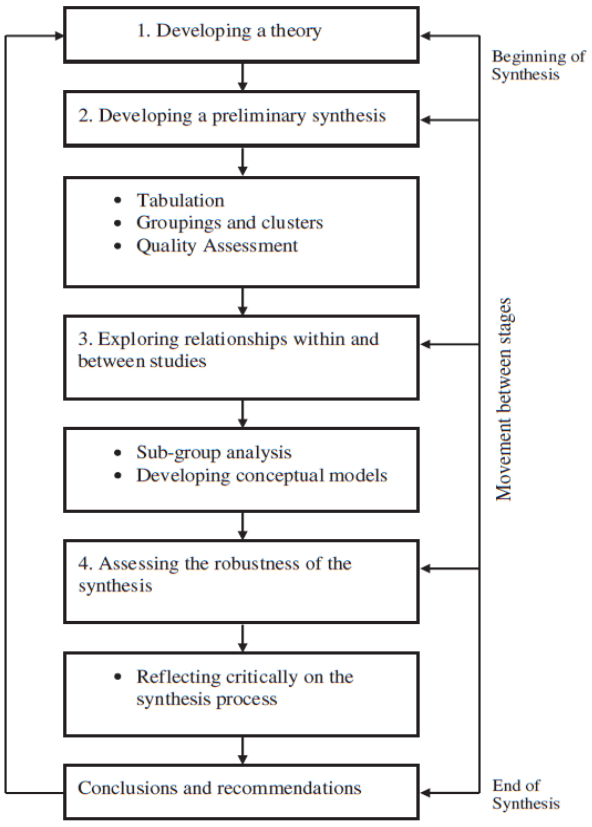


***Figure 2.1**: Narrative synthesis process adapted from Popay et al., 2006 (McDermot et al. 2013)*

Narrative synthesis has been identified as a particularly relevant approach to a review on music therapy literature (McDermott, 2012) as it enables a systematic evaluation of both process- based and outcome - based studies.

The present research will focus on reviewing empirical studies. This restriction will serve to focus the discussion at this stage and to concentrate on examining studies that are in its empirical nature similar to the one that the author is proposing for the present research. Other input and reflections from theoretical

papers in music therapy that are relevant to this project will still find a place in other sections of discussion throughout this study.

Narrative synthesis is broadly divided into 4 stages although Popay et al. "are not suggesting that narrative synthesis should proceed in a linear fashion with these elements being undertaken sequentially" (2006). These four elements are (Figure 2.1):

- Developing a theory of how the intervention works, why and for whom
- Developing a preliminary synthesis of findings of included studies
- Exploring relationships in the data
- Assessing the robustness of the synthesis

2.2 Narrative Synthesis Element 1: theory development

The first element of this model, developing a theory of how the intervention works, why and for whom, has been addressed in the last sections of the previous chapter, where a model of the therapeutic processes involved has been presented.

This model brings together recognised processes in arts therapies groups (Carr, 2018) for outpatient secondary mental health service users, such as the role of engaging with others and experiencing different ways of interacting and relating with others as well as the importance of doing this through engaging with arts making and art products. The model proposed in the previous chapter for GVI then adds to these elements the specificities of the voice and hypothesises the processes that might emerge from this.

The model proposes that the use of group vocal improvisation might be beneficial for this client group in many ways similarly to other modalities of music therapy, but that it might afford certain therapeutic processes differently. For example:

- Putting emphasis on the embodiment of the music making process given the inner sensory attunement needed for singing. Re-connecting with a sense of

bodily awareness can be important for people suffering from mental health and help provide a grounding sense of control and self-regulation of emotions.

- Enhancing the creative possibilities of working with words. This allows to bring in a range of structures and interventions such as singing pre-composed songs or songwriting. These activities can help address meaning and emotions in a different way than non-verbal communication.
- Developing client's sense of self and identity. Given the voice's links with what is personal and intimate, it offers a platform to work with vulnerable and core aspects of the self.
- Encouraging access to wider community activities. Group singing and community choirs are a rich resource in many communities and a source of opportunities for socialisation and artistic expression that can be very helpful for people suffering from mental health illnesses.

This model will be discussed further at the end of this chapter in the light of the findings of the present literature review.

2.3 Narrative Synthesis Element 2: developing a preliminary synthesis

2.3.1 Keywords model

Looking at group vocal improvisation as a music therapy technique involves the confluence of three parameters within music therapy practice: group work (as opposed to individual sessions), vocal work (as opposed to instrumental) and improvised material (as opposed to pre-composed music). These three parameters, along with "music therapy" are the main keywords for this literature search.

A first search in the literature looked at the overlap of these four keywords: music therapy, voice, group and improvisation. A very limited number of results were yielded from this search strategy and it became apparent that there was a need to broaden the focus of the review to include some neighbouring areas that could be relevant for the topic.

The following model (Figure 2.2) was designed to illustrate how four subcategories were obtained, by combining three out of the four keywords at a time, to do a second search in the literature. In the model, O represents the first search, consisting on the Overlap of

the four keywords and, and A, B, C and D represent the four categories obtained for the second search:

- [A] Group singing as therapy (no improvisation)
- [B] Vocal improvisation in individual music therapy (no group work)
- [C] Group vocal improvisation (no therapeutic aims)
- [D] Group improvisation in music therapy (no voice)

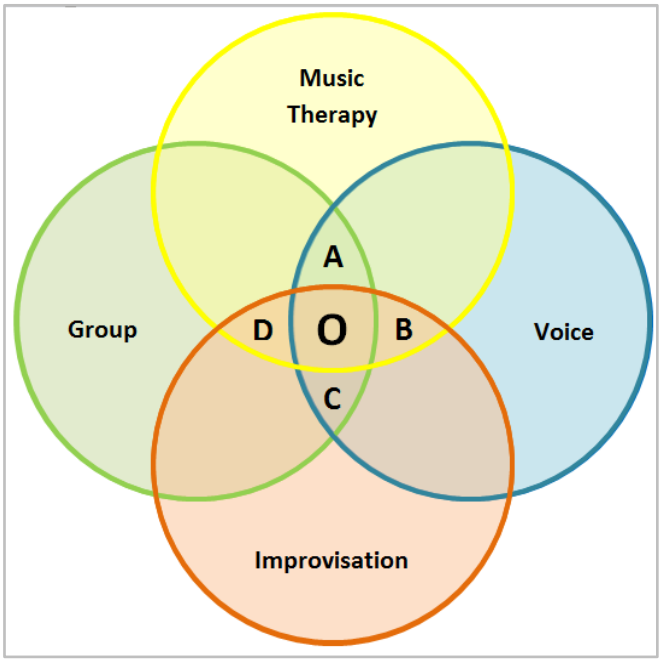


Figure 2.2: Model for literature review

Adding these subcategories serves both to gain insight from neighbouring areas of research as well as to delimit more clearly the differences between those and the specific interest of the present study.

The proposed model does not include mental health as a keyword despite it being one of the distinctive aspects of this study. Instead, this parameter is considered in a later stage of this review. There are various reasons for not taking mental health as a determining factor into consideration for the initial search strategy. The main reason is that music therapy, as a psychological therapy, tends to attend to the emotional needs of every client group regardless of whether there is a physical or developmental primary reason for referral.

For example, many studies addressing the use of music therapy in neurological conditions such as Parkinson's or aphasia look at anxiety levels and quality of life (Talmage *et al.*, 2013; Yinger & LaPointe, 2012), or studies addressing cancer patients look at depression (Kim *et al.*, 2010). Although these client groups have not been diagnosed with a mental health illness, their mental health is partly the focus of the music therapy intervention. Therefore, this review has included such titles, as they remain very relevant to the area of interest of this study.

In addition, as presented above, the limited literature on the use of group vocal improvisation informed a broad and inclusive approach to the review. Therefore, mental health was used in a broad sense (including emotional well-being and quality of life) as an inclusion criterion during the first screening of abstracts rather than as a keyword in the initial search.

2.3.2 Sources

This systematic literature review makes use of databases that are relevant to the music therapy discipline and client group as well as other sources such as specific journals that were not included in the databases. Finally, a by hand search was conducted in a music therapy library (Table 2.1).

***Table 2.1**: Three levels of search*

Three levels of search	1. NICE databases	First search [O] Second search [A][B][C][D]
	2. Other sources	Joint search [O][A][B][C][D]
	3. By hand search	Joint search [O][A][B][C][D]

Since the clinical part of the project will take place within an NHS setting, the databases provided by the Health Database Advanced Search (HDAS) and suggested by the NICE Evidence platform were considered as the starting point.

This tool provides 8 databases, from which only 5 were used:

- PsychINFO (psychology and allied fields, 1806 to present)

- EMBASE (Excerpta Medica Database, 1974 to present)
- MEDLINE (General Medical Database, 1946 to present)
- CINAHL (Cumulative Index to Nursing and Allied Health Literature, 1981 to present)
- AMED (Allied and Complimentary Medicine, 1985 to present)

The remaining 3 were excluded due to their specific and non-directly related focus of attention:

- HBE (Health Business Elite)
- HMIC (Health Management Information Consortium)
- BNI (British Nursing Index)

A further level of search included more generic databases such as JSTOR and Google Scholar, and specialised journals: Arts in Psychotherapy, Nordic Journal of Music Therapy British Journal of Music Therapy and Psychology of Music. A further search on RILM (Répertoire International de Littérature Musicale) was also included. These sources offer different levels of advanced search but none is as advanced or allows saving and accumulating searches as the HDAS databases. Therefore, the search in these cases has had to be more tailored to each specific source and therefore less systematic, but it has nevertheless been useful in order to access other kinds of sources.

Finally, a by hand search was conducted in other relevant places such as the Guildhall School of Music and Drama Library in the music therapy section and the British Library. Grey literature searches were not included.

2.3.3 Search strategy

NICE Databases

The strategy used for the first search (overlap of 4 keywords) aims to be broad and comprehensive due to the limited literature in this specific conjunction of elements. Therefore, in addition to subject headings, some specific words in the titles, abstracts and content of the articles were used in an attempt to identify as many articles as possible.

The following table (Table 2.2) is an example of the search strategy that was used for EMBASE. For each specific database some adjustments needed to be done in accordance to the different subject headings but there were not major differences.

***Table 2.2**: Search strategy example*

MODEL	Nº	Search terms	Results
MUSIC THERAPY	1	MUSIC THERAPY/	4965
	2	music*.ti,ab	18293
	3	(therap* OR psychother*).ti,ab	2879272
	4	1 or (2 and 3)	6382
GROUP	5	GROUP THERAPY/	17412
	6	group*.af	4603830
	7	(choir* OR choral* OR ensemble*).ti,ab	18414
	8	5 OR 6 OR 7	4619559
VOICE	9	VOICE/	15400
	10	SINGING/	2467
	11	(voice* OR vocal* OR sing* OR chant*).ti,ab	1573211
	12	9 OR 10 OR 11	1576390
IMPROVISATION	13	(improvis* OR improviz*).ti,ab	2127
Overlap of 4	14	4 AND 8 AND 12 AND 13	16

In the second search (the 4 subcategories of 3 keywords) mainly subject headings were used in order to limit the search to only the most relevant articles, since using the same strategy as in the first search proved not to be focused enough and also provided unmanageable amounts of entries.

This shift to a stricter search was necessary especially in the keywords “group” and “voice”, since the broader search afforded various aspects of these words, many of which were not relevant for the subject. In the case of “music therapy” only the subject heading was used since in this case the discipline is quite well delimited, which served as a good limitation factor. Later on, the term song* was also included in the voice category.

The following table (Table 2.3) is an example of the second search strategy for the same database:

***Table 2.3**: Second search strategy*

MODEL		Nº	Search terms	Results
1st search	MUSIC THERAPY	1	MUSIC THERAPY/	5074
		2	music*.ti,ab	18706
		3	(therap* OR psychother*).ti,ab	2951040
		4	1 or (2 and 3)	6516
	GROUP	5	GROUP THERAPY/	17633
		6	group*.af	4718441
		7	(choir* OR choral* OR ensemble*).ti,ab	18941
		8	5 OR 6 OR 7	4734604
	VOICE	9	VOICE/	15741
		10	SINGING/	2518
		11	(voice* OR vocal* OR sing* OR chant*).ti,ab	1610505
		12	9 OR 10 OR 11	1613712
	IMPROVISATION	13	(improvis* OR improviz*).ti,ab	2204
	Overlap of 4	14	4 AND 8 AND 12 AND 13	16
2nd search	Stricter Voice	15	9 OR 10	17650
	Stricter group	16	5 OR 7	36572
	A	17	1 AND 16 AND 15	19
	B	18	1 AND 13 AND 15	13
	C	19	16 AND 13 AND 15	3
	D	20	1 AND 16 AND 13	4

[A] Group singing as therapy (no improvisation)

[B] Vocal improvisation in individual music therapy (no group work)

[C] Group vocal improvisation (no therapeutic aims)

[D] Group improvisation in music therapy (no voice)

Other sources

For the alternative sources mentioned above (JSTOR, Google Scholar and specific arts therapies journals) the same search strategy was adapted to the to the more limited search tools they offer. The results for both the overlap of the 4 keywords as well as the subcategories were combined since the level of refinement of the searches was not very reliable. A similar strategy was used for the by hand search.

2.3.4 Results

The following table (Table 2.4) shows the number of results obtained for the 1st and 2nd searches in the NICE databases consulted. The numbers presented below have the aim of giving a general idea of the emphasis that the areas of interest of this study have generated in the existing literature.

Table 2.4: *Results obtained for first and second searches*

NICE databases	1st search Overlap of 4	2nd search: SUBCATEGORIES			
		A	B	C	D
EMBASE	16	19	13	3	4
PsychINFO	34	14	6	2	17
MedLine	5	25	0	0	5
CINAHL	22	6	0	0	2
AMED	1	4	6	0	1
TOTAL (de-duplicate)	**61**	**60**	**15**	**2**	**22**

This study is not a meta-analysis and therefore it would not be appropriate to conduct statistical analysis on these figures, although they have been obtained through the process of a systematic research, since they contain very different types of sources that would need a more detailed screening process.

Nevertheless, it is useful to look at the general tendencies pointed out by this numbers, since there are very clear differences in the amount of sources in the different subcategories of the second search.

It is important to point out that the sources from the first search do not always represent a real overlap of the 4 keywords (i.e. music therapy, voice, improvisation and group), in

the sense that they may contain the words but do not address them as a main point of the study, which results in a heterogeneous collection of articles that the numbers cannot reflect.

Instead, in the second search, due to the stricter terms of the search, the obtained results tend to be more directly relevant to the main focus of each subcategory. Therefore, it is possible to look at the figures of the second search and to reflect on their significance.

The first noticeable difference between the various subcategories is the total amount of articles in each one of them. The following diagram (Figure 2.3) visualises the numbers given in the previous table (Table. 2.4) to emphasize these differences. It is worth pointing out that these are the numbers from the NICE databases and therefore do not include sources such as foundational texts of the music therapy literature in the format of books or other non-empirical articles that fall out of the peer reviewed journals included in the mentioned databases.

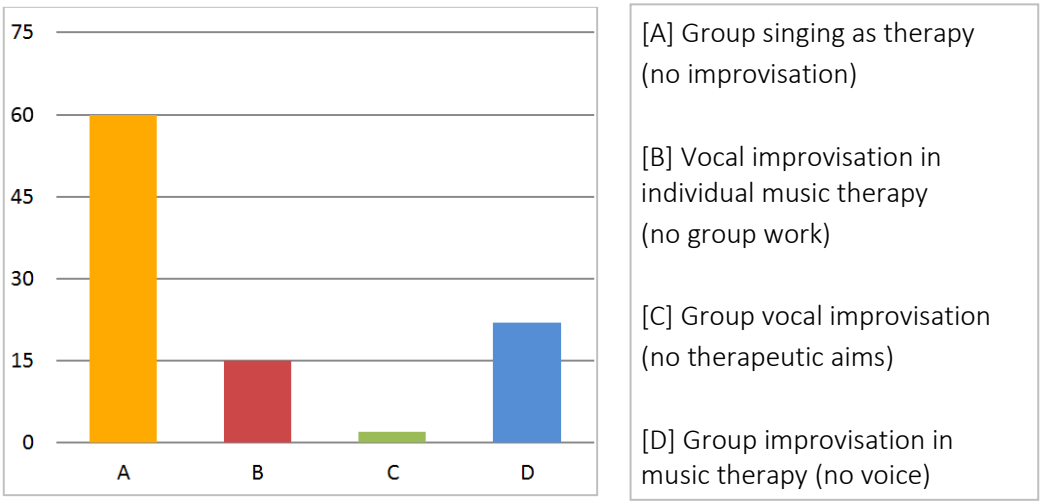


Figure 2.3. Number of articles obtained for each subcategory in the second search.

Therefore, it is useful to think of this more of as a representation of the literature that has made its way to the more scientific community than a representative image of the music therapy bibliographical landscape.

A last consideration regarding the differences amongst the subcategories is that the articles referring to A, which we could say deal mainly with community choirs, are not only the ones with more numbers in total, but have also been the ones with a more exponential rise in the last decade as the following diagram (Figure 2.4) shows.

It is not surprising that the subcategory C has so little numbers, since the sources were from health care databases and this specific category takes the therapeutic element out of the equation would be expected to be the lowest.

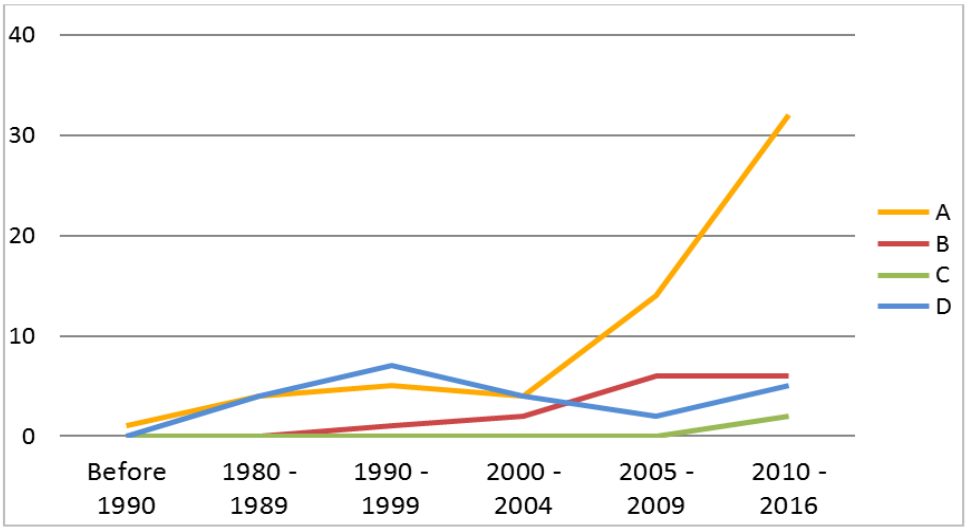


Figure 2.4: *Chronological division of articles obtained for each subcategory in the second search.*

This diagram (Figure 2.4) also shows that in the last 10 years the subcategories that have had a clearer increasing tendency have been the two that focus more specifically on the voice (A and B). Instead, the articles on the use of group improvisation, which dominated the growing tendency and had the most articles during the 90s decade seem to have remained constant without following the general increasing tendency as the other categories.

This superficial analysis reflects (even if approximatively) the evolution of the music therapy discipline. Especially in the case of the subcategory A it could be argued that it reflects the especial attention that has been given to voicework in music therapy as well as the rise of community music and Community Music Therapy (CoMT) in the last decade.

Moving to the other sources consulted and the by hand search, the table below (Table 2.5) shows the numbers of titles obtained. As outlined in the previous section the search tools were not refined enough to make the subcategory differentiations in a systematic way. Table 2.5 shows a sum of the results obtained for each source for both the first and second searches.

Table 2.5: *Results obtained through other sources and by hand searches*

	Combination of 1st and 2nd searches	
Other sources	Google Scholar	39
	JSTOR	5
	AIP	11
	NJMT	25
	BJMT	7
	Psychology of music	39
	RILM	28
	TOTAL (de-duplicate)	**144**
By hand search	**TOTAL** (de-duplicate)	**62**

2.3.5 Inclusion and exclusion criteria

The three levels of search presented in the previous search produced a total of 301 studies: 160 titles from the first and second searches in the NICE databases, 144 from the other sources and 62 from the by hand search. The abstracts of these articles were obtained for a selection process based on the following inclusion and exclusion criteria.

These criteria were purposefully broad in accordance to the exploratory nature of the present research. Since group vocal improvisation is not a standard music therapy technique it is often alluded to in passing comments within articles rather than studied directly and therefore too restrictive inclusion and exclusion criteria would have excluded most articles.

Inclusion criteria:

- Research relating to combinations of the keywords used for the study following the model proposed in the previous section
- Research relating to music therapy within mental health
- Research relating to emotional well-being and quality of life in other client groups
- Empirical studies in English or Spanish Language

- Quantitative, qualitative and mixed methods studies

Exclusion criteria:

- Research relating to melodic intonation therapy
- Research relating to voice in spoken word
- Conference papers, personal opinion and commentary

After this first screening, full texts of 77 studies were obtained for a further screening phase that excluded another 41 titles because of their non-empirical nature (Figure 2.5). Finally, another 3 results were included following a re-run of the researches in 2020.

The theoretical studies were not excluded earlier in the selection process as it was considered that they could be relevant to the study beyond this systematic literature review.

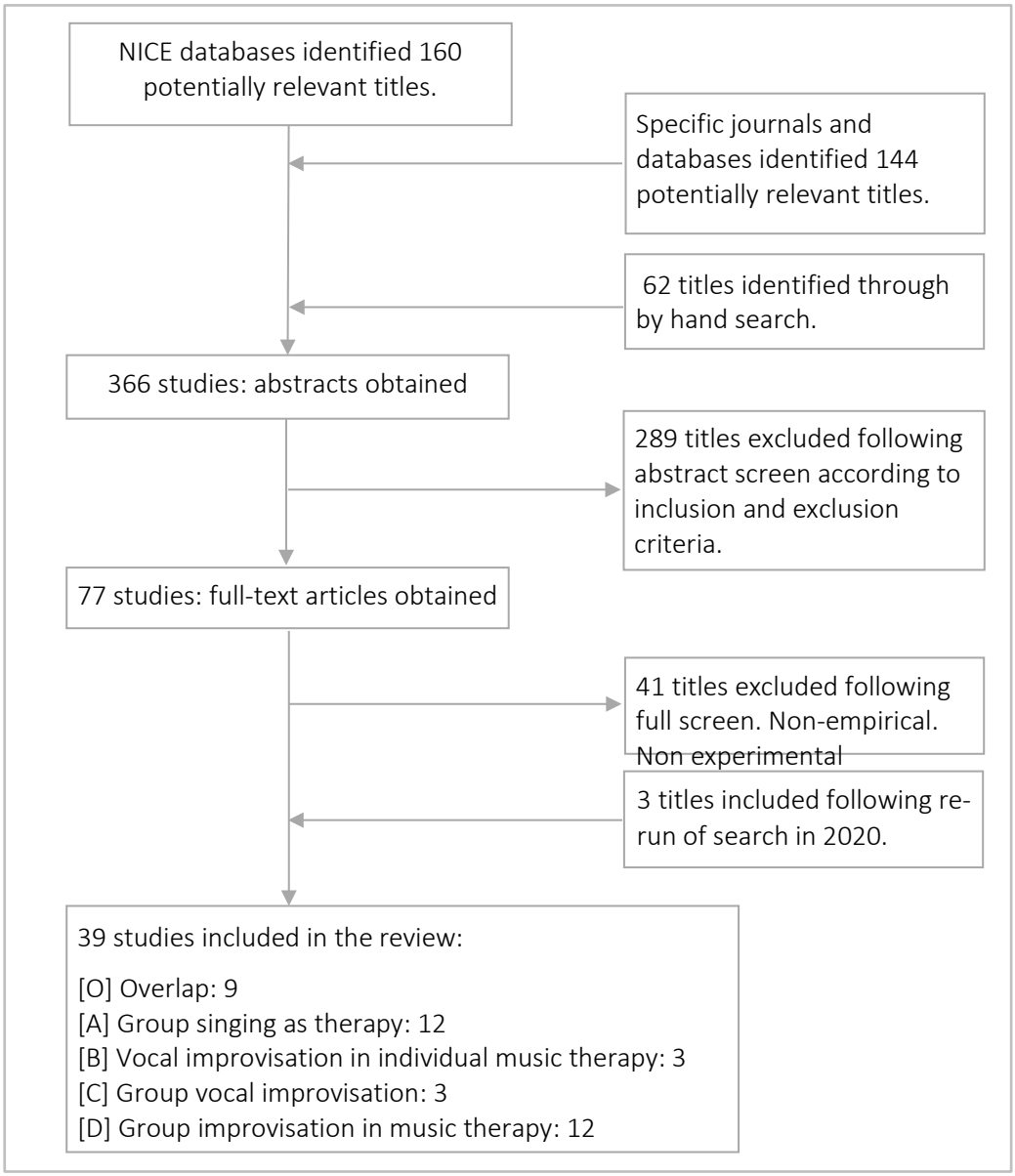


Figure 2.5: Study selection process

2.4 Narrative Synthesis Element 3: exploring the relationships within and between the studies

The 39 articles for discussion have been grouped into five categories (overlap and 4 subcategories) following the model presented at the beginning of this literature review. The studies have been allocated to these five different categories depending on their focus regardless of whether or not they were originally obtained through that particular search strategy.

In each category the selected studies have been tabulated in order to see the main design and outcomes of each study. In addition, following the model of the review, five columns indicating the four keywords and the inclusion criterion "mental health" have been added to illustrate how much each study relates to these elements: music therapy (MT), Voice (Vo), Improvisation (Im), Group (Gr) and Mental Health (MH). This contributes to further map the practices and interventions identified in this review.

Three levels of relevance to each of these five elements have been indicated by 'X' when the study directly relates to that element, '/' when it partially relates to that element or nothing when the study does not relate to that category.

2.4.1 [O] Overlap

Studies were allocated to this category when they were at least partially or directly related to all the five elements and had voice, improvisation and group work as a focus of their study (Table 2.6).

Four of the studies compared an experimental group to a control group (Bradt *et al.*, 2016; Grocke *et al.*, 2014; Magnis 2013; Silverman, 2011), one compared two experimental groups and control (Tamplin *et al.,* 2014) and four evaluated the studied condition without control (Carr, 2014; Cumming, 2011; Iliya, 2011; Grocke, Bloch & Caslte, 2009).

It is interesting to notice the different labels that are given to these different types of vocal interventions. The studies can be divided in two categories: on one side there are three studies that refer to music therapy in general although all or almost all the interventions studied are vocal (Grocke *et al.*, 2014; Tamplin *et al.,* 2014; Grocke, Bloch & Caslte, 2009). Interestingly, this division has a direct correlation to the country of the studies: all three articles in this group are Australian. On the other hand, five of the

remaining studies (from United States and South-Africa) refer specifically to the vocal focus of their interventions in different ways: Bradt *et al.* (2016) use the label 'vocal music therapy'; Magnis (2013) and Cumming (2011) use the term 'vocal activities in music therapy'; Iliya (2011) uses 'voice-centered music psychotherapy methods'; and Silverman (2011) uses 'songwriting'.

The remaining study, by Carr (2014), which incidentally is also the only one from the UK, has been included in this category because although the focus of the group music therapy intervention was not on the use of voice, the findings point at the vocal activities in particular as having a significant impact in both the quantitative measures and qualitative data (p.247):

> *"Duration of singing was the only component of music therapy with a positive association that remained significant in this model […] The qualitative data suggested a possible association with singing as a means of expression emotions and putting these emotions into words. Notably this was often through an improvised structure, rather than through precomposed music."*

These findings are very encouraging for the present research and highlight the need for further research in this area. The study also points out at the fact that some aspects of the use of voice correlated with different dynamics in the group such as: "patient initiation was greater than therapists for all activities apart from singing, where initiation of singing was done equally between the two" (p.228). This suggests a distinct practice at least at some levels, which the present research will look more in depth at.

Regarding the findings of the other studies, the ones with control groups found significant improvements in self-efficacy (Bradt *et al.*, 2016) and quality of life (Grocke *et al.* 2014) and a decrease of depressive symptoms (Magnis, 2013). Silverman (2011) did not find significant differences with the control group.

Regarding the studies without control, they found that the vocal improvisation interventions facilitated self-expression and social interaction (Cumming, 2011), quality of life (Grocke, Bloch & Caslte, 2009) and hope, belonging and acceptance (Iliya, 2011).

Finally, it is interesting to note that Tamplin *et al.* (2014), when comparing active (group singing using Neurologic Music therapy techniques, vocal and respiratory exercises, singing familiar songs, and vocal improvisation) versus receptive music therapy (group music appreciation, song sharing and discussion, musical games, and music-assisted

relaxation) found that “both types of group music therapy had a positive effect on mood/mental state and physical state, encouraged social engagement, and reconnected participants with their music identity or relationship with music. In addition, the participants who participated in the singing groups found singing to be challenging and confronting, but experienced a general increase in motivation.” (p.236).

The added challenge resulting in an increase in motivation in the active singing music therapy is an interesting phenomenon that could have been due to the agency involved in music-making rather than listening or specifically related to the singing component.

The results from the article by Bradt *et al.* (2016) seem particularly relevant as the intervention studied is very similar in content to the one of the present research project: breathing warm up, toning and humming, vocal improvisations and circle songs. The qualitative findings from this study include enhanced self-management, motivation, empowerment, a sense of belonging, and reduced isolation.

The findings from these results point at the positive benefits of group vocal improvisation in various domains of mental health. The variety of interventions covered by these studies shows that the use of improvised singing in groups appears to be feasible and also that its application can be flexible and take many forms in order to adapt to the context, clinical needs and therapeutic aims. The findings of the use of voice appearing as confronting and challenging (Tamplin et al, 2014) also confirm the views presented in the previous chapter, highlighting the potential for feelings of exposure associated with singing. The notion of culture appropriateness introduced by Bradt et al (2016) offers an important insight in this respect.

Table 2.6: Results from category [O] Overlap									
Author (year) Country	Client group	Setting, Number of sessions, Intervention	Study design:	Results	MT	Vo	Im	Gr	MH
Bradt *et al.* (2016) USA	Chronic pain management	Nurse-managed health centre, 8 weeks. Music-guided deep breathing; brief verbal check-in; toning and humming; verbal processing of somatic experiences; vocal improvisations; circle songs for the vocal improvisation segment of the sessions.	Experimental, RCT with qualitative focus groups. Mixed methods. Measurements pre, during post and follow up (4 weeks). Process and outcome study.	Large effect sizes (ES) for self-efficacy; moderate ES for pain interference; no improvements for general activities and emotional functioning. Moderate ES for pain intensity and small ES for coping, albeit not statistically significant. Qualitative findings: enhanced self-management, motivation, empowerment, sense of belonging, and reduced isolation.	x	x	x	x	/
Carr (2014) UK	Acute Mental Health	Impatient psychiatric hospital, 12 weeks (mean attendance around 5). One hour sessions 1-3 times per week. Group Music Therapy: active and receptive techniques. Active techniques included: improvisation with instruments and singing.	Observational multicentre longitudinal cohort study. Mixed methods: questionnaires, video microanalysis and interviews. Outcome measures after each session. Process and outcome study.	Processes of engagement, emotional expression and social connection suggested active music-making, synchrony and singing to be important for group cohesion. Singing was significantly associated with appraisal and motivation. Musical initiation by group members was associated with motivation and commitment.	x	/	x	x	x
Grocke *et al.* (2014) Australia	Severe mental illness	Mental health clinic, 13 weeks Group music therapy (GMT) Singing familiar songs and composing original songs recorded in a professional studio	Experimental, RCT with qualitative focus groups. Mixed methods. Measurements pre, post and follow up. Process and outcome study.	Significant difference between GMT and control on QoL and spirituality. Greater benefit for those receiving more sessions. GMT was enjoyable; self-esteem was enhanced; participants appreciated therapists and peers; and the programme was recommended to others.	x	x	/	x	x
Tamplin *et al.* (2014) Australia	Chronic quadriplegia (risk for social isolation and depression)	Public hospital, 12 weeks (1h) - Active music therapy (group singing using Neurologic Music therapy techniques, vocal and respiratory exercises, singing familiar songs, and vocal improvisation) - Receptive music therapy (group music appreciation, song sharing and discussion, musical games, and music assisted relaxation)	Experimental. Qualitative analysis of interviews from RCT. Process study.	Both conditions had a positive effect on mood/mental state and physical state, encouraged social engagement, and reconnected participants with their music identity or relationship with music. Participants in active groups found singing to be challenging and confronting, but experienced a general increase in motivation.	x	x	/	x	/
Magnis (2013) USA	Depression Adolescents 12-18	Outpatient drug rehabilitation program, 6 workshops. Singing, songwriting, chanting, body percussion,	Experimental, controlled trial. Quantitative. Pre-post measurements.	Mean changes in CES-DC depression scores in the treatment group were significantly less than that of the control group therefore the study yielded positive results.	x	x	x	x	x

		vocal sounding, and vocal improvisation.	Outcome study.						
Cumming (2011) South-Africa	9-17 years old Cerebral palsy (CP)	Nursing home, 8 weeks (40 min) Vocal activities, including 'sing-along' songs, improvisations and vocal games.	Experimental case study. Qualitative analysis of video extracts and session notes. Process study.	Vocal activities in group music therapy may provide institutionalised individuals with CP opportunities for self-expression and social interaction	x	x	/	x	/
Iliya (2011) USA	Male homeless and mentally ill individuals	Community Support Services, Comprehensive Treatment Program (CSS-CTP), weekly sessions. Voice-centered music psychotherapy methods: individual and group singing; chanting and toning; sound and movement; group improvisation (duets with instrument and voice).	Observational, case study. Qualitative analysis of audio extracts. Process study.	Sense of belonging, acceptance, hope, and help.	x	x	x	x	x
Silverman (2011) USA	Acute adult mental health	Psychiatric unit, 1 session - Group psychoeducational music therapy songwriting session concerning coping skills. - Group psychoeducational session concerning coping skills.	Experimental, RCT. Pre-post measurement (single session). Quantitative, outcome study.	No significant between group differences, although slightly higher measures in experimental. Higher enjoyment and higher attendance.	x	x	/	x	x
Grocke, Bloch & Castle (2009) Australia	Severe and enduring mental illness (SEMI) Outpatients	Community centre, 10 weekly sessions. Song singing (familiar and preferred songs chosen by the participants) Song writing (primary music therapy method) and instrumental improvisation ("to enhance the song with instrumental support and effects"). Recording of original song/s in a professional studio.	Experimental. Mixed methods: questionnaires (pre-post), lyrics analysis and focus groups. Process and outcome study.	Statistically significant improvement found on five items of the QoL Scale. No changes on the BSI indicating that QoL improvement was not mediated by symptomatic change	x	x	x	x	x

2.4.2 [A] Group singing as therapy (no improvisation)

Studies were allocated to this category when they were at least partially or directly related to all elements but improvisation (Table 2.7).

The register of the majority of these studies shifts from the clinical tone of the previous category and instead of 'sessions' or 'group' most studies refer to 'rehearsals' or 'workshops' and 'choirs'.

Most of the articles refer to practices around community choirs, mentioning benefits from group singing such as motivation (Yinger & LaPointe, 2012; Baines & Danko, 2010; Silverman, 2007), emotional well-being (Kim *et al.*, 2006; Bailey & Davidson, 2003), positive affect (Talmage *et al.*, 2013; Busch & Gick, 2012), social connectedness (Bailey & Davidson, 2003) and a decrease in anxiety and problematic thoughts (Baines & Danko, 2010).

Of these articles, only three studies identify directly with music therapy (Baines & Danko, 2010; Silverman, 2007; Kim *et al.*, 2006) and none of the studies compare the studied condition to a control group. Only Silverman (2007) compares music therapy with psychoeducation but does not obtain significant differences in outcome measures between the two experimental groups.

Another subgroup of articles addresses songwriting practices (Myers-Coffman et al, 2019; Uhlig et al, 2017; Silverman, 2017; Silverman et al, 2016), reporting benefits around "togetherness, a way to safely express grief-related emotions and experiences verbally and nonverbally, and opportunities for strengthening music and coping skills" (Myers-Coffman *et. al.*, 2019), hope and readiness to change (Silverman *et. al.*, 2016), and emotional self-regulation (Uhlig *et. al*., 2017).

This section suggests that group singing and songwriting practices promote positive outcomes for groups, especially around notions of togetherness and connection with others. These findings resonate with those presented for literature around community music groups in the first chapter.

Table 2.7: Results from category [A] Group singing as therapy (no improvisation)

Author (year) Country	Client group	Setting, Number of sessions, Intervention	Study design	Results	MT	Vo	Im	Gr	MH
Myers-Coffman et al (2019) USA and Australia	Adolescent bereavement	Outpatient clinic, paediatric hospital and a school. 8 sessions of 1.5h each. Songwriting and rhythmic improvisation.	Experimental, multicentre case study. Mixed methods: pre-post test questionnaires and interviews. Process and outcome study	No statistically significant improvements for grief, self-esteem, coping, and meaning making. Greater inhibition of emotional expression was statistically significant. Thematic findings: a sense of togetherness, a way to safely express grief-related emotions and experiences verbally and nonverbally, and opportunities for strengthening music and coping skills.	x	x		x	/
Uhlig et al (2017) Netherlands	Adolescents	Mainstream school. 45min weekly sessions for 4 months. Group involving Rap & Sing Music Therapy or a control group.	Experimental, RCT. Pre-post test. Quantitative outcome study.	Significant differences between groups on the SDQ teacher test indicated a stabilized Rap & Sing Music Therapy group, as opposed to increased problems in the control group. Total problem scores of all tests indicated significant improvements in the Rap & Sing Music Therapy group	x	/		x	/
Silverman (2017) USA	Adults with addictions	Detoxification unit. Single group-based educational songwriting intervention. Three conditions: educational songwriting targeting relapse prevention and recovery, recreational music therapy targeting social and affective gains, or wait-list control	Experimental, cluster-randomized effectiveness study. Pre-post test. Quantitative outcome study.	There was a significant difference in the craving subscale of expectancy between the educational songwriting and control conditions. Although no other difference reached significance, participants in the songwriting condition tended to have lower subscale and total craving mean scores than participants in the control and recreational music therapy conditions.	x	/		x	/
Silverman et al (2016) USA, UK and Australia	Inpatient adult mental health and adults with addictions	Acute care psychiatric unit and detoxification unit. Single-session highly structured blues songwriting intervention.	Experimental. Pre-post test Quantitative outcome study.	Positive and significant correlations between flow and meaningfulness of songwriting and outcomes: state indices of hope and readiness to change. Flow was a significant predictor of therapeutic outcome but that meaningfulness of songwriting was not a significant predictor of therapeutic outcome	x	/		x	/
Talmage *et al.* (2013) New Zealand	Neurological conditions and carers	12 weeks, Weekly 90 min sessions Warm-up: breathing and physical exercises. Vocal exercises. Repertoire (familiar and "easy" songs). Rounds and echo songs between songs.	Qualitative part of mixed methods study. Post intervention interviews and focus groups. Process study.	Positive support for people with neurological conditions	x	x		x	/
Busch & Gick (2012) Canada	Non-clinical	1 choir rehearsal	Observational. Pre-post (single rehearsal). Outcome study.	A single rehearsal is associated with significant increases in positive affect, personal growth, and vitality. Perceived social support was predictive of change in positive affect.	/	x		x	/

Yinger & LaPointe (2012) USA	Parkinson's	6 sessions, 50 minutes. Physical, facial, and breathing warm-ups, vocal exercises, and singing.	Pre-experimental, one-group pretest-posttest design. Quantitative analysis of voice recordings. Outcome study.	Significant increases in intensity of conversational speech, Benefits to improve and maintain vocal functioning in a motivating, social setting.	/	X	X	/
Baines & Danko (2010) Canada	Community mental health	Consumer-initiated song-based paradigm client-centred empowerment model of consumer inclusiveness. Use of songbooks and accompanied singing.	Observational case study. Mixed methods. Post intervention questionnaire. Process and outcome study.	Increases in overall motivation and focused thinking and decrease in problematic thoughts. Healthy expression of creativity, and increase in the beneficial expression of emotion, including a reduction of anxiety.	/	X	X	X
Pavlakou (2009) UK	Women with eating disorders	Non clinical context. 6 workshops, twice a week. Stretching, breathing and vocal exercises. Easy songs including rounds, modern and traditional songs from around the world	Observational case study. Qualitative. Post intervention interviews. Process study.	Some specific clinical issues for eating disordered patients were addressed (e.g. control, self-esteem, external belief system, affective expression, perfectionism, autonomy). Participants were able to transfer some of their valuable experiences into their everyday lives.	/	X	X	X
Silverman (2007) USA	Acute psychiatric inpatients	Single session (45 min). - Group psychoeducational music therapy (Sing along to a song chosen by therapist and lyric analysis) - Psychoeducation	Experimental, RCT. Single session post intervention questionnaires and analysis of recordings. Quantitative. Process and outcome study.	No significant differences in measures of helpfulness, enjoyment, satisfaction with life, or psychoeducational knowledge. A number of process differences however. (i.e. verbalisation numbers and content).	X	X	X	X
Kim *et al.* (2006) Korea	Adolescent11-12 year old female	Mainstream school, 6 session (90min) Five sessions on consecutive days of 1 week followed by one additional session 6 weeks later. Music listening and group singing, changing tempo and tune in music, song-writing and movement.	Experimental case study. Qualitative: analysis of video recordings and of perceived changes. Process and outcome study.	Although the nurse therapists observed positive changes in interpersonal relatedness, only one quarter of the participants recognized these changes. Many adolescent girls perceived one or more benefits related to emotional functioning.	X	/	X	/
Bailey & Davidson (2003) UK	Homeless men	Choir rehearsal. No choice of repertoire.	Observational case study. Qualitative interviews post intervention. Process study.	Therapeutic properties in emotional health, social interaction and reconnection through performance, group process, and mental stimulation.	/	x	x	/

2.4.3 [B] Vocal improvisation in individual music therapy (no group)

Although a lot has been written about individual improvisational voicework in the music therapy literature (Austin, 2009: Baker & Uhlig, 2013; Warnock, 2011), most of these writings are not empirical studies and therefore were not included in this review.

Therefore, studies were allocated to this category when they focused primarily on the use of voice and addressed individual work, without needing to relate even indirectly to improvisation, mental health or music therapy (Table 2.8).

One of the studies (Merret, Peretz & Wilson, 2014) looked at melodic intonation therapy (MIT) and it was included in the review because, although the articles addressing MIT were excluded, this one identified some emotional benefits contributing to the language rehabilitation, which was the primary aim: "Singing is a pleasurable and non-threatening way for individuals with aphasia to express themselves vocally, which may help to enhance motivation" (p. 7).

Another study was extra-ordinarily included in this category as, although the studied subjects were music therapists rather than clients, its implications might be highly relevant to the topic of the present research. Bodner & Gilboa (2006) looked at the emotional communicability of four different instruments: voice, piano, drum and kazoo. The findings from this study give a prominent place to the voice as a highly adaptable and flexible instrument in terms of emotional communicability.

Bodner & Gilboa (2006) found that voice was the best instrument to communicate 3 of the 5 studied emotions: "anger was communicated best on the drum, fear on the drum and the piano, sadness with the voice and the kazoo, and happiness and calmness with the voice" (p. 3). The clinical implications of these findings will be important to take into account when analysing the data from the present study. Also, this paper found that the voice was the instrument whose communicated emotion was most successfully decoded.

Finally, the third study included in this category (Magee, 1998) was in design very similar to the present research as it compared two music therapy interventions. However, its findings might have to be taken with caution as the two conditions introduced two changes at a time, making it difficult to attribute the differences between groups to one variable or the other. Magee compared pre-composed singing versus (mainly instrumental) improvisation. The study concluded that (p. 328):

> *"Songs held temporal and associative properties which enhanced their emotional content and meaning. Through these properties, songs helped individuals to implicitly acknowledge their emotional cores and express unbearable feelings which could not be stated in words. Improvisation possessed primarily interactive properties which validated individuals' emotional states, expressed through music. Although, for some, this resulted in feelings of failure and increased dependence earlier in the therapy process, as the relationship developed over time, the interactive properties served to validate the individual's expression. The combination of physical and interactive properties caused effects on self concepts and shifted individuals' sense of Identity."*

It will be interesting to see of this differentiation between greater emotional expression in the pre-composed condition and greater interactive properties and concept of self in the improvisation condition becomes a relevant feature when comparing vocal improvisation and instrumental improvisation in the empirical stage of the present research.

This section has highlighted the safety that structured singing in the form of songs can provide (Merret, Peretz & Wilson, 2014; Magee, 1998). This compliments the findings from the previous section regarding the potential challenging nature of improvised singing. The emotional communicability of the voice (Bodner & Gilboa, 2006) also is an important finding from this section with potential implications for clinical work.

Table 2.8: Results from category [B] Vocal improvisation in individual music therapy (no group)

Author (year) Country	Client group	Setting, Number of sessions, Intervention	Results	MT	Vo	Im	Gr	MH
Merret, Peretz & Wilson (2014) Australia	Aphasia	Language rehabilitation. Melodic Intonation Therapy (MIT)	Neuroplastic reorganization of language function, activation of the mirror neuron system and multimodal integration, utilization of shared or specific features of music and language, and motivation and mood. Singing is a pleasurable and non-threatening which may help to enhance motivation to continue with an intensive therapy regimen.		x			/
Bodner & Gilboa (2006) Israel	Music therapists, general public	N/A	Anger was communicated best on the drum, fear on the drum and the piano, sadness with the voice and the kazoo, and happiness and calmness with the voice. The voice was most successfully decoded	x	x	x		
Magee (1998) UK	Acquired non-traumatic neurological illness	Residential neurorehabilitation hospital 2 conditions (1 week apart) - Pre-composed song material - Improvisation: Mostly instrumental, however occasionally involving vocalisations too	Songs helped individuals to implicitly acknowledge their emotional cores and express unbearable feelings which could not be stated in words. Improvisation possessed primarily interactive properties which validated individuals' emotional states, expressed through music. The combination of physical and interactive properties caused effects on self concepts and shifted individuals' sense of Identity.	X	X	/		/

Table 2.9: Results from category [C] Group vocal improvisation (no therapeutic aims)

Author (year) Country	Client group	Setting, Number of sessions, Intervention	Results	MT	Vo	Im	Gr	MH
Keeler *et al.* (2015) USA	Non-clinical singers	- Performance of the music as it was written. - Performance of the music following the syntactical harmonic structure of the composition, with improvised melodies.	Group singing reduces stress and arousal, as measured by ACTH, and induces social flow in participants in both conditions with no significant differences. Higher levels of plasma oxytocin in the improvised condition.		x	x	x	/
Siyuan *et al.* (2012) USA	Non-clinical rappers	N/A	Improvisation, contrasted with conventional performance, was associated with relative decreases in activity in supervisory attentional and executive system, reflecting a state in which internally motivated, stimulus-independent behaviours are allowed to unfold in the absence of conscious volitional control.		x	x		
Chong (2010) Korea	non-clinical university students	N/A	Enjoyment of singing (88.3%) for: self-expression, aesthetic experience, interpersonal relationships, stress reduction/mood change, spirituality, empowerment/identity, and self-actualization. Enjoyment when alone (8.2%), no enjoyment of singing (3.5%).		x			/

2.4.4 [C] Group vocal improvisation (no therapeutic aims)

Similarly to the previous category, the literature relevant to this category (which is very scarce anyway) is rarely presented in the format of empirical studies. Only one study (Keeler *et al.*, 2015) was directly relevant to this category, but two other titles were included here as they were relevant to the study and were not related to any therapeutic considerations (Table 2.9).

Keeler *et al.* (2015) compared a pre-composed condition versus an improvisation condition in order to study the neurochemistry of singing, looking at levels of social affiliation, engagement and arousal. The study found that the only significant differences between the two conditions were the higher levels of plasma oxytocin, which is associated to increases in trust, in the improvisation condition.

Although the improvisation condition did not seem very naturalistic, at least for a music therapy session as it was based on a highly structured harmonic sequence, these findings might be relevant to take into account when looking at therapeutic alliance and group cohesion in the present research.

The study by Siyuan *et al.* (2012) has been included although it looks at individual lyrical improvisation as it provides interesting and relevant findings relating to the neural correlates of lyrical improvisation in rappers, which is a common genre used in adult mental health music therapy (Short, 2014), and the findings might be very relevant to some therapeutic processes. This study again compared a pre-composed condition with an improvised one and found that "improvisation was in general associated with relative decreases in activity in supervisory attentional and executive system. [This] reflects a state in which internally motivated, stimulus-independent behaviors are allowed to unfold in the absence of conscious volitional control" (p. 6).

Finally, a last study was included although it did not relate to either group or improvisation, but again its findings had important implications for the present study. Chong (2010) addresses an apparently simple but crucial question: "Do we all enjoy singing?". The findings from this study conducted on non-clinical university students in Korea found that an 88,3% of the respondents reported 'enjoyment of singing', 8,2% reported enjoyment of singing when alone and only a 3,5% reported no enjoyment of singing.

Taking into account that the present research addresses primarily non-singers, these figures are encouraging. However, it is difficult to ascertain up to what extent this population is representative of the potential participants in the present research.

This section provides important findings from neuroscience pointing at the potential for group vocal improvisation to activate certain processes in a distinct way from other forms of music making. The facilitation of bonding reported by Keeler et al (2015) together with enhancing spontaneous self-expression as discussed by Siyuan et al (2012) present interesting bases for the use of GVI in therapy.

2.4.5 [D] Group improvisation in music therapy (no voice)

In this category were included studies that related at least partially or directly to all the model elements but voice: music therapy, group work, improvisation and mental health. Some of these studies also related to the voice in some degree but were put in this category and not in the overlap one because the use of voice was never improvisational, although these studies included improvisation with instruments (Table 2.10).

This category exemplifies the dichotomy presented before of associating the voice with pre-composed material and instruments with improvisation (Pasiali & Clark, 2018; De L'Etoile, 2002; Werner, Wosch & Gold 2016).

For example, Werner, Wosch & Gold (2016) compared 'interactive group music therapy' (group singing, receptive music therapy, instrumental improvisation and dance/movement) with 'recreational singing', concluding that "interactive music therapy significantly reduces depressive symptoms to a greater extent than recreational group singing" (p.147). However, the differences could have been potentially attributed to the different frequency at which the two conditions were administered: 20 sessions of 40 minutes twice a week for the music therapy versus 10 sessions of 90 minutes once a week for the recreational singing.

Another study is very relevant to the present research for its design similarities. Tague (2012) compares general group music therapy to a specific subtype of music therapy, in this case group drumming, and includes a control group. This study looks at mood, behaviour in the unit after sessions, focus on task and interpersonal behaviours. None of these parameters shows significant differences between the two groups. Neither does the study by Mohammadi (2012), who compares 'active' versus 'passive' music therapy.

The studies in this category seem to confirm the widely accepted claim that change in the technique does not reflect a change in outcome (Budge & Wampold, 2015).

This section highlights the evidence for the benefits of group music therapy such as a decrease in depression symptoms (Werner, Wosch & Gold, 2016; Leugner and Hintergerber, 2017), PTSD symptoms (Carr et al, 2012) positive changes in mood (Tague, 2012), increase in motivation for therapy (Mössler et al, 2012). As discussed in the model presented in the first chapter, the present study hypothesises that many of the overall therapeutic processes of group music therapy improvisation in general will be transferable to the GVI interventions and therefore these findings are highly relevant.

Table 2.10: Results from category [D] Group improvisation in music therapy (no voice)									
Author (year) Country	Client group	Setting, Number of sessions, Intervention	Study design	Results	MT	Vo	Im	Gr	MH
Pasiali & Clark (2018) USA	School-aged children with limited resources	Afterschool programme 8 sessions of 50 minutes Combination of pre-composed singing and improvisational instrumental activities and games.	Experimental: single group. Pre-post test. Quantitative, outcome study.	No significant change in individual HBSC subscale scores; however, low-performance/high-risk skills significantly decreased. Significant improvement in communication, significant decrease of hyperactivity, autistic behavioural tendencies and overall problem behaviours, and marginal decreases in internalization as rated by teachers and parents.	x	/	/	x	/
De L'Etoile (2002) USA	Outpatient Adult Chronic Mental Health	Community Mental Health Centre 1h sessions weekly for 6 weeks. Music listening and lyric analysis, music in conjunction with other arts media, instrumental improvisation, song-writing, group singing and music for relaxation.	Experimental, single group, pre-post test. Quantitative outcome study.	While some improvement in symptoms was found, there was no significant improvement in attitudes toward therapy, perhaps as a result of most participants' long-term involvement with the mental health system.	x	/	/	x	x
Silverman (2007b) USA	Adult Mental Health	N/A	Literature review	Participants noted they employed a variety of music therapy techniques such as music assisted relaxation, improvisation, songwriting, lyric analysis, and music and movement to address consumer objectives.	x	/	/	/	x
Leubner and Hinterberger (2017) Germany	Depression	N/A	Literature review	In 26 studies, a statistically significant reduction in depression levels was found over time in the experimental (music intervention) group compared to a control (n = 25) or comparison group (n = 2). Researchers used group settings more often than individual sessions and our results indicated a slightly better outcome for those cases. Additional questionnaires about participants confidence, self-esteem or motivation, confirmed further improvements after music treatment.	x	/	/	/	x
Werner, Wosch & Gold (2016) Germany	Elderly nursing home residents	Care home - Interactive group music therapy: group singing, receptive music therapy, instrumental improvisation and dance movement. (20 sessions of 40 minutes twice a week) -Recreational group singing (10 sessions of 90 minutes 1 a week)	Experimental, RCT. Pre, mid and post intervention. Quantitative outcome study.	Level of depressive symptoms improved significantly more in those assigned to music therapy than in recreational singing.	x	/	x	x	/
Gardstrom *et al.* (2013) USA	Co-occurring substance use disorders and mental illnesses	Residential unit in dual diagnosis treatment program. 3-4 weekly sessions per participant (45 min sessions) Composition, receptive (listening), re-creation (performing), and improvisation	Experimental, randomised trial. Pre-post test. Quantitative outcome study.	A third of the participants who were involved in the treatment groups reported a decrease in anxiety, sadness, and anger.	x		/	x	x

Tague (2012) USA	Psychiatric inpatients	Psychiatric hospital, 6-10 weeks in each condition - GMT (General MT: hello song, group singing, music listening, lyric discussion and goodbye song) - MTD (music therapy drumming: improvisational drum circle), - No music (recreational therapists).	Experimental randomised triel. Pre-post test single session. Analysis of video recordings. Process and outcome study	Positive changes in mood in all three treatment conditions with no statistical differences among groups. No significant differences between experimental groups in observation of behaviours 30min after. Social approval and neutral behaviours were also not significantly different by type of treatment.	x		x	x	x
Carr *et al.* (2012) UK	Persistent PTSD	10 weeks. Combination of active and receptive activities, with emphasis on free improvisation.	Experimental, RCT with qualitative analysis of interviews and content of therapy. Pre-post test. Process and outcome study.	Treatment-group patients experienced a significant reduction in severity of PTSD symptoms and a marginally significant reduction in depression compared to control group	x		x	x	x
Mohammadi (2012) Iran	Inpatients with schizophrenia.	Hospital setting, 4 sessions - Active music therapy (Active group: playing of different musical instruments, singing together and making bodily movements according to the rhythm). - Passive music therapy. - No music therapy sessions.	Experimental, RCT. Pre-post test. Quantitative outcome study.	Both types of music therapy had significant effects, but no significant differences between the groups.	x	/	/	x	x
Mössler *et al.* (2012) Norway	Mental health	Psychiatric clinic, up to 26 sessions (twice a week) 45 min. Music therapy guided by a manual of resource oriented principles: production, reception, and reproduction. Individual sessions.	Observational case study. Pre, during and post measurements. Quantitative process outcome study.	Reproduction techniques might play an important role in music therapy when interacting with clients in mental health care with low therapy motivation. Reproduction techniques might also play an important role in predicting outcomes related to relational aspects.	x	/	/		x
Albornoz (2011) Venezuela	Adolescents and adults. Substance abuse	12 weekly sessions Group improvisational music therapy: participants instructed on how to improvise music using simple percussion instruments.	Experimental, RCT. Pre-post measurements. Quantitative outcome study.	Significant differences found between the groups on HRSD but not the BDI.	x		x	x	x
Troice & Sánchez-Sosa (2003) Mexico	Schizophrenic outpatients	40 sessions (1h) twice a week. Thematic improvisational techniques	Experimental case study. Pre-post measurements in each session. Quantitative outcome and process study.	No statistically significant differences in any of the scales but progress in the qualitative scores. The main changes on the answers “having fun”, which increased by 26.7% at the end of the treatment, and “find a solution to my problems” (27.7%).	x		x	x	x

2.5 Narrative Synthesis Element 4: assessment of the robustness of the synthesis

This narrative synthesis systematic review has followed the guidelines provided by Popay *et al.* (2006) in order make the process of the review transparent and to minimise bias by defining inclusion and exclusion criteria, applying a rigorous search strategy and systematically analysing the findings of the selected studies.

However, the broad and inclusive approach to the inclusion criteria has provided a varied range of article typologies and robustness, not all of the same quality. One of the limitations of the present study is that it has not included a formal systematic assessment of the methodological quality of the included articles. As Popay et al (2006) point out, there is not a well-established method for doing this in literature reviews including both intervention and implementation studies as well as qualitative and mixed methods research. However, this review has aimed at ensuring that "studies judged to be of equal technical quality are given equal weight" (Popay et al, 2006) in order to minimise the bias that could be derived otherwise. The following section provides a review of the methodologies of the included articles and will also contribute to highlight this disparity.

A second limitation of this study, highlighted by Popay et al (2006) as a common issue in similar reviews, is that in some of the studies included the description of the different interventions was not always very detailed, making it difficult to assess whether, for example, an element of improvisation was included or not within 'group singing'.

Due to this heterogeneity, lack of detail in the description of some of the interventions and diversity of the addressed interventions, it was difficult to consolidate enough evidence to develop a new theory in regards to the use of group vocal improvisation in music therapy. Nevertheless, promising findings were identified that will inform the present study.

The use of the four keywords model, with a first search looking at their overlap and a second search looking at subcategories deriving from different combinations of those words, has been valuable in structuring this review and in analysing the included studies. It has also proved to identify discrete areas of research (more clinical, more towards community music, more neurological, etc.) that have been articulated and juxtaposed through the presented model.

Review of studies' methodologies

This literature review has also been useful to assess the methodology of the studies in order to inform the design of the present project.

It was noticeable that an important number of articles introducing a comparison between two types of interventions did not find significant differences in outcome measures between two experimental groups (Silverman, 2011, 2007; Tague, 2012; Mohammadi, 2012) and only one study (Werner, Wosch & Gold, 2016) found a significant difference between the two interventions (group music therapy including group singing versus recreational singing).

The study by Tague (2012), which in design was the most similar to the present research as it compared general music therapy to a particular music therapy technique (group drumming) through a range of observational and self-rated scales, did not show any significant differences in any of the data sets. This study did not include qualitative methods to look at more nuanced differences and all the measures were outcome-based rather than process-oriented.

Other mixed methods studies reviewed here that did not observe significant differences in the quantitative measures relied mainly in the findings from the qualitative and process -oriented methods (Grocke *et al.* 2014; Silverman, 2011, 2007). However, in some cases the weight that had been given to the qualitative part within the study was not big enough to capture deep reflections and sometimes remained in the surface.

One study with a robust design combining an RCT with qualitative findings (Bradt *et al.,* 2016) specifically found in the qualitative data that "participants were highly critical of the outcome measures related to physical functioning, particularly the Multidimensional Pain Inventory (MPI) General Activities Subscale, and the Hospital Anxiety and Depression Scale (HADS) for emotional functioning scale, as not capturing the treatment benefits they had experienced" (p. 11).

Therefore, the findings from this literature review, in agreement with Braakman (2015), suggest using mixed methods and more thorough qualitative and process-oriented tools to study the differences between different music therapy interventions.

2.6 Conclusion

This systematic literature review has organised the evidence that supports the investigation of group vocal improvisation (GVI) as a music therapy technique and has interlinked the findings from neighbouring areas and put them into perspective. The findings of this review suggest that some therapeutic benefits have been documented on different aspects of GVI in the domains of:

- Sense of togetherness and belonging in groups
- Quality of life, positive affect, mood, motivation
- Improvements in clinical mental health symptoms in depression, PTSD and psychosis

Similarly, specificities around the use of voice were also found:

- Emotional communicability advantage
- Structural and symbolic function of songs
- Potential challenges of singing and cultural appropriateness

These findings align well with the proposed model of GVI presented in the first chapter and add more detail around existing practices. Figure 2.6 shows how these new insights have been incorporated into the proposed model of processes. The following sections will discuss these findings further.

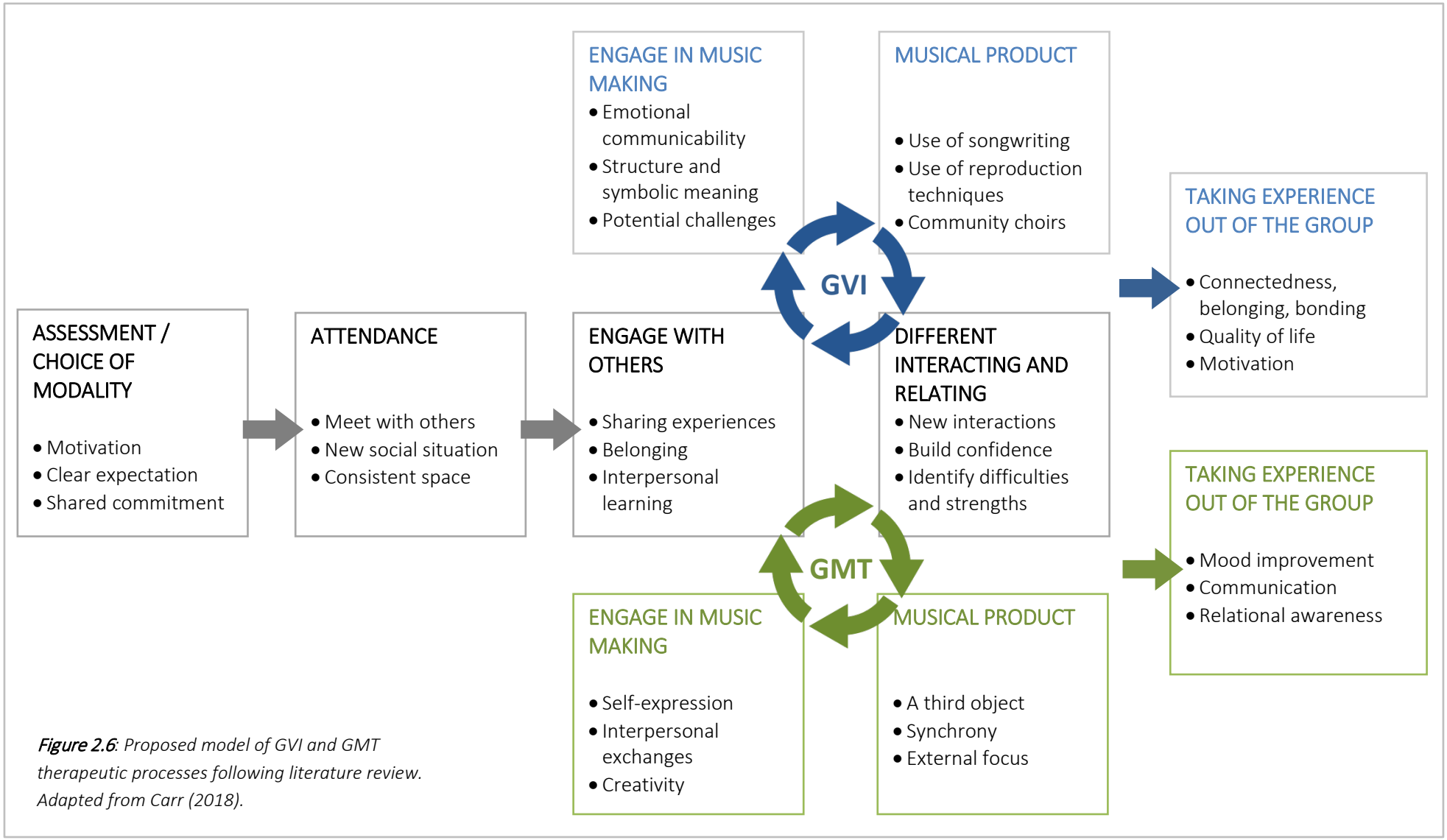


Figure 2.6: Proposed model of GVI and GMT therapeutic processes following literature review. Adapted from Carr (2018).

2.6.1 Scattered evidence

The main finding of this review is that GVI is not yet an established differentiated technique that is researched specifically in the literature. It has been shown how different interventions that involve some form or degree of GVI have been given very different names, from very specific to very generic. It has also been shown how these differences can in some cases respond to differentiated national schools and traditions of music therapy.

This is evidenced by the fact that in the 'Overlap' category, which brings together all the four elements of GVI plus the variable 'mental health', only 3 studies related directly to all 5 parameters (showing an 'X' symbol rather than a '/'): Iliya (2011), Magnis (2013) and Grocke *et al.* (2014). Looking at these studies in detail it is possible to see that even they are not directly comparable to the present project as the following paragraph argues.

Iliya (2011) provides some interesting reflections but they are based in general case examples that are not presented very systematically. Also, in terms of presenting the benefits of the intervention it is very generic and does not provide specific areas of improvement. In the case of Magnis (2013), the intervention is delivered in the form of "6 vocal workshops", which is a short term format that differs slightly from that of therapy. Another difference between this study and the present project is that the participants in Magnis's study were adolescents (12-18 years old).

Finally, the study by Grocke *et al.* (2014) was more angled towards songwriting, with specific output expectations and an element of "performance" at the end of the therapeutic process. This approach, although it uses elements of GVI, is fundamentally different from one where the goal is not to create a well-defined song, but the accent is put on the process of generating different ideas in order to explore interpersonal relationships.

2.6.2 An implicit dichotomy

Another phenomenon that this review has highlighted is the implicit dichotomy within group music therapy in the field of mental health that associates the voice with pre-composed songs (addressed in category A) and instruments with free improvisation (addressed in category D). In the context of this polarisation, GVI could be thought to

happen as a by-product or extra-ordinary event derived from one of these two categories (A and D).

For example, a community choir might sometimes make use of some improvisatory techniques during their warm-up, and whilst this might be an important component of the session it is often not the studied phenomenon. On the other hand, a group music therapy session that is instrumentally-based might involve some improvised singing initiated either by the therapist or one of the members, but again this would not be the main activity, not all participants might join and it might not occur frequently.

Some authors have made this non-specificity of GVI explicit when describing the music therapy interventions studied. For example, in the study by Mössler *et al.* (2012) where the Questionnaire for the Assessment of Music Therapeutic Working Modes was used as one of the data collection methods, the authors point out that "the original scale suggested a separation of vocal improvisation techniques and improvisation techniques in general. This separation was viewed as redundant and we therefore merged the vocal improvisation techniques into the improvisation techniques" (p. 335).

Another example of the presented dichotomy and of the non-specificity of GVI can be found in Magee's investigation (1998) where two conditions are studied, comparing pre-composed song material where "participants chose which instrument the therapist played the songs on and whether the words were sung" versus improvisation, where "mostly improvisations were purely instrumental, however occasionally they involved both instruments and vocalisations" (p. 83).

It becomes clear that the literature reflects a disparate set of working practices. However, it is worth pointing out that the literature reviewed here does not show "what people do" behind the therapy doors. Therefore, it could be that GVI is being used more than it appears in the literature but has not been researched, and it could also be that moments or episodes of GVI happen in music therapy settings that are indeed being researched but they are not being studied as being separate from song singing or instrumental improvisation.

2.6.3 General lines

It is possible to say that, despite the useful and in some cases positive results, the evidence is fragmented in that every study looks at slightly different aspects of different

interventions in different client groups. However, this review has been able to identify some general tendencies that will inform the present project.

In the 'Overlap' section there are generally positive responses in areas such as self-efficacy, quality of life and decrease of depressive symptoms. Some studies also point out at benefits that are specific to singing, such as Tamplin *et al*. (2014) who in their active music therapy group, which was based in vocal techniques, found that the singing was 'challenging' at first but in the end provided an increase in motivation for the participants.

Bradt *et al.* (2016) bring up the notion of culture appropriateness in regards to using 'vocal music therapy' with an African American population. The level of cultural relevance and meaningfulness of group singing is an important aspect of the work that might play a crucial role during the sessions. The present study is conducted in London, with potentially a variety of participant's cultural backgrounds. It will be interesting to note whether this variety has an impact on each participant's reception of the proposed intervention. In this sense, the study by Carr (2014) provides potentially promising grounds for the reception of group vocal improvisation techniques in the UK by mental health service users.

2.6.4 Neighbouring areas

This fragmented evidence is complemented and supported by more thoroughly researched neighbouring areas that have also been captured in sections 2.4.2 – 2.4.5 of this review, corresponding to categories A, B, C and D. The findings from these subgroups are in agreement with some other systematic reviews especially in categories A and D.

For example, category A included studies showing motivation increase, emotional well-being, positive affect, social connectedness and decrease in anxiety, which is concordant with the systematic mapping and review by Clift *et al.* (2008).

As has already been argued in this review, in category B there is a need for more systematic research since many authors have written about the use of voice in individual music therapy (Austin, 2009: Baker & Uhlig, 2013; Warnock, 2011) but this literature is not based on empirical research studies.

In this category, the study by Bodner & Gilboa (2006) supports an argument for the voice as a distinct instrument in music therapy in terms of its emotional communicability advantage over other instruments.

In category C, two studies comparing improvisation versus pre-composed music making (with no therapeutic aims) found that the improvisation condition correlated with a higher levels of plasma oxytocin, which is associated with an increase in trust, and with a decrease of conscious volitional control. Both these biological observations point at specific elements of vocal improvisation that might be very influential and positive for mental health patients.

Finally, in category D general positive results similar to those pointed out in the review by Carr, Odell-Miller & Priebe (2013) have been shown by the present literature review. Despite the general benefits, often no significant change was observed between two experimental conditions looking at different music therapy interventions. When facing this phenomenon, it is important to consider Grocke, Bloch & Castle's (2009) confirmed hypothesis that differences in therapeutic change might not be mediated by difference in symptoms, which are often the targeted outcomes.

An important finding from this section, with potentially great influence on the present study, comes from the article by Mössler *et al.* on music therapy techniques as predictors of change in mental health care (2012). Mössler concludes that "reproduction techniques might play an important role in predicting outcomes related to relational aspects. In contrast to production and reception techniques, reproduction techniques tend to decrease interpersonal problems and increase social relationships" (p. 337).

This is important in two ways. On one hand, it stresses the relevance of adopting an 'improvisatory approach', as has been argued in the introduction of this document, rather than proposing an intervention exclusively based in improvisation only. Moreover, since relational aspects and interpersonal matters are core to the therapeutic work in the context of the present study, it is worth noting that, in theory, it should be easier to introduce reproduction techniques within a vocal medium than with instruments since, whilst all verbal individuals are naturally skilled at modulating their voice, most people do not possess the musical skills to be able to 'reproduce' a pre-composed piece with instruments. Therefore, including some reproduction techniques within GVI might be an easy and useful resource.

2.6.5 Situation of present project within the existing literature

Having reviewed the existing literature on the use of GVI and similar interventions in music therapy for mental health, it is important to situate the present project in relation to the map that has been outlined.

The study will make use of an intervention that is very similar to that described within the label 'vocal music therapy' in the investigation by Bradt *et al.* (2016). It will take place within a clinical setting resembling Grocke, Bloch & Castle's (2009) research: outpatient mental health. The design will also be parallel to this study in that it will include three sources of data collection: self-report, analysis of musical material (and in the present project also analysis of conversation) and a qualitative analysis of the experience after the clinical intervention. In Grocke, Bloch & Castle's case the method used was focus groups and in the present study this data will be collected by means of individual interviews instead.

Finally, the starting point of the study is very similar to that of Tague (2012) in that it compares general music therapy to a sub-type of it. The rationale for these choices will be explained in the following section.

3. METHODOLOGY

3.1 Introduction

The present research will make use of a mixed methods design with a qualitative focus in order to study the use of group vocal improvisation as a music therapy technique. With this choice of a mixed methods approach, this study aims "to participate in dialogue about multiple ways of seeing and hearing, multiple ways of making sense of the social world, and multiple standpoints on what is important and to be valued and cherished'' (Greene, 2007, p.20).

In addition, mixed methods designs combine the strengths of different methods and have been identified as an appropriate methodological start point in music therapy research as it "provides an approach to understand complex music therapy phenomena" (Bradt, Burns & Creswell, 2013, p.124).

Mixed methods designs challenge the notion of adopting a single-paradigm stance as they juxtapose methods that respond to somehow contradictory or mutually excluding worldviews. Different responses are possible in facing this challenge. This study adopts a dialectic stance "in which multiple paradigms may be used in a study, and the investigator needs to honour each of them and realize that the tension among them may lead to new insights" (Bradt, Burns & Creswell, 2013).

An underlying pragmatic approach is also relevant to this study, as different questions regarding the studied phenomenon can be best answered in qualitative or quantitative means, depending on the nature of the questions.

Apart from these global considerations, other more discipline-specific methodological standpoints need to be addressed. Within the field of psychotherapy research there are two complementary types of studies: those looking at outcomes and those looking at the process (Gelo, Pritz & Rieken, 2015). This study will be focusing on looking at how processes of change unfold during therapy rather than the particular outcomes that these processes bring to the clients (Hardy & Llewelyn, 2015).

Process research in psychotherapy is defined by Greenberg & Pinsoff (1986) as the study of the interaction between patient and therapist systems with the goal of identification of change processes as these systems interact. Therefore, the present study prioritises the question 'How does it work?' rather than 'Does it work?'.

This emphasis in the process comes from two realisations. The first one is that due to limitations in accessibility and resources, this study is unable to provide enough participants in order to look at outcomes in a statistically significant way.

The second realisation comes from the evidence gathered through the literature review and from the nowadays established claim that "although the debate between common factors and specific factors remains heated, there is an overwhelming amount of evidence to indicate that there are more similarities in efficacy among treatments than there are differences" (Budge and Wampold, 2015, p.215).

Therefore, it seems more useful and productive to look in depth at the ways in which the therapeutic process facilitates the emergence of the common factors than to focus in measuring outcomes that probably may not be able to capture these subtle changes. However, the study has identified relevant measurable aspects for analysis within its qualitative mixed methods stance, namely a measure of therapeutic alliance.

3.2 Research Questions

Very limited literature has been identified concerning research on group vocal improvisation (see literature review section). Therefore, this study will be mainly focused on exploratory questions regarding the interactions, therapeutic processes and change mechanisms occurring during this specific practice.

Music therapy can be understood as a complex intervention (Carr, 2014) since it involves different components and processes in effecting change, as defined by the Medical Research Council (MRC, 2000). Within this framework, the present research sits in the development stage of the intervention development process as it aims at identifying an evidence base, developing theory and modelling processes and outcomes. This is reflected in the exploratory nature of the research questions of this study.

The following research questions look at different layers of meaning and different perspectives of the same phenomenon: 'group vocal improvisation' (GVI). As has been described before, in order to illuminate the dynamics of the use of GVI this will be compared through a comparative case study design to another practice which will represent 'generic music therapy' (GMT).

3.2.1 Interactions

Research question 1: What kinds of verbal and musical interactions take place in GVI and GMT?

This question is concerned with the types and quality of verbal and musical interactions. By looking at what discursive and musical manifestations arise during the different GVI interventions it will be possible to identify characteristic aspects of interaction. This question will then compare the findings with those from the interactions from the GMT.

3.2.2 Therapeutic processes

Research question 2: What therapeutic processes emerge when using GVI and GMT?

The second question is a further degree of enquiry where the study will be looking at the influence that the explicit communications observed in the first question have in the group's therapeutic alliance. Alliance measures are good predictors of the effectiveness of group psychotherapy (Gelo, Pritz & Rieken, 2015). Therefore, in this section the interest will be put on the therapeutic processes that GVI offers to the participants. Again, the GVI and GMT findings will be contrasted in order to reflect on any potential differences observed.

3.2.3 Change mechanisms

Research question 3: How do patients and therapist experience GVI and GMT?

Finally, the third question will aim to link the observed and measured phenomenon with the reported therapeutic experience from in depth explorations of the significant experiences of GVI by both the participants and the therapist. This will allow the researcher to outline the value and limitations of GVI and to reflect on what might be the underlying change mechanisms. The experiences reported from each modality (GVI and GMT) will then be compared.

3.3 Research Design

Amongst the examples of characteristic mixed methods designs introduced by Bradt, Burns & Creswell (2013), one design presents significant similarities to the three levels of questions of the present research (p.13):

> *"What program will work with a group, how does it work, and why does it work? To answer this question, three sequential data collection phases may be used namely qualitative data collection, quantitative data collection, and then again qualitative data collection. This type of question and data collection procedure serves a program/intervention evaluation purpose."*

This model of mixed methods implies the use of a convergent parallel design. This design consists in obtaining concurrently quantitative and qualitative data. The analysis level still happens within each stream of data independently and the integration of the two types of data only takes place in the discussion, where "the researcher examines in what ways the two datasets converge, diverge, or simply relate to one another" (Bradt, Burns & Creswell, 2013, p.13)

The following table (Table 3.1) shows the design of the study in accordance with the research questions that it answers. As shown here, this study will make use of two types of data: observation and self-report. The terms 'observation' and 'observational' will be used in the description of the present research design to follow the research convention of reporting methods of data collection, despite the fact that the nature of the data 'observed' will be sound and therefore it will be perceived aurally and not visually. The observation will consist in the audio recordings of the clinical sessions and the self-report measures will be provided by the participants and the therapist at the end of each session and at the end of the treatment. Research questions 1 and 2 will be addressed in parallel whereas Research question 3 will be introduced at the end of the clinical work.

In order to illuminate the findings, a comparative element has been introduced in the research design as a point of reference, in order to contrast GVI with a standard music therapy practice. The study will compare the data from the GVI intervention with the data from a general music therapy (GMT) group, as described in the introduction, since the overall purpose of the study is to find out in what ways the use of voice would affect the established use of group improvisation in music therapy groups in mental health settings.

***Table 3.1**: Methodology and design outline*

SUBJECT	GVI as Music Therapy in Mental Health								
RESEARCH QUESTIONS	INTERACTIONS			THERAPEUTIC PROCESS		CHANGE MECHANISMS			
	1) What kinds of verbal and musical interactions take place in GVI and GMT?			2) What therapeutic processes emerge when using GVI and GMT?		3) How do patients and therapist experience GVI and GMT?			
METHODOLOGY	Convergent mixed methods								
	Qualitative			Quantitative		Qualitative			
METHODS	Observation			Self-report		Self-report			
	Measure and categorisation of the interaction dynamics			Therapeutic alliance		Significant experiences			
	Text		Music			Patients		Therapist	
DESIGN	Comparative case study: Group 1 – GVI, Group 2 – GMT Naturalistic, longitudinal study. Purposeful sampling								
DATA COLLECTION	G1	G2	G1	G2	G1	G2	G1	G2	G1	G2
	Verbatim transcription		Audio recordings		Questionnaires post session (GSRS)		Interview		Process notes	
DATA ANALYSIS	Interaction analysis				Statistical analysis		Thematic analysis and IPA		
	Comparison G1/G2		Comparison G1/G2		Comparison G1/G2		Comparison G1/G2		Comparison G1/G2	
	Discussion of results								

The notion of GMT is used in this study similarly to Tague (2012), where general music therapy (GMT) is compared with music therapy drumming (MTD). Paradoxically, Tague uses mainly vocal interventions within the GMT condition in order to "provide maximum contrast between a MTD [drumming] group using musical instruments, the GMT group using music activities without instruments". However, in the UK it is considered an established and standard practice to focus in free instrumental improvisation (although of course not exclusively), especially within mental health groups (Carr, 2012; Odell-Miller, 2007; Wigram, 2004).

At this point it is important to note that the comparative nature of this case study does not aim to provide experimental controlled evidence of causal relations between variables. Instead, the comparison will aim to look at exploring the differences in the nature, intensity and distribution of relationships and meanings. Hermeneutic analysis will inform these comparisons through a systematic interpretation process.

The two groups will be facilitated by the same therapist (who is also the researcher – implications of this dual position are discussed in section 3.4 of this chapter), whose experiences will also be relevant in the analysis and discussion. A similar overall therapeutic frame will be shared in the two groups with the defining difference being the focus on the use of instruments in the GMT and the focus on the use of voice in the GVI group. As described in the introduction, the use of voice in the GMT group or of instruments in the GVI group will not be excluded but it will not be encouraged or initiated by the therapist either (apart from the therapist's use of harmonic instruments in the GVI group as explained perviously).

The choice of musical and verbal interventions will be based on the clinical judgement of the therapist as in non-manualised approaches to music therapy. The use of the musical activities will therefore not be pre-determined but rather approached collaboratively and in response to the participants' presentation, suggestions and discussions. However, project planning and clinical strategy will be discussed and explored in clinical and academic supervision.

The data collection and data analysis methods will be the same for both groups, GMT and GVI. The data collected for each of the three research questions from the GVI and GMT groups will be compared once analysed. Finally, in a later stage, the findings from the comparisons of the three research questions will be brought together to inform the discussion of the study's findings. At this stage the discussion will be able to reflect on how GVI is similar and or different from GMT.

The groups will be closed and each group will have 5 members. This number reflects a naturalistic practice in the experience of the therapists and will be a manageable sample for the research purposes as well. Sessions will take place weekly for six months. The decisions on the frequency and duration of the groups is similarly based on previous experience of regular music therapy practice in this setting and specific context as well as on the resource management from the research perspective.

A cross over design was considered in order to provide more direct comparability between the groups. However, given the time constraints of the present study, such design would have implied that each group would have only received each of the interventions for three months. It was considered that clinically, this would not allow sufficient time to develop each of the techniques, especially as the focus of the research was on the process rather than on the outcomes of the groups. A cross over design would also have meant that each participant would have had to agree to take part in both conditions, which might have limited the recruitment of potential participants who might have only consented to take part in one of the two modalities.

Including service user feedback on the design of the present study was contemplated and two research advice service user groups were contacted. Unfortunately, it was difficult to arrange a convenient way to meet with them in the timeframe available. This feedback would have been valuable in further refining the design and discussing different ways of implementing.

3.3.1 Sampling

After some discussion with clinical and academic supervisions it was considered that it would be appropriate to direct the project towards outpatients: patients who have had an admission to the hospital in the past and are now living in the community but are still linked with the Local Community Teams.

Several factors influenced the process of choosing to address this particular client group:

- Outpatients are likely to be more able to commit to weekly sessions
- Inpatient attendance would depend on length of admission, compromising the measures and continuity of data
- Outpatients are more likely to have capacity to provide informed consent to participate in a research project
- There already is a music therapy group for inpatients whereas there is not one for outpatients in the arts therapies department where the study will take place

The recruitment of participants in this study will follow a naturalistic purposeful sampling, which is suited to a small sample and to the use of IPA, as it provides a "closely defined group for whom the research question will be significant" (Smith, 2015, p.28). The potential participants for the study will be identified by the two standard community arts therapies referrers: the local community mental health teams and the arts therapies service.

The two groups will not be diagnosis-specific. Instead, following an assessment with the therapist, the focus will be put on the patients' presentations, trying to group together people who present similarly and who are at a similar stage in their respective recovery journeys.

The inclusion and exclusion criteria for the study will be as follows.

Inclusion criteria

- Mental Health service users within the local community
- Service users managed by the community teams (2 nearest locality teams)

Exclusion criteria

- Service users that the community team considers unable to commit to weekly attendance
- Service users that do not understand or speak English (since this will be the main language used in the group)
- Service users that have had an admission to a mental health hospital in the last 3 months
- Service users who do not have capacity.

3.3.2 Data collection

The data collection methods for this study have been chosen in order to attempt to maintain a naturalistic environment to the research.

Research question 1

The observational data for the first research question will be collected through audio recordings of the sessions. The recordings will be subsequently edited to extract indicative musical fragments.

The sessions were only audio recorded and not video recorded. This decision was partly based on issues of confidentiality and anonymity, but also guided by the focus of the question, since the methodological choices for data analysis did not require the analysis of non-verbal cues for the types of interactional analysis chosen (detailed in following sections). This choice does bring limitations to the level of analysis of the interactions studied but the level of depth provided by the audio recordings was deemed sufficient for the purposes of this research question.

Research question 2

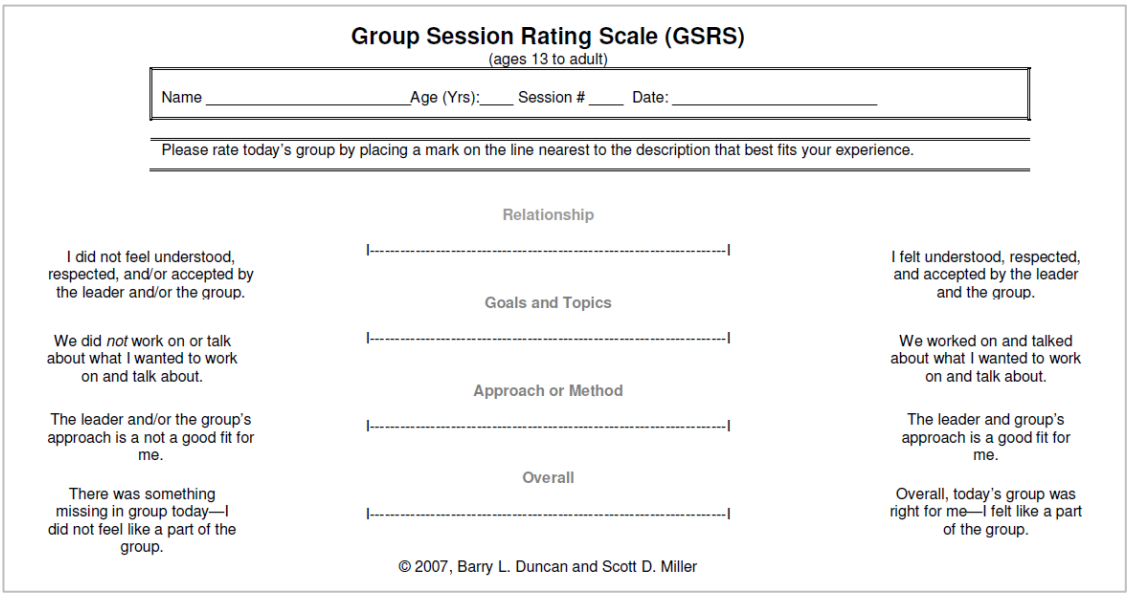
For the second question, the group session rating scale (GSRS) will be used as a measure of therapeutic alliance. This method has been chosen primarily for its ultra-brief format and because of its focus on the process rather than the outcome of the therapy. In addition, from the psychometrically valid psychotherapy measures available, the GSRS, probably due to its succinct approach, has been found to be the most relevant to a music therapy session rather than a talking therapy session.

The GSRS is a four-item visual analogue scale, designed to be a brief clinical tool to measure group-therapy alliance (Quirk *et al.,* 2012). Similar to the construct of group climate and group cohesion, therapeutic alliance is conceptualised as a collaborative experience, characterised by an agreement on treatment goals, methods used to obtain those goals, and the relational bond between client and therapist (Quirk *et al.,* citing Bordin, 1979).

Therapeutic alliance has been identified as a good outcome predictor (Arnow *et al.*, 2013) across dissimilar psychotherapy treatments for chronic depression. Also, relationship components have been shown to be more prominent in group therapy than in individual therapy, where emotional awareness, insight and problem definition are more central.

The parameters measured by the GSRS focus on four items: relationship, goals and topics, approach and overall fit. The items are presented as bipolar anchors requiring a response on the ten centimetre line (see figure 3.1). GSRS scores are obtained by

measuring the marks made by the client and summing the lengths to the nearest centimetre on each of the four lines (Quirk *et al*, 2012).



Group Session Rating Scale (GSRS)
(ages 13 to adult)

Name _____Age (Yrs):____ Session # ____ Date: _____

Please rate today's group by placing a mark on the line nearest to the description that best fits your experience.

	Relationship	
I did not feel understood, respected, and/or accepted by the leader and/or the group.	I----------I	I felt understood, respected, and accepted by the leader and the group.
	Goals and Topics	
We did *not* work on or talk about what I wanted to work on and talk about.	I----------I	We worked on and talked about what I wanted to work on and talk about.
	Approach or Method	
The leader and/or the group's approach is a not a good fit for me.	I----------I	The leader and group's approach is a good fit for me.
	Overall	
There was something missing in group today—I did not feel like a part of the group.	I----------I	Overall, today's group was right for me—I felt like a part of the group.

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Figure 3.1: Group Session Rating Scale

The GSRS is a relatively new measure for therapeutic alliance, but the study by Quirk *et al.* (2012), which compared the GSRS to other more widely used measures (Group Climate Questionnaire, Working Alliance Inventory, and the Therapeutic Factor Inventory – Cohesiveness Scale), found that "GSRS scores correlate with other measures that assess similar key group processes, thus providing evidence for concurrent validity" (p.5). The advantage of GSRS in relation to the other measures is its brevity, since it takes under two minutes to complete the four items, whereas the other measures are significantly longer.

Therefore, this minimally intrusive measure seems an appropriate tool to monitor the group processes. The scale will be filled by the participants at the end of each session. Participants will have to be identified in the questionnaires in order for individual processes to be analysed, but will have the choice of either using their name, their initials or a pseudonym.

No music therapy research studies have been found to have used this process measure. However, the four items seem to be general enough to be relevant to the content and structure of a music therapy session. The present research will be the first study to assess the applicability of this tool to a music therapy context.

Research question 3

Finally, the data for the third question will be collected through individual semi-structured interviews with the participants at the end of the treatment in order to obtain in-depth reflections of their experience of the interventions. Individual interviews are widely used by health care researchers in order to "co-create meaning with interviewees by constructing perceptions of events and experiences" (DiCicco & Crabtree, 2006, p.316).

The interviews will focus on the participants' significant experiences during therapy, looking at what worked best and worst for them and why. This method of data collection focuses on the subjective experiences of each individual, allowing space to provide nuanced and rich views on their therapeutic journey. The interviews will be audio recorded and transcribed verbatim.

Focus groups were contemplated but it was considered that individual interviews would be more appropriate both clinically and in terms of the research aims of this question. In clinical terms, consideration was given to how focus groups could interfere with an 'ending' process which would have already taken place in the last group sessions. The opportunity to have an individual space with the therapist after the end of the group would also contribute to the clinical closing, where it is usual to have individual follow up sessions.

In research terms, the individual interviews offer the opportunity to capture every individual's voice and avoid disproportionate dominance of certain individuals in a focus group context. Also, given the group cohesion that would had already formed during the sessions, there might be the risk of different participants wanting to agree with others' views or arrive at a consensus, whereas, individual interviews offered potentially richer and more varied experiences to be captured.

3.3.3 Data analysis

Research question 1

The audio recordings of the music and the transcriptions of the text will be analysed through interaction analysis. Interaction analysis is an interdisciplinary method for the empirical investigation of the interaction of human beings with each other and with objects in their environment (Jordan & Henderson, 1995).

This analysis will focus in general styles of collaboration (music) and conversation (text). In addition to traditional interaction analysis parameters, this study will also include musical parameters such as timbre, rhythm, variation and motivic analysis. The study by Healey, Leach & Bryan-Kinns (2006) is a good example of interaction analysis applied to music improvisation.

Research question 2

The analysis of the Group Session Rating Scale will be based in the numerical scores across time. A descriptive statistical analysis will provide a picture of quantities and distribution of the alliance scores across time, which will be analysed at a group and individual level.

Research question 3

The transcripts of the interviews will be analysed through thematic analysis. This will allow identifying, organising and describing the data set in rich detail (Braun & Clarke, 2006). Thematic analysis also affords to go one level further to interpret various aspects of the research topic using Interpretative Phenomenological Analysis, the combination of these methods will be further addressed later.

A detailed account of how the data analysis methods will be applied to the data will be provided in the findings section separately for each method used. In order to organise the data and focus the analysis, three levels of analysis will be used dividing the analysis into macro, meso and micro aspects, particularly for research questions 1 and 2, as indicated in figure 3.2.

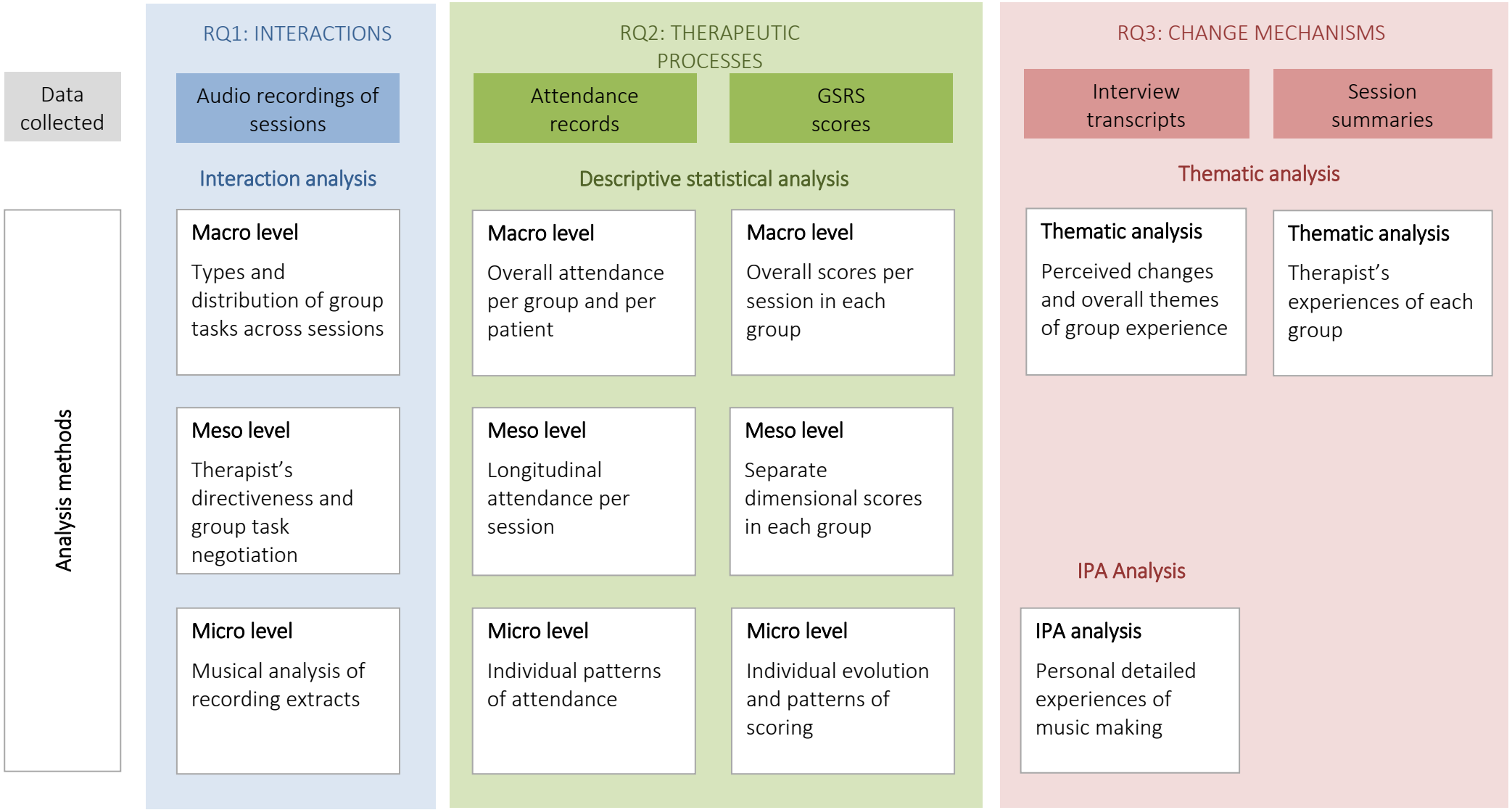
This approach based on multiple levels of analysis, specifically looking at macro, meso and micro aspects, has been used before by music therapists (Plahl, 2004; Pavlicevic *et. al*., 2004; Stige, 2010; Ansdell, 2014) and is a way of "combining different data qualities in a multi-method approach" (Plahl, 2004, p. 5) in order to integrate various perspectives

on one phenomenon and therefore "enhance the scientific reliability as well as the clinical relevance of the findings" (Plahl, 2004, p. 5). This approach provides a richer understanding of the findings from the interaction analysis since:

> "events can be analysed at many different levels from micro- to macro-analysis. There is no single level that is the only possible or the only correct one. To achieve a holistic view of a phenomenon it is necessary to use multiple levels and perspectives." (Plahl, 2004, p. 24)

Although this model of analysis has been used by other music therapists to research practice from an ecological and political perspective (Pavlicevic *et. al*., 2004; Stige, 2010; Ansdell, 2014), in the present project it is used more in line of Plahl's (2004) research. In this case, the macro level will look at different sessions within a group, the meso level will look at different interventions within a session and finally the micro level will look at different participant contributions within an intervention. These findings will later on be compared between the two groups for each level.

Figure 3.2: *Data analysis methods summary*



The combination of these different methods and layers of analysis aims at providing a rich picture of the phenomenon studied in order to be able to explore it in depth and from different angles and perspectives.

3.4 Ethics

This study was registered and approved by the Integration Research Application System (IRAS), which regulates the ethics approval for research project conducted within the NHS. The letter of the Health Research Authority (HRA) Approval is included in Appendix B.

The key areas addressed in the IRAS application were the participants' protection of confidentiality and the procedures by which they would be able to make an informed decision of whether to take part in the study or not.

All the details regarding the treatment of identifiable and anonymised data are described in the IRAS application included as an appendix to this document (Appendix A).

Another important ethical aspect to consider in this study is the dual position of the author as being both therapist and researcher and how to manage the overlapping and potentially conflictual interests of the two roles. The close supervision and methodological tools built in to this project will attempt to counter any potential conflict.

It is acknowledged by the British Association for Counselling and Psychotherapy (BACP) that "in the field of counselling and psychotherapy there is a long history of the practitioner researching work being undertaken with his or her own clients" in the Ethical Guidelines for Research in the Counselling Professions (BACP, 2004). The ethical complexity around this dual position is also acknowledged as well as the effect that it might have "either positively or negatively, both the therapy and the research" (British Association for Counselling and Psychotherapy – BACP, 2004). Below are the five points proposed by this body in order to ensure 'good practice' and how the present study will address them:

1. *Care is taken to ensure that the undertaking of any research by the practitioner is both beneficial to the client and also consistent with the integrity of the research.*

This will be ensured by keeping the clinical needs at the forefront of the clinical work. The author will receive usual clinical supervision which will be separate from the academic supervision for the research process. The researcher is a qualified music therapist having previously worked in this clinical area as well as in this specific setting, with strong links with the MDT to ensure that the practice is well-monitored and recorded in clinical notes.

2. *Thorough consultation, with both a research consultant or ethics committee, and the practitioner's counselling or psychotherapy supervisor, is undertaken before the research commences and continues throughout the duration of the research.*

The present study has undergone the scrutiny of the research ethics committee from the Health Research Authority, which governs the research undertaken within the NHS, prior to starting the recruitment of participants. As mentioned before, during the planning, data collection and analysis, the author was academically supervised by a team of experts in fields of music therapy research, psychology research and group therapy, who all provided advise around the ethical considerations including the dual position of the therapist-researcher.

3. *The challenge of obtaining free and informed consent in these circumstances is adequately considered and the procedures for obtaining consent outlined in section 3.1 followed.*

The study design incorporated the obtaining of informed consent from participants as well as mechanisms for assessing capacity to consent prior to commencing and during the research as has previously detailed.

4. *The impact of the dual relationship is carefully monitored and, when appropriate, addressed in any reports of the research process and outcomes.*

This aspect of self-reflection was addressed by the completion of a research journal, regular supervision and crucially session summaries where the therapist-researcher was

commenting on both the interventions used in the sessions as well as any other reflections.

5. *The use of any records is restricted to the purpose(s) for which they were created and authorised by the client's consent.*

Again, all the clinical work followed the usual clinical information governance procedures and with clients' consent.

Helps (2017) has engaged with her dual position as researcher and family therapist and explores "the ethics involved in the twofold task of providing a clinical service and conducting systematic research" (p. 348), proposing 'dynamic relational ethics of care' as a way of manging the challenges of this position, arguing that "insider research exploring one's own practice fits neatly within a postmodern, social constructionist epistemology and with contemporary reflexive systemic practice" (p. 348).

Aligning with the notion of practice based research, she argues that researching one's own practice in psychotherapy can be thought of as a third layer of professional development which adds a "deeper and more systematic layer of exploration, scrutiny and reflection" (Helps, 2017, p.362) alongside self-reflection on one's practice and use of supervision.

Helps (2017) puts an emphasis on continuing to engage with the ethics around various aspects of the research and practice throughout the project: "Keeping an eye on the ethical issues involved is a dynamic and carefull (*sic.*) activity that persists long beyond the signing of the application to the ethics committee or the signing of the consent form." (p.363). This includes remaining particularly aware of power dynamics and how these influence practice and research:

> "if I do my best to ensure that whatever I do is in the service of the patient rather than in the service of the research question, if I continually stay alive to the impact of my positions, including my power over others, then this can guide me in my thinking about how to go on in my twofold conversations with families. A dynamic relational ethics of care involves using all of the

> 'usual' clinical, therapeutic and relational skills as I go about my research work." (Helps, 2017, p.361)

This quote sums up the notion of 'dynamic relational ethics of care', which this study aims to seek inspiration from.

As well as the dual position of researcher-therapist, this study also presents the bias potential for 'researcher allegiance (RA)' to occur. Researcher allegiance can be a form of expectation bias in psychotherapy research where it "predicts the outcome of treatment comparison studies systematically increasing the effect of the researchers' favoured one" (Botella and Beriain, 2010, p.55). Although the present study is much more process oriented than outcome focused as explained previously, since there is an element of comparison between two groups, it is still relevant to consider its potential impact on the ethical considerations of this project, especially since the 'interest' placed by the researcher in one of the two compared conditions is one of the main factors contributing to this type of bias.

From a constructivist perspective it is possible to say that "we actively contribute to co-create the realities we end up observing because there is no such thing as a pure and 100% neutral observation" (Botella and Beriain, 2010, p.58) and therefore it is difficult to completely block the effects of researcher allegiance. Botella and Beriain (2010) suggest that process research can be a way of compensating this by looking "in more detail at clients' theories of change instead of almost exclusively at therapists' preferred ones" (p.60). He also points at the value of using a multiplicity of methods and research approaches, suggesting that "an alternative approach would call for methodological pluralism in psychotherapy research and especially for an increase in qualitative, hermeneutic, phenomenological and discovery oriented case studies" (Botella and Beriain, 2010, p.63), which aligns well with how the present study is situated.

4. DESIGN

This chapter outlines the practical application of the study's methods in the clinical setting where the music therapy sessions took place. For this reason, the chapter starts by describing the professional and clinical setting and also includes a section on the preparatory clinical work that took place in order to refine the links with the different professionals and clinical teams.

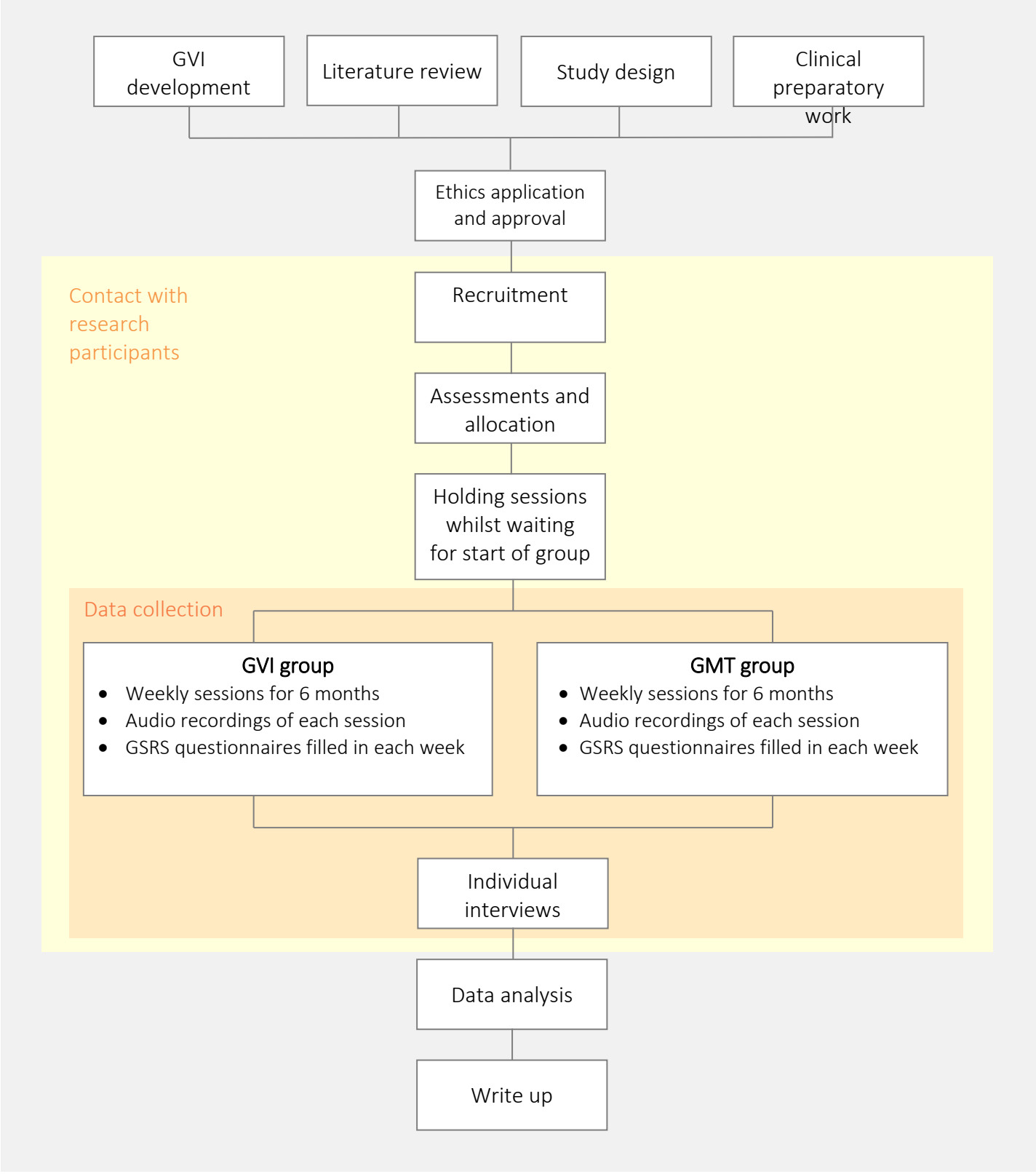
Later, two sections on recruitment and assessment detail the process of identifying and selecting the participants for the study groups. Finally, a section on data collection provides more detail on the different tools for data collection and how these worked in practice.

The Research Protocol document submitted for ethical approval detailing the design described in this chapter is included in Appendix C.

Following an established convention in clinical writing, the document will from this point refer to 'the therapist' in the third person. However, this refers at all times to the principal researcher and author of this thesis, as there were no other music therapists involved in the clinical work for this study.

Figure 4.1 provides a chronology of how the study design was applied to the clinical work and is provided to contextualise this chapter and link the presented literature review and methodology (Chapters 2 and 3) with the findings (Chapter 5) of the study.

Figure 4.1: *Chronology of study design*



4.1 Professional work context

This section will describe the setting and environment where the clinical study was conducted. Given the naturalistic design of this study, it is important to contextualise the work and to demonstrate that the clinical work was devised at all times to be relevant to the needs of the patients in the local service. For this reason, some of the choices and elements of the research frame are influenced by the clinical context, spaces and organisational structures of the milieu where the work is happening.

4.1.1 Arts therapies provision on site

The clinical work was conducted within an existing Arts Therapies team based within a psychiatric hospital in an urban area of the UK. The Arts Therapies provision within the hospital offers both an inpatient service for the patients of the three wards of the hospital itself but also an outpatient service for patients who have been discharged and also for patients referred from the local community mental health teams (CMHT). Other teams such as Psychology, Psychotherapy and Occupational Therapy also offer a similar combined approach seeing both inpatients and outpatients in different areas of the hospital.

The Arts Therapies team on site comprised two part-time music therapists, two part-time art therapists and one part-time dance and movement therapist as well as the therapist/researcher for this project. This team was part of a larger Arts Therapies Service in the wider Trust. Although this local team was relatively small it had been established for a number of years in the hospital and had ongoing clinical supervision as part of its regular monitoring and governance.

In terms of the services offered to the community patients, the hospital had a close link with two main local Community Mental Health Teams (CMHTs). The CMHTs work both with patients who have been discharged from the hospital but require support and monitoring whilst in the community as well as those who have not required an inpatient hospital admission but have high needs and require secondary mental health services.

The Arts Therapies service only takes on patients from what is known as a 'cluster 5' onwards. A cluster is "a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT)", as defined by the NHS (NHS England, 2019). A cluster of at least

5 means that the patients seen have severe psychiatric presentations. Depending on the case some of the outpatients referred to the Arts Therapies team are followed by one of the CMHTs, who hold their case and have an allocated care coordinator. Other patients are considered not to require an open case with the CMHT, in which case their arts therapist is allocated as their lead professional care (LPC).

4.1.2 Space and setting

The Arts Therapies team is based on one of the floors separate from the inpatient wards, containing several arts therapies rooms as well as offices. The initial individual assessment sessions for this study were conducted in the music therapy room, which is dedicated only to music therapy sessions. This is mainly used for individual sessions as it is not very large, although small groups are run there as well. The initial idea was to conduct the group sessions in that space. However, a decision to change rooms was made due to the lack of ventilation in that room which meant that when it was warm weather it became quite hot. Since the group started in June this was a particularly important aspect to consider.

A multipurpose room on another floor, also separate from the wards, was chosen to run the groups. The room in question was used for various groups and activities as well as music therapy groups on other days of the week and so it contained an upright piano and a cupboard full of instruments. This room was less private as some of the walls were made of glass and therefore some of the people working in the offices nearby could see into it, but had a lot of windows and was much larger. The privacy issue as well as the fact that the music might be heard from the offices if it was relatively loud, were factors that were considered as potentially affecting the containment in the group. This was discussed with participants as well as with people working in the offices in order to make all parties aware. The post therapy interviews were again conducted in the smaller room.

Both groups (GVI and GMT) were conducted on the same day at different times that were negotiated with the other therapists who used the room. One group was planned to start at 9.45am and the other at 2pm. The groups were scheduled based on the availability of the majority of the participants allocated to it. In the end, the GMT took place in the morning slot and the GVI in the afternoon slot.

The hospital had only one reception for both outpatients and inpatients and therefore the participants might encounter inpatients whilst waiting in the waiting room or whilst

making their way to the room. This appears significant as most of them had been inpatients in the past and therefore sharing spaces could have a range of associations and trigger different emotions for them.

4.1.3 Music therapy equipment

The two groups took place in the same room but it was set up differently for each. In both cases the chairs for the participants were arranged in a circle in the middle of the room. The pictures below (Figure 4.2) give an image of the usual set up for both. As shown, for the GMT group a range of instruments was disposed around the circle, along with the upright piano. The instruments included:

- Electric guitar (connected to an amplifier)
- Acoustic guitar
- Cello
- Melodica
- Pentatonic xylophone
- Glockenspiel
- Two gato drums
- Tone bass bars
- Two djembe drums
- Darbuka drum
- Bongo drums
- Range of hand drums
- Gong
- Bells of different tones
- Tubular bells
- Rainsticks
- Ocean drum
- Tambourine
- Small percussion: maracas, claves, shakers…

By contrast, the set up in the GVI group included only the upright piano, the acoustic guitar, individual microphones and two amplifiers.

Figure 4.2: Sessions setup

As the pictures show, the overall impression of the room was very different between the two settings as all the instruments were kept in the cupboard for the GVI group and therefore there was a lot more empty space.

4.2 Preparatory work

Before moving to the recruitment and data collection, it would be helpful to discuss the preparatory clinical work that was conducted prior to the start of the research groups. This preparatory work was carried out in order to gain clinical experience on the site with the aim of becoming part of the clinical team within the arts therapies service. The practical application of the present research project required a strong link with the healthcare provision, with its spaces, databases, structures and healthcare professionals in order to be embedded in a real environment.

The clinical work consisted of running a group for outpatients that would focus on the use of voice in order to refine the ideas for referral criteria, data collection and data analysis for the GVI research group. This seemed an important preparation given that the therapist had previous experience of running groups in the GMT style but had never run a sustained music therapy group where the focus on the voice, as proposed in the methodology, would be the main musical feature. It is important to point out that this

preparatory group was part of the therapist's professional clinical activity and no data were collected from it for any research or evaluation purposes.

The preparatory group was part of the clinical provision of the arts therapies service and therefore the referrals for it came through the usual pathways and followed a routine assessment procedure. In this sense, the group was useful in starting to liaise with the local CMHTs and in understanding how they work and how they discuss and process referrals. This liaison with the community teams was very useful in order to plan a feasible and realistic referral process for the participants of the research groups.

Patients were informed that this would be a six-month music therapy group that would focus on the use of voice primarily. Three patients became the core membership of the group, after another patient decided not to join in the end following the assessment. Different group vocal improvisation activities took place in the sessions, both using pre-composed material as the basis for some of the improvisations as well as free verbal and non-verbal improvisations. The therapist tended to be at the piano supporting the group.

The following subsections address some of the emergent themes from the preparatory group and demonstrate how these informed the thinking for the research groups.

4.2.1 Emergent themes in the practice

The preparatory groups provided opportunities to reflect on the challenges and issues of setting-up this kind of clinical intervention focusing on the voice with the outpatient mental health community. Below are listed some of the main challenges encountered whilst setting-up and running the preparatory group.

Dynamic administration

One of the main challenges, which was already anticipated for this project, was the difficulty in getting enough appropriate referrals. This was confirmed as being the case, mainly due to the difficulty of introducing a new service to busy teams who are not directly linked with the arts therapies service, but also due to the specificity of the proposed group. This point will be further discussed in the following section.

It is an established convention that "much thinking and planning has to be done before beginning the assessment of prospective group members" (Behr & Hearst, 2005, p.28). Practical arrangements, preparation of the setting and creation of structures are an

essential part of the group and will have an important impact on the therapeutic process. The responsibility of taking care of the arrangements that surround clinical sessions is often referred to as the 'administrative role' of the therapist, as opposed to the 'expert role', which has to do with the delivery of therapeutic interventions within the sessions.

Within a psychodynamic approach these administrative tasks relating to the management of the group might be seen as having a direct dynamic component. Therefore, this construct is known as dynamic administration: "the term 'dynamic administration' refers to the various activities which the conductor performs in order to create and maintain this setting" (Behr & Hearst, 2005, p.42). The emphasis on not only creating but also maintaining the setting for the group will be more relevant during the process of conducting the sessions, when issues about consistency, continuity and holding a therapeutic container may arise.

It is important that the therapist "takes on these tasks because they have dynamic significance and have to be woven into the material which forms the analytic process" (Behr & Hearst, 2005, p.42). Therefore, the therapist needs to consider the wider system where the group will be placed. As explained in the previous section, much effort went into liaising with the community teams in order to raise awareness of the new group and to obtain referrals, since "the most time-consuming way of stimulating referrals, but also the most rewarding, is for therapists to make personal contact with key professionals in the network to inform them of their intention to run a group, and to describe the sort of person most likely to benefit from that particular group" (Behr & Hearst, 2005, p.39).

However, referrers are not the only parties the therapist needs to liaise with. The following list by Behr & Hearst (2005) of "people who might have dealings with the future group members and whose cooperation will be necessary for a well-functioning group" (p.29) shows the network that needs to be put in place before starting a group:

- potential referrers
- professionals who share responsibility for the care of the patients in the group
- administrators with responsibility for managing the premises housing the group
- colleagues sharing the same work environment

– staff responsible for the secretarial work, reception, administration and security in relation to the group

Taking all the above considerations into account in a practical sense proved challenging during the setting-up of the present project. Some of the reasons contributing to this challenge were the organisational change that the CMHTs were undergoing at an institutional level at the time when the project was starting, or the appropriateness of the referrals.

However, other pragmatic factors contributed to the challenges faced in the dynamic administration of the group. For example, the CMHTs were not based in the same premises of the hospital as the arts therapies service. This meant that no spaces were shared, nor opportunities for discussion arose, other than the weekly meetings that the therapist attended. This issue contributed to the sense of disconnection and made the relationship less fruitful than expected.

Secondly, the priorities and needs of the CMHTs did not always meet those of the therapist, making dialogue difficult. The therapist presented the group to the governance meeting and distributed leaflets to referrers outlining the aims and characteristic of the group following the guidelines by the Behr & Hearst (2005) “a letter or leaflet describing the group in jargon-free terms goes some way towards raising interest and allaying the scepticism of professionals whose thinking might be geared more towards individual treatment methods or those focused on symptom relief as the ultimate therapeutic goal” (p.38).

Although presenting at the meeting and distributing leaflets was useful, it became clear that in order to generate the amount of referrals required for the research groups it would be necessary to employ further methods for communicating regularly with the CHMTs. Instead, the preparatory group members were referred to the group through the arts therapies team. This meant that all the patients had engaged previously in arts therapies, mostly in individual sessions, and it was felt that they might benefit from further therapeutic input in a group format.

Due to the above factors influencing the referrals for the preparatory group, the three participants who attended the preparatory group were patients who had a special interest in the use of voice and showed some confidence in singing. Although the idea of improvising together with their voices was a new experience, their initial interest and

confidence influenced their capacity to access and make use of different activities involving an element of improvisation.

That group was successful in that it had brought together people with a similar interest and who were able to work together. However, the purpose was not to create a form of music therapy for people who are confident singers, in the same way that music therapy is not aimed at people who are confident musicians, although this might be an appropriate referral reason at times.

Following the preparatory group, it was felt by the therapist that it would be important that in the research groups this aspect was emphasised and that referrals were not based on whether people were particularly confident in the use of their voice, since the aim was to see if it was possible to use GVI techniques in a generic music therapy population, just as any other music therapy technique. Another fear was that if some people were relatively confident in their singing this might affect other patients' self-consciousness in the sessions. This point is further explored in the following section which considers the narratives associated with singing.

Talking about the voice

Following from the previous point, another reflection regarding the communication of the aims of the project to others was that of the implications of presenting a group that focuses on voice work. Talking about the voice proved delicate in different ways, both with colleagues as well as the multidisciplinary team and patients. This aspect might have contributed to the kind of specialised referrals received for the preparatory group.

Different implicit social and cultural associations often came into play when mentioning the voice:

- a group of people singing is a choir
- singing means to 'sing along' to pre-composed songs
- one needs to have a good voice in order to sing
- singing is a 'light', superficial or recreational activity

These became apparent in discussions around this project in different contexts: academia, music therapy, psychiatry and musicology. It also reinforces the argument that was presented in the literature review, where in the bibliography around neighbouring fields some of these assumptions are also implied.

The implications of these associations made the communication of this project difficult at points, as clarifications were necessary. For example, a great emphasis needed to be put when explaining the project to referrers on the fact that patients did not need to have any previous experience in singing, or "a good voice" and did not need to be extrovert and outgoing people in order to be able to take part in the group.

The therapeutic aims also needed to be emphasised beyond the notion of a sing-along session or choir rehearsal. Despite these efforts in making these points explicit and clear, often colleagues made comments such as "how is your choir going?", "will you sing carols for us on Christmas?", and "this patient would be great for the group, she loves to sing along to the songs on the radio".

These narratives were also present when assessing patients for the preparatory group. Some patients' immediate reaction after the therapist mentioned that the group would be focusing on the use of the voice was to withdraw and become hesitant about coming to the group, as if instantly feeling that it was not what they were interested in. Again,

this showed how referrers might not have mentioned it or introduced the idea when suggesting it to their patients and therefore the communication of the 'singing' element had been problematic.

This is an interesting phenomenon and it reflects how strong and deep the relationship between the Self and the voice is (Austin, 1998, 2008; Warnock, 2011) and it will be explored further in the discussion chapter. Whilst this aspect is used in order to substantiate the reason for using the voice in the first place from a theoretical point of view, in practice it turned out to be a potent dissuasive element for some people in accessing the group. Whilst there are many cultural factors that affect how people feel about the idea of singing, there is also an element of identifying with one's voice at an intimate level that already seemed delicate territory.

For this reason, it was felt that for the research groups effort would have to be made in attempting to find a formula and vocabulary for the idea of using the voice that could move beyond the above mentioned associations. Focusing more on the words "voice", "vocal" or "vocalisation" rather than singing might be a starting point, as well as talking about why the use of voice might be important. This also influenced the thinking around group allocation procedures for the research groups.

A more directive stance

When conducting the preparatory group, one of the main reflections from the therapist was that the stance adopted in the sessions appeared to be more directive than the usual client-centred approach that characterises a more traditionally psychodynamic approach. In this traditional approach, the therapist tends to wait for the patient to bring something for the therapist to follow, and this is an approach that the therapist tended to adopt in previous groups. This approach was challenged by the use of voice in several ways as explained in the following paragraphs.

Vocal warm-up

In order to use the voice for singing it is good practice to go through a preparation or warm-up. This does not need to be technical nor fixed, and there is scope for including the patient's needs, worries or preferences within the warm-up, but it still needs to be directed either by the therapist or a patient. This presents as an immediate difference

when contrasted with the use of instruments, which are ready to be played when displayed in the music therapy room.

Although it is perfectly possible to sing without warming up the voice, preparing the body in order to be ready to sing is both useful technically (as it provides exercises to start to activate the parts of the body that will be required for the sustaining of vocal sounds) and also a usual practice in most activities that involve using one's voice in other contexts, such as choir rehearsals or actors' warm-up routines. Moreover, this opportunity for preparing the voice for singing offers good potential to be a transition moment between outside the session and a speaking voice to inside the session, bringing awareness to the body, focusing the attention on the breath and introducing the idea of a singing voice.

Therefore, the fact that there is some preparation and this is usually directed by the therapist was already a more directive and structured approach to the sessions than the therapist had experienced when running other music therapy groups that did not focus on the use of voice. The discussion will provide further reflection on the potential for responsiveness to the group within a more directive role.

Invisibility of the voice

Another obvious difference between the voice and musical instruments is that the mechanism of singing is internal and therefore invisible to the singer: singing is the result of the vocal chords vibrating and the rest of the body providing resonance to the sound produced by the vocal chords, like a sound board. In contrast, the other instruments are external, outside the body, and therefore, paradoxically, might appear as more accessible in that the mechanism of producing the sound is visible.

Although the prospect of playing an instrument can appear significantly daunting for someone who has never played, some of the basic sound possibilities are easy to spot, even to someone who has not experienced the instrument before. For example, in the piano the different keys are clearly visible and in order, similarly to the different strings on a guitar. Other elements such as the pedals in the piano or the frets in the guitar might appear more obscure but it is possible to play the instruments without knowing about those. For instruments with more restricted sound possibilities, such as percussion instruments this is even more straightforward. Although expertly playing some of the percussion instruments available in the group requires specialised knowledge and

practice, when approaching a drum, maracas or a gato drum the mechanisms for producing sound appear as quite straightforward and in that sense can appear more accessible to patients who are independently mobile.

From a psychological point of view, the instruments might also appear more accessible than the voice for some people – depending on their cultural context, individual personality and diagnosis – in the sense of the psychological risk involved. Arguably, it might seem easier or safer to physically reach for a nearby instrument such a drum and make a small, unintrusive sound that the therapist can respond to than make a 'musical' sound with one's voice, which might appear much more assertive and might require a certain confidence, given the strong and intimate association to sharing one's voice.

It is important here to highlight how these considerations reflect a clear separation between the speaking voice and the singing voice. This is not necessarily the case in all contexts or cultures, but in the context of this research it appeared as if using one's voice to sing or to speak were two very different things. A patient who came for an assessment might not experience any difficulties in communicating verbally to the therapist but could feel incredibly exposed by the prospect of singing in front of the therapist or other patients.

This invisibility of the voice therefore meant that the therapist felt that, as well as the warm- up, it was important to model some of the sounds and in some occasions add some limitations in the activities (such as suggesting particular vowels or consonants) in order to show the sound possibilities of the voice and make them more explicit.

No intermediate object

In a similar line, the externality of the instruments means that they can be used as intermediate, transitional objects (Winnicott, 1971) to negotiate the therapeutic relationship (Bunt & Stige, 2014). In this sense, they can be very useful to initiate tentative attempts to start a bond in a relatively safe way. This is another reason why a more directive stance from the therapist might be relevant when working with the voice, in order to bridge this gap when there is no intermediate object. In a way, therefore, the introduction of structure and 'objects' such as pre-composed songs can be an alternative or substitutive way to mediate the relationships in the music.

As was seen in the pictures showing the set up for the two research groups, the space appeared a lot emptier when taking the instruments out of the equation, which possibly also contributed to the therapist feeling pushed to be more actively present in order to support the patients in navigating this empty space.

Despite the various presented factors which contributed to the therapist adopting a more active approach, it was possible to maintain a client-centred approach at the core of the work and in how the therapist thought about the work whilst being slightly more directive and without shifting into a psychoeducational or teaching stance. This was particularly relevant in the points in the sessions where there were spaces for discussion and reflection on the musical interactions. Providing some structure and direction appeared important and relevant to the clinical situation, but did not feel to the therapist as abandoning the main central skills and ways of approaching the work from a psychodynamic perspective, although there were some tensions at points in the therapist's mind in how to reconcile the stance and the frame.

Since this was an important feature of the research groups as well, this will be discussed in depth in the findings and discussion sections.

4.2.2 Reflections for the main study

As has just been presented, the preparatory group provided an opportunity to rethink the methods, design and content originally proposed for this project in terms of appropriateness, limitations and access. Below are some of the considerations that were derived from the emergent themes in the practice from the preparatory group, which have just been presented.

Referrals and liaison with CMHTs

Given the difficulties of obtaining referrals for the preparatory group, the possibility of running an additional 'pilot group' prior to the research groups in order to refine the intervention and try some of the methods was viewed as problematic and eventually discarded. This would have meant to have two waves of referrals: one for the pilot and one for the main study, which would have required more resources than were available. It was considered that putting all the effort in just one phase of recruitment would be more efficient.

Another element that became clear was that a greater and more regular physical presence in the CMHTs would be needed in order to remind referrers about the study and support them in thinking about possible participants. This would have been necessary in order to obtain appropriate referrals and to discuss the groups in more detail with regard to the 'singing' aspect of the GVI group.

Similarly, thought was given to how to make the idea of the use of voice more accessible to the potential participants. One of the ways to mediate this was to do a joint assessment for both groups and to involve the participants in the allocation process, in such a way that when they learned about the vocal element in the initial meeting they could think about it whilst knowing that their choice of instruments or voice would be at the centre of the decision on allocation to one group or the other. This would mean that they would have some time to consider the voice for the three remaining assessment sessions and try some vocal exercises before deciding. It would also give them a taste of vocal improvisation beyond the associations that they might have had initially about it. This will be detailed later when the assessment process is described.

Questionnaire

The rationale behind choosing the Group Session Rating Scale (GSRS) was explained in the methodology section. In the original proposal other validated measures were considered, such as the Group Climate Questionnaire (GCQ) and the Curative Climate Instrument (CCI). During the work with the preparatory group it was considered that introducing the GCQ or CCI might feel slightly intrusive towards the therapeutic relationship due to the length of these measures.

Therefore, there was a need to find a similar measure that was more synthetic and less time and energy consuming. The GSRS seemed the best option as it is the only ultra-brief measure of therapeutic alliance in groups available. Brevity was an important attribute given that the questionnaire would have to be administered at the end of each session and therefore it was important that it did not take a long time to complete.

The GSRS also had the advantage of being more easily relatable to a music therapy context than the others given the generality of its statements. Whilst other questionnaires developed for talking therapies were specific in enquiring about the verbal aspect of the interventions, the GSRS refers to a more generic sense of the session and the questions are less specifically worded for a talking therapy context. This was an

important aspect in enabling the participants to answer a questionnaire that felt relevant to the sessions.

Therapist's stance

Finally, the therapist's stance in approaching the preparatory group was an issue that became relevant to setting up the study groups. Adopting a more directive and proactive stance was initially uncomfortable as it felt far from some of the therapist's preconceptions. This invited a process of self-enquiry where the therapist thought, together with supervisors, about the affordances and frame implications of different therapist stances. The preparatory group was very useful in this sense to anticipate questions around the frame which then became relevant again for the research groups.

Each therapist is influenced by different factors such as their training, their client group and their own character when forging their identity as a therapist, which will continue to evolve through their career. Since the therapist had only recently qualified when undertaking this research, questions around frame and therapeutic identity were not still deeply engrained or established and although this felt disorientating at times it also provided a relatively open mind to considering different options. A further reflection on this process and the considerations around the stance and frame will be discussed throughout this document.

4.3 Recruitment

This chapter has so far explored how the preparatory group supported the thinking around the recruitment and running of the groups. The following sections will detail how the methodology was applied in the design of research groups. They start with detailing the recruiting process from introducing the group to the CMHTs through to analysing the referrals obtained and the group allocations for the study's participants.

4.3.1 Introducing the project

The recruitment for the research groups started with a presentation at a strategy meeting with the heads and managers of the two local CMHTs. The study was introduced and the teams were encouraged to refer to it. Leaflets for potential participants were distributed (included in Appendix I) as well as guidelines for referrers (included in Appendix H). It was then agreed that the therapist would be attending their team

meetings weekly to remind referrers about the study and to point them towards the leaflets, which were always available in the team's offices.

In the initial presentation as well as the weekly visits to each of the two teams, the simplicity of the referral was highlighted, as it was felt that given the significant pressures on the teams it would not be feasible to expect them to fill in complex referral forms. Instead, they were invited to just write an email stating briefly the patient's presentation and why they thought referring to the group would be a good idea.

Another aspect that was emphasised when liaising with the CMHTs was the fact that each of the participants referred, if it was felt that it was an appropriate referral, would be offered three assessment sessions. Given the long waiting lists for other support services, this aspect was particularly well-received by referrers.

Liaising regularly with the teams appeared to open up communication channels which were helpful in obtaining referrals for the study. Being able to discuss individual cases in the meetings and to explain the aims of the research in an informal way, beyond the documents provided was also useful.

Through the course of the first weeks of recruitment the therapist was able to identify individual professionals who showed particular interest in the study and who started referring some of their patients. It was interesting to see how a small number of specific professionals provided most of the referrals.

4.3.2 Referrals summary

The recruitment process took slightly longer than originally planned, as it spanned over six months. During that time, a total of 28 referrals were received. These comprised different diagnoses such as bipolar affective disorder, schizophrenia and depression. Of these 32% per cent were women and the average age was of 49 years old. The referrals came from a variety of professionals from the two teams, ranging from nurses, social workers, psychologists and consultant psychiatrists. A more detailed demographic analysis of the final participants will be provided later and the full list of referrals is provided in Appendix J.

Figure 4.3 shows how the 28 referrals came to the final figure of the 10 participants needed for the study. The referrals were closed when it was felt that the target number

of 10 participants had been obtained. At this point the CMHTs were notified and any further referrals were redirected to the general arts therapies referrals list.

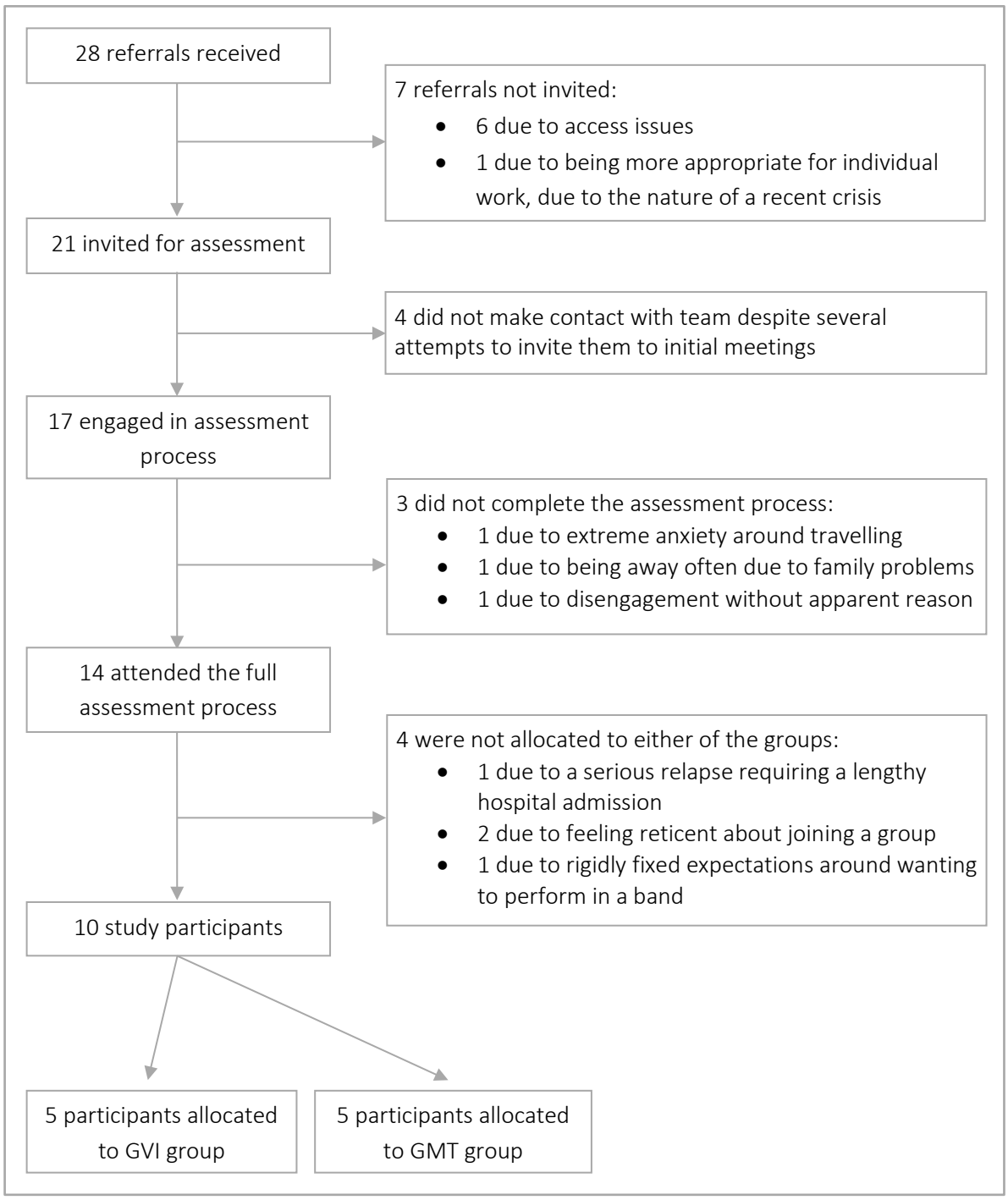


Figure 4.3: Recruitment process

4.4 Assessments

The assessments consisted of an initial 30-minute meeting and three 50-minute sessions. The initial meeting involved initial introductions, familiarisation with the setting and giving potential participants information about the study (Patient Information Sheet included in Appendix E). Patients were informed of the data collection methods and about the two modalities of the study groups.

The aims of the three assessment sessions were to:

- Assess mental state and appropriateness for group therapy
- Assess capacity to make use of the medium (instruments and voice)
- Discuss group allocation collaboratively

At the end of the third assessment session potential participants decided whether they wanted to take part in the research. If this was the case they filled in the consent form (included in Appendix D) and a decision was reached about either an allocation to one of the groups, or if they were open to both, it was agreed that the therapist would let them know before the start of the groups what group they had been allocated to.

Finally, those participants who completed the assessment towards the beginning of the recruitment process were invited to one or more 'holding' sessions. This is a regular clinical practice of offering fewer regular sessions but still some contact in order to maintain the therapeutic relationship and support individuals whilst they are waiting for the start of a group.

Table 4.1 shows the assessment process of all 17 potential participants who engaged partially or fully in the assessment process and their attendance throughout the 21 weeks that the assessment lasted for in total. The column on the left hand side lists the referrals that engaged at least partially with the assessment process. The number that they have been given corresponds to the chronological order of received referrals (as seen in Appendix J) but on the table (Table 4.1) they have been ordered according to when the first session was scheduled in order to show more clearly the flow of referrals chronologically. The last column of the table corresponds to the identifier that has been used for each participant throughout this document.

Table 4.1: Assessment process throughout 21 weeks [Legend shown in the next page]

W	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	
R1	IC	A1	-	A2	A3					H			H			H		-		H		
R3		IC	-																			
R5		IC	A1	A2	A3				-						H		H					
R4		-	-	IC									A1	A2	A3							P6
R6			IC	-	A1	A2	A3			H			H									P5
R11					IC	A1	A2	A3					H			-	H					P2
R9					IC	A1	A2	A3				H			H			H				P7
R8					-	IC	-	A1	A2	-	A3			H								P9
R12						-	-	-			IC				-	-		-		-		
R14								IC	A1	A2	A3			H				H				P1
R21								IC	A1	A2	A3											
R13									-			IC	A1	A2	A3							P8
R22									IC		A1	A2	A3				H					P3
R24													IC	A1	A2	A3						P4
R25																IC	A1	-		A2	A3	P10
R26																	IC	-	A1	-		
R27																		IC	A1	A2	A3	

This table (Table 4.1) shows three categories as indicated in the table below (Table 4.2): the referred patients who completed the assessment fully and partially and those who became part of the study.

Table 4.2: Legend for assessment process table	
	Assessment completed: suitable for the project
	Assessment completed: not suitable for the project
	Assessment only partially attended.
IC	Attended 30min initial individual consultation
A	Attended a 45 min individual assessment session
H	Attended a 45 min individual holding session
-	Did not attend scheduled appointment

The assessment sessions were very important to the study clinically, and in beginning to inform the narratives and cultures of each of the research groups despite no data being gathered from the assessment sessions. As in the beginning of any therapeutic relationship, establishing a therapy contract and the foundations for therapeutic alliance to emerge are fundamental processes. The collaborative discussions around allocation to either the vocal or the instrumental group as well as consent to take part in research were helpful in establishing these bases.

4.4.1 Allocation process

All potential participants were encouraged to try both modalities during the assessment and to think about how each might be a useful platform for them to work therapeutically in a group. There were a range of reactions to this, from individuals who had a strong preference before even trying either modality, to others who were more open, to some who initially were more leaning towards one modality and later thought the other would be better. By the end of the assessment process, five participants were clear on what modality they preferred to attend (three for the GVI and two for the GMT), to the point that they would probably not attend if they were allocated to the other group, whereas the other five participants were more or less open to both, as shown in Table 4.3. In the latter cases, allocation was decided based on their availability, group membership and the therapist's assessment of their use of both modalities.

Table 4.3: Modality preferences following assessment		
Preference for GVI	Preference for GMT	Open to both
P1, P3, P4	P7, P9	P2, P5, P6, P8, P10

It was encouraging to see that out of the 10 participants, 8 were open to trying the vocal group following the assessment, where they were able to experience some of the vocal improvisation activities with the therapist.

The rationale for the two patients who preferred GMT was slightly different. In P7's case, she felt very self-conscious about her voice. She did try some vocal improvisation exercises in the assessment but this was very difficult for her. She talked about never wanting to sing in any social situations and it appeared like a major blockage for her. It was discussed that this might be something that could be addressed progressively in the context of individual sessions but it felt for both the therapist and her that this could not be addressed within the group format given her very strong resistance to it. Instead, for P9 there were other cultural factors that played an important role. He assumed that singing was for women and that men play instruments, in a very clear separation. He found the idea of a man singing rather strange and he thought that he would certainly not feel comfortable singing. Here it was important to acknowledge that the work might be encountering avoidance or resistance and in a different clinical context one might find a range of ways to work with this. This example is only provided here in order to reflect on some of the narratives attached to the use of voice.

For the three participants who felt strongly about attending the vocal group there were a range of reasons too. For P1 for example, he was worried that given his sensitivity to pitch he might find the instruments group out of tune, which he felt he would be unable to cope with. It was unclear why he felt that this would not happen if it was a singing group. However, he also talked about previous experiences of music groups where people were just 'banging things'. It seems possible therefore that he associated the instruments with an experience from the past that was not pleasant, whereas he used to sing in his school choir and reported very positive memories from that.

For P3 there seemed to be a similar association with the instruments being loud and chaotic and in some way singing felt more manageable. Due to his diagnosis of Asperger's

syndrome, his worry was around volume levels and the sensory experience from the variety of timbres from the different instruments. Finally, P4 talked about being interested in exploring his voice and also expressed that he had in the past accessed individual music therapy sessions, where he emphasised his experience using instruments, and he reported that he would like to try the singing instead this time.

When deciding how to allocate the groups, particularly the participants who were open to both, one of the criteria was to attempt to obtain balanced groups with pairings of people who shared similar characteristics or presentations as a way of trying to ensure that people could work well together.

This process of allocation was clinically relevant and worked well for the small sample of the present study. In a larger study, allocation based partly on preference following the assessment period could still be done, although some adaptations might be needed if different therapists were participating in the assessments and the different groups, and waiting groups might need to be considered.

4.4.2 Participants' demographics

This section provides some more detail about the demographics of the final participants in order to both introduce them to the reader but also to address the balance of each group and an initial comparison of the two at the starting point.

Table 4.4 provides a summary of the participants' demographic characteristics, including age, gender and diagnosis, as well as a summary of their level of need in different areas of life such their employment situation, social isolation, level of independence in their housing and whether they were accessing any further psychological support. Each of these aspects as well as their cluster and CPA level were scored from 0 to 2 as indicated in the legend in order to provide a picture of the areas of need for each individual. This table provides a total score of the level of need per individual as calculated in the various categories presented. In the last column on the right an average for the scores is provided in order to appreciate the overall difference in the participants' background and context.

As this table shows, the GVI group had overall higher scores, reflecting a greater level of need, particularly around the areas of employment and independence of living. This is indicative of a greater chronicity in average for these participants, who were stable enough to attend the sessions but were able to lead a less active life, in average, due to

the severity and pervasiveness of their illness, which had a greater disability impact for them than for the GMT participants. It is difficult to infer any conclusions from these demographical differences and their impact on the choice of modality, given the small size of the study. Also as has been shown, the narratives attached to the preferences of allocation to the instruments group or to the singing group were varied amongst the different participants.

In terms of diagnoses, it is possible to see that the main types amongst the participants were bipolar affective disorder and different variants of depressive disorders. One participant (P2) from the GVI group was diagnosed with paranoid schizophrenia, although at the time of the study he was not suffering from any positive psychotic symptoms. In the GMT group, there was also a participant (P7) who had relatively recently suffered a manic episode with psychotic symptoms, similarly to P1 in the GVI group, but those were not present at the time of the groups either. As well as the primary diagnoses, previous or concurrent diagnoses are also shown in the table. For example, some of the participants had been diagnosed with Post Traumatic Stress Disorder in the past.

There was also a case of an ambiguous diagnosis of personality disorder for P3, which seemed to overlap with some of the traits from the primary current diagnosis of Asperger's syndrome. Finally, P8 had a diagnosis of dissociative disorder, which apart from the dissociative episodes mainly presented with anxiety. Although the diagnoses were mixed in both groups, there was a stronger prevalence of depressive disorders (3) in the GVI group and a stronger prevalence of bipolar disorder (3) in the GMT group.

Three out of the ten participants were women and the gender balance was discussed in the assessments, particularly with P7, who was the only woman in the GMT group. She felt that she would feel comfortable in the group. In terms of age, the GVI group had a smaller age range, from 36 to 57, whereas in the GMT group the ages ranged from 25 to 61. This was also discussed in the assessment, particularly with P6 and P7 who would be both significantly younger than the rest of the group members. They both felt confident about this prospect. It felt important in this case that at least there were two younger participants so as to provide some pairings, as discussed earlier.

Table 4.4: demographics analysis summary

	DEMOGRAPHICS				DIAGNOSIS	LEVEL OF NEED							
		Age	Average	Gender	Diagnosis	Cluster	CPA level	Further support	Employment situation	Independence level	Isolation level	Total score	Average
GVI	P1	36	47.6	M	F32.3 – Severe depressive episode with psychotic symptoms	2	2	0	1	2	0	**7**	**6.8**
	P2	56		F	F31 – Bipolar affective disorder	2	2	1	0	1	0	**6**	
	P3	57		M	F32.9 – Depressive episode, unspecified F84.5 – Asperger's syndrome. (previously F60 – Personality disorder)	1	1	1	1	1	2	**7**	
	P4	39		M	F20.0 – Paranoid schizophrenia (previously F43.1 – PTSD)	2	2	0	2	1	0	**7**	
	P5	50		F	F32.1 – Moderate depressive episode	1	1	1	2	1	1	**7**	
GMT	P6	25	42.8	M	F31.7 Bipolar affective disorder, currently in remission	2	1	2	0	1	0	**6**	**4.4**
	P7	29		F	F31.7 Bipolar affective disorder, currently in remission (2017: F31.2 manic episode with psychotic symptoms)	2	1	0	0	0	0	**3**	
	P8	61		M	F44.9 Dissociative disorder, unspecified F43.1 –Post Traumatic Stress Disorder	1	1	1	0	0	0	**3**	
	P9	44		M	F31.6 – Bipolar affective disorder, current episode mixed	1	1	0	0	0	1	**3**	
	P10	55		M	F41.2 – Mixed anxiety and depressive disorder.	1	1	1	2	1	1	**7**	

4.5 Data collection

This section will detail the data collection methods presented in the methodology section as they were applied in the study. The data collection took place throughout the 23 group sessions, which ran in parallel for the two groups as has been explained before, from June to December 2018. Following the end of the group sessions, data were collected from the post therapy interviews which took place shortly after the end of the sessions in December 2018.

There were two breaks of one week each throughout the six months of sessions, at the same time for both groups. These breaks were scheduled after sessions 9 and 16 in order to structure the course of the sessions in three phases. The initial phase was longer with 9 sessions, whereas the middle and ending phases had 7 sessions each.

The sources of data collection, as described in the methodology, included audio recording all group sessions, administering a short questionnaire at the end of each session to all participants who attended and audio recording the post therapy interviews. Each one of these data collection methods addressed one of the three research questions of the study, as the following sections detail.

4.5.1 Audio recordings and session summaries

The recordings of the sessions were an observational method of data gathering in order to address the first research question, which enquired about the kinds of interactions that took place in the GVI and GMT sessions.

The sessions were audio recorded with two recording devices which were placed in opposite sides of the room in order to make sure to capture both the music making and the talking from all group members. The recording devices were the same model, which was a Tascam DR-05.

As will be seen in the results section there were technical issues in a small number of sessions which meant that the recording devices turned off automatically halfway through the sessions, and for that reason some of the audio data for those sessions were lost. This was the case in sessions 3 and 4 for the GVI group and session 13 for the GMT group. Apart from these, the recordings of the remaining 43 sessions were obtained without problems and were able to be analysed for the purposes of the interaction analysis which was conducted at different levels, as will be seen in the findings section.

As well as the recordings, after each session, the therapist filled in a session summary form which contained a chronological account of the various events in the session and some reflections to provide some context and further information around the recordings. This was particularly helpful for the sessions where the recordings were incomplete.

4.5.2 GSRS questionnaires

The Group Session Ration Scale (GSRS) questionnaires were a self-report tool for gathering data on the experience of participants after each session. The GSRS is a valid measure of therapeutic alliance, which is one of the fundamental aspects of therapeutic processes and "a reliable predictor of positive clinical outcome" (Ardito and Rabellino, 2011). This data source therefore was aimed at answering research question 2 from a concrete and specific perspective, which concerned the therapeutic processes occurring in GMT and GVI.

The questionnaire only has four parameters, which are scored by making a mark across a 10cm horizontal line that sits in between a positive and a negative statement a different aspect of the therapy in each one of the four lines. As can be seen in Appendix F the horizontal lines did not state specific levels or degrees of agreement or disagreement with the statements and therefore the participants were free to place a mark at any point in the continuum between the positive and the negative statement. Patients also wrote down their name (or initials or pseudonym) and the date in order to be able to identify each questionnaire.

A license was obtained to use the original questionnaire from the author's (Scott, D. Miller) website (www.scottdmiller.com) for research purposes. The questionnaires were printed on A5 sheets of paper and distributed to all attendees for each group around 3-5 minutes before the end of the session and participants were provided with pens. Participants were encouraged to rate their personal experience in the group rather than their opinion of the value of the session or therapist's performance in order to encourage them to be honest in their answers. Prompts were often given by the therapist, like: "feel free to answer the questionnaire in a way that reflects your own subjective experience in the session today rather than rate how good or bad you think the session was. It may be that you thought some parts of it were interesting but you felt disconnected from the group for whatever reason."

Participants did not struggle to answer the questionnaires and this was quickly established as an ending ritual that became rather non-eventful in the sessions. Discussions around how each participant scored the questionnaire did not normally emerge although this was not done in a secretive way either as they could see each other's questionnaires.

4.5.3 Semi-structured interviews

The post therapy individual semi-structured interviews took place between 1 and 3 weeks after the end of the group sessions. These were a method for gathering rich and nuanced accounts of the participants' experience of the course of the sessions in order to answer research question 3, which addressed the change mechanisms for GMT and GVI.

The interviews lasted for up to one-and-a-half hours, and followed the outline of the change interview (Elliott, Slatick, & Urman, 2001), which is shown in Appendix G. The interview covered generic aspects such as positive and challenging experiences as well as more specific questions around significant moments and changes perceived before and after the therapy. Participants were given the outline of the interview's questions on the last group session in order to familiarise themselves with the topics that would be covered.

In order to focus on the research aspect of the interviews, another session for clinical follow-up and discharge planning was planned after the interview. The research interviews were audio recorded and later transcribed verbatim in order to conduct the data analysis. They were recorded with the same Tascam audio recorders as the recordings of the groups.

4.6 Data storage

All the physical data, such as questionnaires and recording devices containing the audio files, were safely stored in the premises of the hospital in a locked cabinet. The audio files from the sessions and the interviews were also transferred to the NHS encrypted computers in order to analyse them.

The data from the study will be kept for seven years before it is destroyed, as approved in the ethics form.

4.7 Methods summary

A sample of 10 mental health service users with heterogeneous diagnoses accessing secondary mental health outpatient services were allocated to one of two music therapy groups running in parallel weekly for an hour for 6 months. Participants attended either a General Music Therapy (GMT) group (n=5), which made use of group improvisation through the use of instruments, or a Group Vocal Improvisation (GVI) group (n=5), which focused on the use of improvised singing. Both groups were facilitated by the same therapist. Sessions were audio recorded and participants filled the Group Session Rating Scale questionnaire at the end of each session. Each participant also attended one individual post therapy semi structured interview with the therapist, following the Change Interview model (Elliott, Slatick, & Urman, 2001).

5. FINDINGS

This chapter presents the findings from the different analyses on the collected data organised in three sections according to the initial three research questions. Each question is introduced and the analysis methods are explained before presenting the findings accompanied by preliminary discussion considerations. The overall findings from the study are then explored further in the discussion chapter where additional considerations for the music therapy practice and discipline are examined.

Before presenting the findings from each of the separate research questions and methods of analysis a short summary of the overall process of each group is provided here to contextualize the following sections.

GVI group summary

This group experienced a slightly disjointed beginning with one participant (P5) joining late due to being away in her home country around the planned start of the group. Another participant (P2) was just recovering from a mental health relapse at this time as well, which also affected her attendance towards the beginning. However, the group progressively became more cohesive throughout the sessions, although towards the middle sessions another participant (P3) disengaged from the group for a few sessions but was able to come back with the therapist's support and encouragement.

The group appeared notably invested in providing peer support between members and sharing experiences of different mental health diagnosis with each other. The music making combined a variety of activities and in each session there was a process of deciding what people felt most comfortable doing on that day. Participants initially showed difficulties freely improvising with their voices and communicated a certain insecurity as well technical difficulty around this. The therapist then designed different more structured interventions to help them become more autonomous with their use of improvised singing.

GMT group summary

This group ended up having only 4 members after one of the participants (P9) dropped out from the study. This conflict marked the group from the beginning, when in session 2 he attended for the first time and was perceived by others as confrontational or challenging of the group's cohesion. P9 attended another session towards the middle of the group and this time the relationships appeared less tense, but he did not return. Another participant missed a number of sessions towards the end of the groups due to a professional engagement which clashed with the time of the group, but she came back for the few last sessions.

The group members were very open to sharing individual introspection towards the beginning, as well as exploring different ways of being with each other through playing different instruments in different ways. The group members felt limited in their musical skills at points and commented on how this affected their capacity to express themselves in more purposeful or intentional ways during the sessions. The group often discussed and compared how different individuals responded to the musical experiences of consonance and dissonance, chaos and order, sameness and variation.

5.1 RQ1 - INTERACTIONS

Research question 1: What kinds of verbal and musical interactions take place in GVI and GMT?

This question was an initial and very exploratory first level of enquiry to start to reflect on the notion of using group vocal improvisation in music. By looking at what happens in the sessions, it is possible to begin to get a sense of where the main similarities and differences are when comparing GVI to the more usual form of clinical group music therapy in this client group, which has been labelled general music therapy (GMT) to help to differentiate it from the GVI group.

As explained previously, the main differential feature of the two groups was that in the GVI group, all musical tasks were concerned primarily with the use of voice, which was supported by the therapist on piano and guitar, whereas the GMT group had a range of instruments available, as is usually the case in music therapy, and participants were

encouraged to use them. The use of voice was not banned from the GMT group, but neither was it encouraged or initiated by the therapist. As will be detailed below there was one instance when the recitative voice featured in the GMT group when one of the participants read out a poem, but never the singing voice. This distinction will be further explored when examining this example in more detail.

This might have been influenced by the fact that all participants were aware that the research had two groups where one was 'instrumental' and the other was 'vocal'. However, the therapist's previous experience in similar therapeutic formats with similar client groups confirms that it is rare that in these situations a client would start to sing or vocalise. It would not be unusual that during a 6 month group singing had not featured spontaneously, particularly as a group.

This initial research question has been answered through an observational method, through analysis of the interactions captured in the audio recordings of the sessions. The analysis has been divided into three different levels of detail: macro, meso and micro.

The first 'macro' level provides a broad account of what kinds of musical activities took place in each session and when, in order to provide both an initial inventory of the different techniques used in each music therapy modality as well as a map of how these were distributed throughout the sessions.

Later, a 'meso' level allows a closer look at how the different activities were negotiated amongst the therapist and participants. For that purpose, three sessions from each group have been selected according both to the participant account of significant moments as well as displaying key moments in the therapist's clinical reasoning, which will be detailed later. The selection was also influenced by an effort to portray all participants at least in one of the sessions, a purposeful selection of different types of interventions and finally an aim to choose sessions that were not too close together in time in order to show a more longitudinal sample that contained one session from towards the beginning, one from the middle and one from the end.

Finally, a 'micro' level will examine in musical detail extracts from the musical interactions from the same three sessions and significant moments from each group to have a chance to get a more concrete sense of what was happening in the groups.

5.1.1 Macro analysis: types and distribution of group tasks across all sessions

The macro analysis of the audio recordings involved timing each of the sessions' recordings and labelling the different tasks of the group. This has been visualised in Figure 5.1. The first main differentiation consisted of marking where the musical tasks took place after which each musical task was described. Once all activities had been labelled, 8 main categories emerged concerned with the content and nature of the activities. These categories served to colour code the different fragments of music from each session in order to provide a global picture of what happened in the sessions.

Figure 5.1: Macro level of audio analysis (legend shown in the next page)

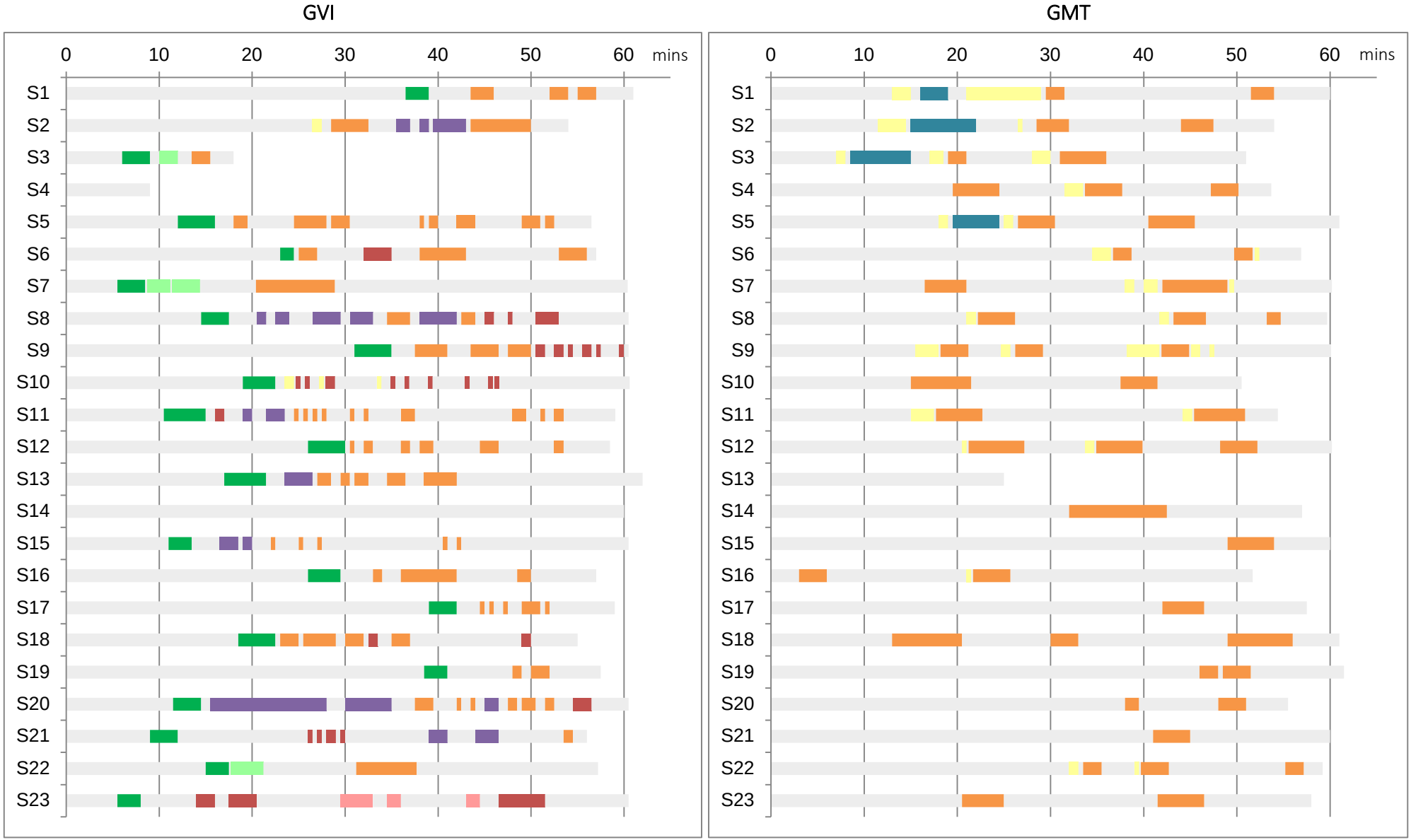


Table 5.1: Legend for macro level figure (Figure 5.1)			
THERAPIST LED		GROUP LED	
	Physical warm up (stretching and breathing)		Group improvisation
	Therapist lead breathing exercises		Making music and talking either preparing for an improvisation or commenting on sounds from an improvisation
	Group creating lyrics for a song as part of a songwriting activity (improvising with words, but no singing)		Individuals sharing a 'sound signature' and commenting verbally with the rest of the group, in turns
	Group singing a learned or pre-composed song		Group discussions
	Individual singing a pre-composed song		

Timing and labelling process

In order to identify and categorise the musical activities, these needed to be defined by separating the 'music' from the 'talking'. Although many aspects of relationships and communication can be understood as musical or having a certain musicality (manifested in the rhythms and interactive phrasing of speech, for example) in music therapy, here the categorisation of music has been based on whether the group was jointly involved in making music together as a collective activity. Further considerations on some categories of mixed verbal and musical engagement are detailed later.

In order to separate the music from the talking, some decisions about timing had to be approximate as there were moments where the two were overlapping, mixing or very briefly alternating, as happens organically in music therapy sessions. Given the scope of this analysis, which was to offer an 'overall' picture, providing specific detail about these occurrences was not the aim and the priority was instead to offer a simplified summary of the musical distribution across the sessions.

Therefore, when the main task of the group was talking this has been considered as non-music, even when there were musical elements briefly interspersed by individual members. However, when the group as a whole became a mix of trying out sounds and commenting at the same time, this has been described as a discrete musical task. As will be described later in more detail, this was labelled generically as 'preparing for music making', as it tended to happen before going into an improvisation, where people were finding and exploring different sounds. Another example of a mixed task that included both music and talking was the activity named 'sound signatures', which will also be described later.

Both of these types of 'musical' activities tended to take place in the GMT group, but there were other cases of mixed activities in the GVI group, which have been marked as different from the group discussions, although the musical content was not necessarily the most salient feature. For example, there were physical warm-ups and breathing exercises where there was certainly a sense of the group being engaged in a task which was different from talking, and where there was often little talking. In the case of the breathing exercises there was also arguably an element of musical creativity through the expression of the breath.

Finally, there was another mixed activity which was specific to the GVI group which was linked to songwriting activities. When either songwriting or elements of it featured in the group there were periods of time in those sessions where the group's task was to contribute verbal or non-verbal phonetic material to be sung later. Although this was less clearly defined in timing than the warm-up and breathing exercises and did not include a particularly musical character, it was again certainly different from other instances of group discussions in that we were trying to generate material creatively and in an improvisatory manner which would later be sung by the group. For these reasons, this has also been marked as a 'musical' task and constitutes its own category in order to differentiate it from the generic group discussions.

Once the various activities had been timed and labelled for each recording, the timings of each fragment were inputted into a Gantt chart (Figure 5.2) in order to produce the graphic representation in Figure 5.1. In order to translate the original data which was counted in seconds into numerical data for the Gantt chart approximations of 30 seconds were made as is shown in Table 5.2. The editing of the audio recordings was done using the software Audacity.

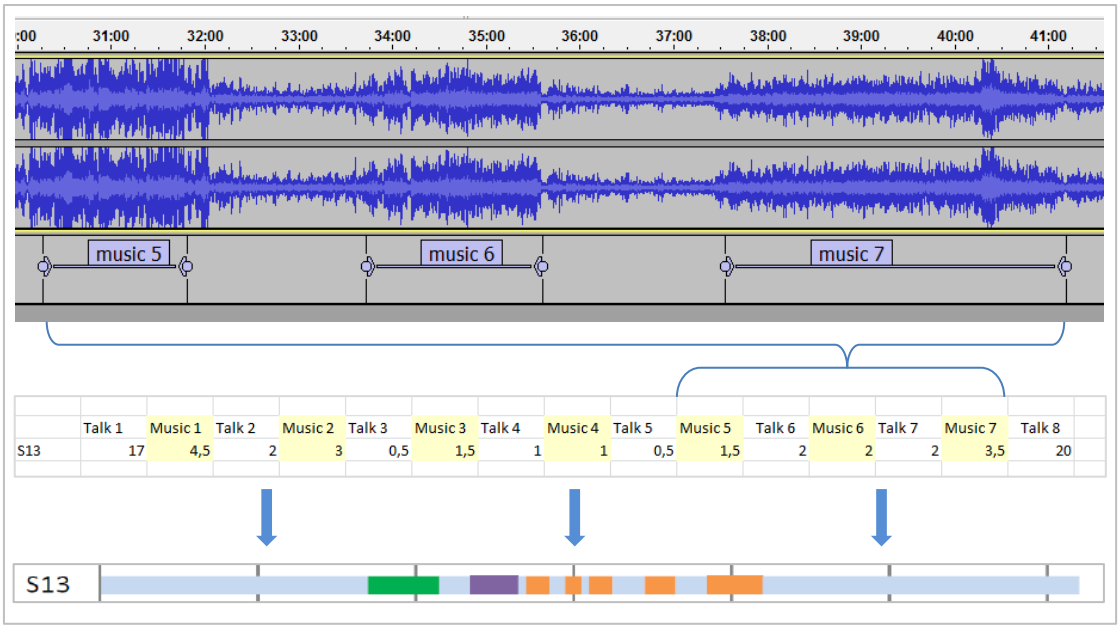


Figure 5.2: Macro data coding and visualization example

Table 5.2: Macro data: calculation adjustment		
	Time in seconds	Numerical adjusted value
Music 5	1,32 s	1,5
Music 6	1,53 s	2
Music 7	3,38 s	3,5

The differences in the total amount of minutes per recording are due to the organic variations in start time of the sessions and to when the recording started, which sometimes was a few minutes into the session. On that note, there are three sessions where the recordings are particularly short. This was due to technical difficulties with the recording devices. This happened on sessions 3 and 4 for the GVI group and on session 13 for the GMT group. Finally, on session 14 for the GVI group there are no musical activities marked, which is due to the fact that only one participant attended (P5) and she preferred to use the session for discussing different issues and preferred not to do any music.

Comparison of timing and distribution of activities

In regards to the initial differentiation of 'musical activities' versus group discussions or 'talking', clear differences emerge between the GVI and the GMT groups are apparent (Figure 5.1). The first most noticeable difference is that in the GVI group there tended to be a lot more instances of musical activities but these also tended to be a lot shorter than the musical activities in the GMT group.

This difference gives a visual sense of a more segmented nature in the music making for the GVI group whilst the GMT group shows more sustained segments in the session. This was echoed in the therapist's perception of the sessions in the reflective notes, where often there was a sense of not achieving a sense of a sustained musical activity in the GVI group when compared to the GMT group. There was a clear sense in the sessions that the vocal activities could not be sustained for long, which is why different activities with different kinds of structures were proposed and tried in order to support participants' sense that they could sustain their engagement. These will be described later in detail.

This idea of the music in the GVI being shorter and more fragmented will be explored further during the analysis of the interviews since different participants from that group commented on the sense of never getting to the full singing. The notion of perhaps further preparation or training needed in order to get to the singing will be considered. However, here it is important to focus on the shorter duration of the vocal activities in itself and reflect on the impact of the more embodied nature of the vocal activities when compared to the instrumental activities.

Despite the fact that playing instruments might involve a greater body movement in terms of range of limb movement for example, it is possible to argue that singing requires a greater engagement of the body in the sense that it requires a constant control of the breath which involves an active bodily awareness in order generate and sustain the sound, as described in the introduction chapter. In a way it is easier to play an instrument whilst being relatively bodily passive than it is in singing. Also, the movement required for the playing of instruments is more externally visible than that of singing, which is internal and therefore less visible. The inner bodily functioning required for singing, although is very similar to that of speaking requires a different control of the breath which, unless has been practiced in the past, can feel relatively alien and new since most of the time those movements in daily life are performed outside explicit voluntary control. Instead, the movements needed for playing instruments at this amateur level (such as hitting, plucking, pressing or shaking) tend to be mechanically a lot more well-known and more easily controlled.

At a more cognitive level, it is also more energy consuming to improvise with the voice than it is to improvise with instruments, at least at an amateur level, since in order to improvise vocally one needs to have an idea of the sound they want to generate before attempting to produce it. Contrastingly, with instruments one can try different 'actions' on the instrument and play with the different resulting sounds that are produced as a consequence of that action. In other words, one needs to 'sing from somewhere', there needs to be some notion of what it is that will be sung before this happens, which requires a more active or more engaged attitude towards the music making than is necessary to participate in the instrumental music making. It arguably is also necessary to have some idea of what to play before one can start to play an instrument, but this can be a lot more vague, timid and exploratory.

These considerations around the different bodily and cognitive processes involved in improvising with the voice and with instruments might be factors contributing to the musical activities in the vocal group being generally shorter and more fragmented than those in the GMT group. A further reflection on this will be presented in the discussion chapter.

The other side to this phenomenon is that, because the vocal activities were shorter and often several instances of the same activity were repeated within short periods of time as can be seen in Figure 5.1, this also meant that it was possible to come in and out music more often and the conversations remained more closely related to the musical activities in between the different 'attempts'. Meanwhile, in the GMT group, because there tended to be more clear separations between the different musical activities, there was a greater sense of the talking being more clearly separate from the music making. At points the conversations would quickly move on to other domains which were less directly related to the musical activities and sometimes it felt more difficult to come back to the music, as it felt as if we were in a different 'way of being' by then.

Other overall comments to make around the timing and distribution of the music making in the sessions are more generic and apply to both groups. For example, it is noticeable that in both groups there is great variability of number and duration of musical activities across the different sessions for each group. Another observation is that often there was a relatively long period of group discussion before the first music activity took place. This tended to reflect that the initial informal check in with the different participants became longer either because of something that had happened to one or more participants that they wanted to expand on, or because a group discussion took off from the individual check ins. Although there was not a particularly formal structure around checking in with everyone at the beginning, this tended to happen spontaneously in the sessions.

It would be fair to consider these phenomena as typical of this format of music therapy – outpatient adult mental health music therapy groups – and they were similarly present in both groups.

Types of group tasks

A second level of differentiation at this macro level consisted of categorising the different 'musical activities', as has been explained before. This process involved firstly a description of each of the activities in terms of the equipment, instruments, instructions formats and structures used. The aim of this categorisation was to show the reader the

different types of techniques as this appeared as a markedly distinct element of each group.

Apart from the five 'mixed' categories, which have been briefly explained earlier in order to describe the process of deciding what was categorised as 'musical activities', there were three further categories that distinguished between different types of music making. These concern mainly whether the music making was improvised or if it was pre-composed, and within the pre-composed whether the activities were done as a group or individually. Below is a table (Table 5.3) with further details for each category.

Table5.3: *Types of group tasks*

Task categories			Description
Talking	*Talking*	Group discussions	Group discussions of different topics, including commenting on the musical activities.
Musical	*Mixed*	Sound signatures	Activity where participants were encouraged to explore different sounds and choose one as their 'sound signature'. Following the phase of exploring and 'finding' the sound participants were invited to share the sound briefly with the rest of the group and to comment on why they had chosen it.
		Preparation	Whole group engaged in trying different sounds whilst commenting on them often in preparation for an improvisation or following an improvisation.
		Physical warm up	Therapist led activity involving gentle stretching of the neck, face and arms as well as awareness of the posture.
		Breathing exercises	Therapist led breathing exercises where participants were encouraged to notice their breath and sometimes certain conditions of air pressure through the use of consonants (such as 's', 'z', 'f' and 'sh') and of duration of inspiration and expiration were introduced.
		Creative writing	Process of ideas-storming verbal or non-verbal material for musical activities. This process often involved inviting individuals to provide their ideas and then a second phase of finding consensus in the group as to how to structure the material gathered.
	Only musical	Group improvisation	Group improvisations ranging from free improvisation to referential improvisation pieces and instances with different types of structures (i.e. duet and accompaniment, different subgroups taking turns, etc.) and sets of limitations (i.e. using certain syllables, using particular instruments, etc.)
		Pre-composed song in group	Reproducing a pre-composed piece of music in a group, either that participants already knew or that was taught in the session
		Pre-composed song individually	Reproducing a pre-composed piece of music individually, either that participants already knew or that was taught in the session

Looking at the distribution of the different categories across the sessions and between groups several clear differences are evident. Firstly, apart from the group improvisation category, the rest tend to be only present in one of the groups, showing a clear distinction between the musical activities happening in the GMT and GVI groups. Also, as will be described later on, the type of group improvisations also tended to be different in format and level of structure in the two groups. In that clear separation of activities, it is possible to see that the GMT group did not have any warm-ups or breathing exercises, as well as creative writing or use of pre-composed music. Similarly, the GVI group did not feature the sound signatures activity and had only a few instances of 'preparation', whereas in the GMT group this is a lot more present.

The other observation when comparing the activities of each group is that in the GVI group there seems to be a lot more variety of activities when compared to the GMT group. Most of the categories described allude to one specific kind of activity whereas others include other subcategories that are relevant to the subject of the study and therefore will be described in more detail in the following sections.

Although this will be discussed later on, it is important to highlight that the aim of describing the musical activities is neither to claim that these are what constitute either a GMT or GVI 'practice', nor to assume that this is an exhaustive catalogue of what might be part of it. Instead, the aim here is to report what activities took place for the reader to understand the kinds of musical interactions that took place in order to be able to reflect on their clinical relevance later on.

Finally, it is also worth pointing out that the choice of activities throughout the six months of sessions did not follow a premeditated plan but rather attempted to respond to the groups' states, interests, capacities and needs in each session.

Group improvisations in the GMT group

It has already been mentioned that the category of group improvisations contained different types of formats of improvisation with varying levels of structure. In the GMT group, the group improvisations tended to be 'free' and on some occasions referential. On those instances the therapist asked the group whether they wanted to name a theme for the improvisation, and if the participants wanted to do this was decided before starting the piece. On one occasion the instrument choice was also set before starting the

improvisation. This was the first session of the group, where one member enquired about whether it was possible to take off the front board of the upright piano. The group decided they wanted to all play on the piano in different ways (e.g. strumming and plucking the strings, playing the keys, knocking on the wooden sides, etc). There was another instance in session 2 where one of the participants suggested that two other participants play a duet. Since this was only the second session and one of the participants was not very comfortable with the prospect, the therapist suggested that they could be on the main melodic / harmonic instruments (cello and guitar) which they had already been playing in the previous improvisation and that the remaining members could accompany them on percussion instruments, which everyone was happy to do.

Finally, there was one other particular case of group improvisation where one participant had brought a poem she had written as other members had invited her to do so when they learned in the previous session that she was a published author. In that case, the poem was used as the reference for the improvisation on two occasions and was also recited by one of the participants during one improvisation. This is one of the extracts that will be further illustrated in the 'micro' section of this analysis.

GVI group activities

Compared to the GMT group, in the GVI group there tended to be a greater variety of formats within the group improvisations as well as a greater variety of activities, as has been already discussed. A full inventory of the activities that took place in the GVI group is shown in Table 5.4, where they have been ordered within a spectrum from the most improvised and non-verbal on the left hand side to the more pre-composed and verbal.

The improvisations in the GVI group tended to have more structure and musical limitations to focus the scope of the improvisations. One of these limitations was when the therapist suggested humming or a specific vowel sound to improvise on. At the same time, such improvisations were often accompanied at the piano or guitar by the therapist who played repeating chords. Although this did not impose a strict harmonic limitation, it certainly framed the harmony in a way that was intended to support the participants by providing a predictable context that would focus the melodic options for the participants.

***Table 5.4**: GVI group activities*

Improvised / Non-verbal						Pre-composed / Verbal	
Sound and movement, call and response in turns	Humming and vowel sounds over piano chords accompaniment	Imaginary language in turns or dialogue a capella	Improvisation with lyrics from a well-known song over chords accompaniment. In turns and together	Syllables in harmony over chords accompaniment in different structures formats and rhythms	Songwriting	Practicing sustaining harmony (major triads or clusters)	Singing well known songs
Air soundscape with microphones over piano accompaniment	Vocalisations, call and response in turns with chords accompaniment	Free improvisation with syllables over piano chords				Learning Yonana (song) a capella, with chords accompaniment, unison and with harmony	Singing carols
	Free improvisation on 'lalala' over piano chords						

When the activities are described as having chordal accompaniment these tended to be on the piano and consisted of either simple harmonic structures using tonic, subdominant and dominant chords, cycles of fifths or combinations of two alternating chords. When this was not the case a more generic description of 'piano accompaniment' has been used. The chords were played on the guitar particularly when doing the 'syllables in harmony' activity, which will be described below.

It is important to highlight that use of the piano to support vocal improvisation has some resonances with the 'vocal holding' techniques described by Austin (2008), although Austin mainly described the use of these techniques within individual music therapy work. The techniques were known by the therapist and were one of the resources that was initially thought that might be useful in some of the GVI group activities.

In terms of the use of the microphones, most activities were done (or could have been done) both with and without microphones. Where it has been specified that microphones were used (soundscape) this is because the reverb effect on the microphones contributed crucially to the sound effects that constituted the soundscape.

Group improvisations in the GVI group

One of the activities in particular requires further explanation. This has been named here as the 'syllables in harmony' activity. This was an activity designed to support the participants in engaging with the idea of harmonising in improvisation in a more accessible way. This was as a result of realising that the notion of singing a different note from someone else at the same time as them was particularly difficult for them. This caused confusion in some participants and others found it difficult to stay in their own lines when someone else came in with a different note. Often they would immediately match the new note. For this reason, we did the activity of practising harmony, both in major triads and in clusters and then this activity was introduced.

This consisted of coming up with four syllables by matching four vowels and four consonants of their choice. The therapist initially requested the group to choose the vowels and then asked what consonant might go well in front of each vowel. Once the four syllables were chosen the group had an opportunity to arrange them in any order that they wanted in order to form two 'words', which would be the non-verbal (verbal, but non-semantic) basis for the improvisation. This was a quick, entertaining and effective way of having a limitation around what to say in the improvisation so that the participants could then focus on other aspects and did not have to continuously think of syllables to sing.

Once the group had agreed on the two words then the therapist suggested that they might say the words all together at a certain tempo with each syllable having the same duration as the others (e.g. four crotchets) and repeat the two words continuously. The participants were encouraged to continue to repeat the words whilst the therapist introduced a sequence of chords (tonic, subdominant, dominant, tonic) on the guitar, at one chord per repetition of the two words.

As this exercise was going on and without stopping the chords the therapist invited the participants to now 'sing' the words instead of saying them. Since no melody had been given but the participants had heard the simple sequence of chords several times they all started to sing the words in different ways. Having had that experience, they were then able to repeat the exercise without the need to speak the words first. Participants were encouraged to explore different 'tunes' and try to stay in their tune without matching others'. The fact that they had 'words' to sing but they did not have to think about them appeared to help them to maintain the focus on the melodic 'horizontal' lines rather than

thinking about the harmony or the vertical harmonic combinations with what others were singing.

Once the participants were familiar with this way of singing some new elements were introduced. The first element was to play with formats, for example singing a 'chorus' (repetitions of the two words) all together and alternate this with duets where only two people sang before going back for the chorus, singing all together. Later, we tried holding one syllable per bar, meaning that the words were spread over four chords rather than one. From this we practiced having half the group singing the short syllables and the other half singing the long syllables simultaneously. Finally, we started to mix all the elements together so that each participant could chose to sing short or long syllables at any time, which again reinforced the sense of holding a separate line amongst the group improvisation.

We used this activity in several consecutive sessions (changing the syllables in every session) as participants enjoyed the exercise and found it a new experience that allowed them to improvise and harmonise. This will be explored further in the analysis of the interviews.

Another characteristic of the GVI improvisations (as well as other activities) was the fact that the therapist tended to model possible sounds, before starting and generally also counted participants in, for example in the syllables in harmony activity. It is interesting to note that, whilst those interventions were felt as necessary in the GVI group, they did not appear needed in the GMT group. Further reflections on the therapist's stance and directive role will be discussed in later sections.

Song writing and use of pre-composed music in the GVI group

The technique for song writing used in the GVI group consisted of inviting the participants to provide a short sentence about a certain topic (i.e. 'how you got here today' or 'what has been the experience in the group like so far'). Each sentence was written on flip chart paper and then participants were invited to arrange the sentences together by ordering, modifying, combining or adding to the existing sentences. Following this process there was a chance to start trying the lyrics out on different melodies, which the therapist accompanied with chords.

The other activity that used verbal language was the use of pre-composed songs. Initially, some members suggested singing well-known songs. The therapist invited them to reach a consensus of a song that they would like to sing in the group and the following week copies of the lyrics were provided. After having sung the song with the therapist's accompaniment at the piano the participants were encouraged to comment on the lyrics and to then choose phrases or words to use as verbal material for an improvisation where the therapist would play a simple harmonic sequence and invite the participants to improvise with the lyrics, initially in turns and later on as a group. This only took place in session 6 initially and then on the last session of the group, which took place just before Christmas and where participants had requested in the previous weeks whether it would be possible to sing carols in the last session.

Another type of activity involving the use of pre-composed music was when the therapist taught an easy song called 'Yonana' to the group. This is a short song that was taught orally in the past to the therapist but whose composer or origin remains unknown despite having researched it. Initially, the main melody was learned and then a higher voice was introduced so sing it in harmony.

Evolution of activities throughout the sessions

Having looked at the differences in the timing, distribution and types of activities for the two groups it is worth noticing how these evolved within the context of a session and across the six months.

Making use of the data from Figure 5.1 it is possible to find out the approximate amount of time dedicated to the musical activities. This has been calculated and the results in numbers of musical activities per session are shown in Figure 5.3. Due to the mixture of different activities, some of which – as has been discussed before – mainly consisted of verbal discussions, the figures are shown with the aim of appreciating the variety and longitudinal evolution rather than for comparing the amount of music between the two groups.

For that purpose, an average of minutes per session has been calculated per each phase of the groups: beginning (sessions 1 – 9), middle (sessions 10 – 16) and end (sessions 17 – 23).

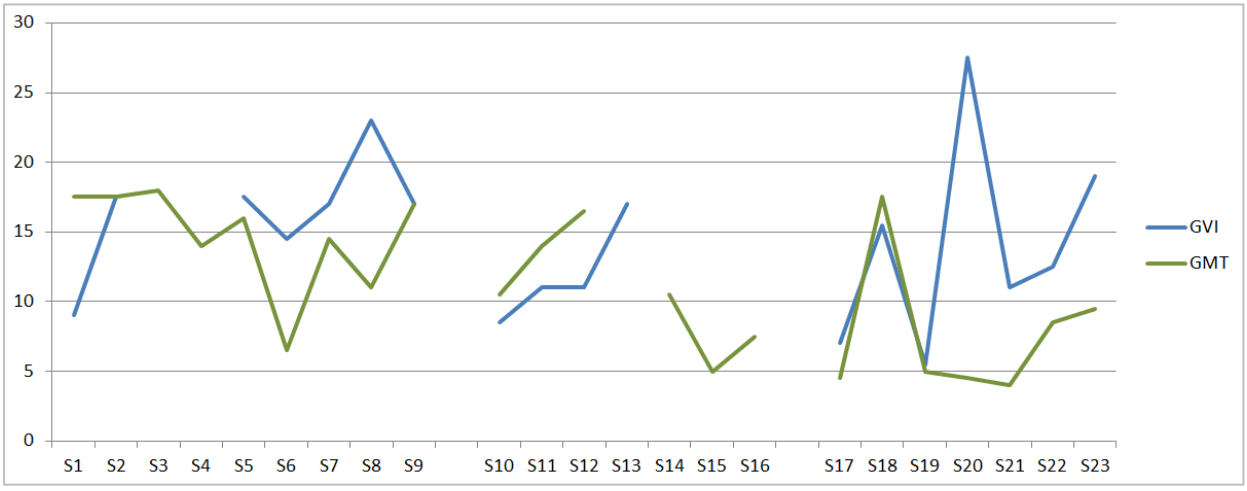


Figure 5.3: *Minutes of musical activities per session*

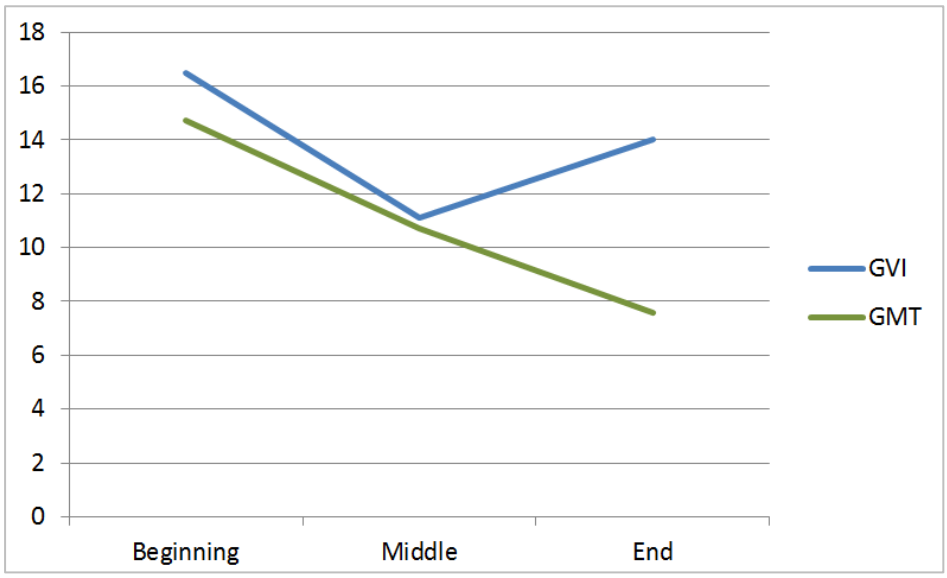


Figure 5.4: *Average minutes of musical activities per phase*

These results shown in Figure 5.4 have again the aim of comparing the overall trend in the two groups, since the timings of activities have been calculated equally across all the sessions, rather than to compare the amount of music in each group. This analysis shows a different trend for the two groups, where the GMT group progressively contained less musical activity as the sessions progressed, whereas the GVI group initially followed a similar trend from the beginning to the middle phase, increasing in musical activity in the ending phase.

The decrease in overall musical activities in the GMT group appears related to a progressive decrease of mixed activities (i.e. sound signatures and preparation), which in the ending phase are almost non-existent. This phenomenon could be linked to a sense of the group getting used to the idea of improvising with the instruments and therefore organically needing less preparation for the improvisations.

This does not appear to be a feature in the GVI group, where instead, the main 'preparative' activity, which consisted of a gentle physical warm-up, continued to take place in the sessions until the end of the group. This seems linked to the more 'embodied' nature of singing when compared to playing instruments at an amateur level, which has been discussed before. The warm-up before singing is a common element in most amateur singing groups, whereas it does not tend to happen in amateur instrumental groups.

The distribution of the different activities in the GVI group does not appear to have any particular trends, although it is worth noticing the location of the activities making use of pre-composed music in relation to other activities, as this points towards the different functions that these activities had in the group. A further reflection on that will be presented in the discussion section, but Figure 5.1 shows how at points the use of pre-composed music would take place before an improvisation, which has already been described before when talking about the use of lyrics from a song for an improvisation. In other cases, the pre-composed elements (marked in red) come after a series of song writing and improvisation, which means that the group is singing the song that they have just composed.

In other cases, like in session 11, the pre-composed song comes before a songwriting activity as the participants wanted to sing the song that they had learned and practised in the previous session. Therefore, in this case, the use of pre-composed music served to go back to where we had left the previous session.

Finally, it is important to note the use of pre-composed songs sung individually in the last session of the GVI group. This was part of a song sharing which had been discussed by some participants in the sessions leading up to the end. Some of those activities consisted indeed of just an individual singing sharing a song of their choice, whereas in other cases the group would join in for the chorus, for example to support individuals

who were not very confident in singing an entire song on their own. In those cases, the therapist also sang with them in the 'solo' sections for further support.

This is a good example of a certain focus on product and final outcome which was more present in the GVI group than it was in the GMT group. This is very relevant to the group processes, therapist stance, theoretical framework and aims of the group which stems from various distinct elements of the singing practice which are different from the use of instruments. The possibility of using musical reproduction in the GVI group is a main feature in this phenomenon as is the relationship with the body when singing. This will be discussed further in the discussion section.

5.1.2 Meso analysis: therapist's directiveness and group task negotiation

Following the summative account of the 'macro' level of analysis of the audio recordings across all sessions, this 'meso' level focuses on three sessions from each group. This will enable the analysis to provide more details about how the tasks in the group were negotiated, how different members of the group, including the therapist, adopted different leadership roles, and how different levels of directiveness emerged. This will start to show individual profiles for the different participants and illustrate an aspect of the configurations of the interpersonal structures and of the relational anatomy in the sessions.

Different aspects of the relational characteristics of the groups were considered for the focus of this level of analysis. This consideration included: dynamics of leading and following, active and passive individual profiles of participation in group tasks, configurations of how the space in the sessions was shared, content of discussions, language to talk about the music, how the music was introduced and left, and fluidity or stuckness of conversations.

Ultimately, following the trial of various possibilities, a decision was made to focus on the negotiation of the tasks in the group and levels of directiveness and leadership. This seemed the most relevant clinical aspect in relation to the research questions and a key element that was particularly distinct from the macro level analysis. In order to analyse this aspect of the relationships in the group, the audio recordings for each of the three sessions per group were coded following a scale of directiveness and leadership in session management.

This scale was generated after having described the different interventions where a member of the group verbally actively contributed to negotiating the group tasks. Different categories were ordered based on their impact on deciding on the group tasks. Following discussions with the supervisory team the categories below were chosen for the analysis:

- 1: Invites commentary
- 2: Asks a specific question
- 3: Initiates new commentary
- 4: Invites suggestion of task
- 5: Offers choice of task
- 6: Suggests task
- 7: Initiates task

These categories came from the analyses of the different interventions from the data as well as from a similar frame of reference as the Interaction Process Analysis by Bales (Bales, 1950). Other indigenous music therapy existing models of interaction categorisation such as Bruscia's Improvisation Assessment Profiles (IAPs) (Bruscia, 1987) were considered but since here the emphasis was mainly on the verbal discussion, this model by Bales and subsequent variations appeared most suitable as an inspiration.

In order to provide a level of detail that was manageable for this analysis, where the focus was to be able to look at an entire session and explore how the tasks were negotiated, the categories for the leadership interventions only focused on the active interventions from the group members. The more passive interventions such as showing agreement or commenting on the topic of the conversation were not coded. Equally, there were no categories for opposition interventions as there were none in the sessions that were analysed.

As a result, this level of analysis does not represent how much each participant contributed to the group's conversations or how the topics of those conversations evolved or moved between focusing on discussing the music, other aspects of the group experience or personal experiences from outside the group. Instead the priority has

been given to who assumed roles of leadership, along with when and how directive those interventions were.

The reason for giving such emphasis to this aspect of the relational dynamics in the group is twofold. On one hand, the different more directive stance needed from the therapist in guiding the activities that have been described in the 'macro' level was a recurrent theme in the therapist's process notes as this difference in stance affected the overall therapeutic framework and dynamics in the session. On the other hand, because of this it seemed important to contrast this perception from the therapist with a more observational analysis of the data to be able to address this issue in the results and discussion sections.

Selection of sessions

The purposeful selection of the three sessions for each of the groups followed the four criteria listed below, as has been briefly mentioned before:

- To portray all of the participants at least in one session
- To show different types of musical interactions
- To represent musical activities that had been mentioned by the participants and the therapist as significant
- To spread the different sessions so as to obtain one that was close to the beginning of the group, one from later on, towards the middle, and one closer to the end.

The selection of the sessions had not only the 'meso' analysis in mind but also the 'micro', since the musical extracts for the 'micro' analysis would be taken from the same sessions. In the end, sessions 7, 12 and 18 were chosen for the GVI group and sessions 2, 9 and 18 were selected for the GMT group. Members of the supervisory team were also involved in supporting the extract selection process.

Coding of interventions

The process of coding the leadership interventions consisted of listening to the audio recordings and tagging and coding each intervention by a group member or by the therapist that fell under the seven categories of leadership described above. Those

categories aimed to cover all types of interventions that had a direct impact in steering the group's conversations and negotiating the group's tasks.

Since both the macro and micro analyses emphasised the musical activities, the meso level put the priority on the group discussions, which is where the negotiation could be more explicitly measured given the semantic specificity of verbal language. The possibility of applying similar categories of leadership in the music was considered but it seemed like this would require a completely different set of categories. Moreover, the 'micro' level will provide a more appropriate language for appraising the leadership taken in the music by the different participants. Therefore, only the verbal interventions have been coded and the periods of musical activities have been clearly marked in the analysis.

The process of labelling and coding the interventions was similar to the process used for the macro analysis. Once each intervention had been timed and coded the data was inputted into a table in order to then generate a scatter XY chart as can be shown in Figure 5.5. Each intervention was given a value from 1 to 7 following the increasing level of directiveness from the seven categories described earlier. The value 8 was given to signal the beginning and end of the music making in order to be able to show the timing of the musical activities in the chart.

Since the scatter chart allows exact measurements of time from the recordings, it was possible to avoid the step of adjusting the timing to a decimal value, which had been necessary for the Gantt chart in the macro level.

The resulting chart shows each member of the group in a different colour and each of their leadership interventions when they happened. The further up the mark the greater the level of directiveness that it denotes. Consequently, if a particular member has a lot of interventions in the higher values of the scale this would mean that they were being more directive than if their interventions were at a lower value (closer to the lower limit of the y axis). However, those interventions would still show a greater level of leadership than no or fewer leadership interventions. Once again, it is worth reminding the reader that the fact that certain group members do not feature often in this analysis does not necessarily mean that they contributed less to the group conversations (although sometimes this is the case), as they might have been participating in the discussions but not being active in negotiating the group's tasks or providing new topics to steer the conversations

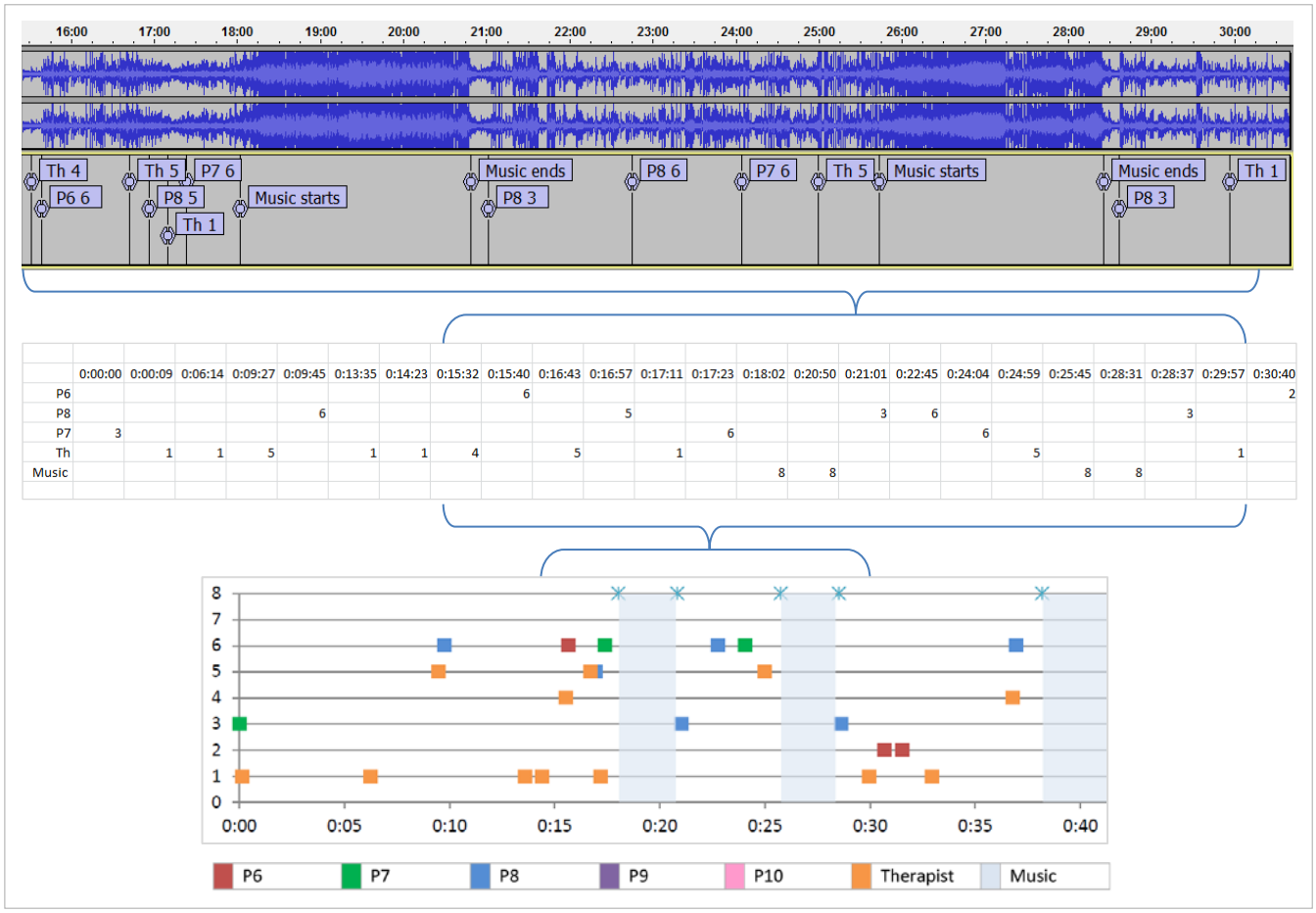


Figure 5.5: Meso data coding and visualization example

Finally, it has already been pointed out that the leadership interventions could relate to having an impact on either the topic of the conversations or the tasks of the group. In the scale of directiveness, the three lower categories of interventions refer to having an influence on the topic of the conversation whereas the top 4 are both influencing the conversation (which is now about the group's tasks) as well as negotiating the group's tasks.

The resulting analysis is shown in Figures 5.6 and 5.7, which specifies which participants were present for each of the sessions.

Comparison of leadership roles between the GVI and the GMT groups

When comparing Figures 5.6 and 5.7 there do not seem to be immediate significantly contrasting differences between the two groups, contrary to what happened in the 'macro' analysis level, where the analysis had provided distinctively different patterns in the data for the GVI and for the GMT.

In this case, when looking at the level of directivenes of the therapist and that of the participants, there does not seem to be a clear difference leading up to the different musical activities, where in most cases for both groups it is the therapist who suggests a task just before a musical activity takes place. However, there is a phenomenon that happens in the GVI group following the musical activities which does not appear to be very present in the GMT group.

In the GVI group, the distribution of the musical activities shows a more fragmented pattern where shorter instances of an activity take place and then repeat in a short amount of time. This has already been discussed in the macro level analysis. This analysis allows us to see how this breaks down, and how patterns were negotiated. As shown in Figure 5.6, it is the case on practically all occasions that the therapist takes a highly directive role in between those activities that are fairly close together. It almost appears as if the activity continues (since it has been already discussed that those short activities tended to repeat) with a brief interruption where the therapist would suggest something, perhaps an element that could be changed or in the next iteration of the activity.

This phenomenon where the therapist quickly suggests a new task appears almost as if the therapist is trying to keep the momentum up. This was certainly a notion that was present in the session notes. This seems to resonate with the reflection around the greater difficulty to sustain the musical activities when singing compared to playing instruments.

In the GMT group instead, the wider sections of group discussion in between pieces allow for a more varied negotiation of the space. In that sense, it is interesting to notice in the GMT group, when there are activities that follow shortly from each other (particularly in session 2), the same phenomenon where the therapist adopts a highly directive stance takes place as well.

Figure 5.6: *Meso level of audio analysis GVI*

Figure 5.7: *Meso level of audio analysis GMT*

Another similarity between the two groups is that most of the interventions belong to categories 1 – 3, which means they are not highly directive. In terms of the interventions from 4 to 7 another commonality appears where most of those are done by the therapist, which indicates that in both groups the therapist seems to have adopted the position of being the one who suggests the musical tasks. Session 9 for the GMT seems to be an exception to this, which will be discussed in the section on directiveness around specific musical activities.

Finally, looking at the leadership roles from each participant it is possible to see some individual differences. For example, participants 8 and 9 in the GMT show a more directive role, particularly compared to participant 10, who hardly features at all in the analysis. Participants 6 and 7 seem to be at an intermediate level. In the GVI group participants 2, 3 and 4 seemed to be at a similar level of leadership, depending on the session, whereas participants 1 and 5 tended to adopt a less directive role.

Different kinds of 'climates'

In both groups it is possible to notice different styles or 'climates' at different points across the three sessions. The concept of 'climate' is taken from the methodology of the Interaction Process Analysis (Bales, 1950) which has been mentioned earlier as one of the main starting points when devising this method for analysing the sessions. Within this methodology, 'climate' refers to an identified subset of interactions resulting from the combination of different categories.

The different climates could be described according to the frequency of interventions, the level of directiveness of the interventions and the balance between interventions from the therapist and from the participants. For example, in the GVI group, in the second half of session 7 and in the first half of session 12 there seems to be a similar climate dominated by lower level interventions that come mainly from participants and a relatively high frequency of interventions. This reflects that in this climate the group discussions flowed more or less organically and that participants were guiding the topics spontaneously. In both examples different participants are adopting similar leadership roles in the group.

Instead, this is not the case at the beginning of session 18, where the interventions are still at a very low level but come mainly from the therapist and are more spaced out. In this instance this climate reflects that the initial check in was mainly directed by the

therapist. It is interesting to notice that this was the session where there were more participants present out of the three.

Another different climate takes place towards the end of sessions 12 and 18 for the GVI group, where the interventions are more spaced out, are varied in level of directiveness and also combine interventions from the therapist and from the participants. This reflects that the conversations grew and developed organically without the need for members to introduce new topics.

In the GMT group there seems to be a similarity between the role adopted by the therapist in sessions 2 and 18, where the therapist tends to make more directive and more frequent interventions. Looking back at the session notes, this seemed to respond to a phenomenon that can subtly be seen in the analysis, which was that in each session there was a participant who dominated the group conversations (P9 in session 2 and P8 in session 18). For this reason, the therapist intervened more frequently to redirect the conversations and allow other participants to contribute to the discussions as well.

Instead, in session 9, the entire session seems to have a very different climate where the tasks are mainly being negotiated by the participants and the interventions are less frequent in general. It is interesting to reflect on the impact of the musical activity of the group on that particular session, which was different from any of the other sessions as it contained verbal material in the improvisations. Further considerations around this will be presented in the following section. Finally, to close this section, it is difficult to identify a particular sense of evolution or development of particular climates throughout the course of the sessions in the sense of a longitudinal narrative in either of the groups.

Directiveness around different kinds of musical activities

As has already been mentioned in the previous sections, the climate in session 9 in the GMT group seemed to be different from that of any other of the analysed sessions. This was a session where one of the participants (P7) had brought in one of her poems after the other participants had encouraged her to do so when they learned that her poetry had been published. The introduction of text and of a tangible referential element for the improvisation appeared to stimulate a more proactive role in all the participants who attended and the therapist therefore was able to adopt a less directive role.

It appears as if having a verbal reference had supported participants to feel more creative in suggesting how to use the music around it. This element helped to shape the entire

session, where there was an ongoing discussion about how the music making related to the poem in different ways. It is also interesting that this was one of the most significant sessions for all the participants, although in a negative way for the author of the poem, who felt very self-conscious, and in a contrastingly enthusiastically positive way for the other two participants. Further comments on this will be discussed when presenting the analysis of the interviews where this comes up again.

In the GVI group the phenomenon where a certain activity is 'repeated' (although often introducing changes in each repetition) has already been mentioned. This was true for all three of the sessions: in session 7 there are two breathing exercises that follow the physical warm-up at the beginning of the session; in session 12 a similar activity of 'syllables in harmony' takes place several times following the warm-up; and in session 18 a similar activity involving sound and gesture develops through the course of four occurrences after the warm-up. It already has been discussed how these repetitions tended to generate a climate where the therapist adopted a directive role, although this seemed to relate more to the pattern of timing and distribution than to the activity itself.

5.1.3 Micro analysis: musical analysis of extracts

This is the final stage of the progressive 'zooming in' process that started from an overall look at all 23 sessions, where the interactions were viewed at a group level. The following level of analysis allowed a more detailed look at the interactions at an individual level by looking at a selection of six sessions to reflect on how the group tasks were negotiated in the groups. This was still a level where the individual contributions were summarised and codified. At this point in the analysis of the interactions that took place in the groups there is an opportunity to look at a detailed transcription of some of the interpersonal exchanges that happened in the musical activities in each group.

The current part of the analysis reflects on the musical activities that characterised each group in further depth as well as showing the reader examples of the activities that have been described and how the participants were able to engage with those at different levels.

The analysis of these musical excerpts follows broadly the microanalysis of musical improvisations described by De Backer and Wigram (2007). This method uses a

phenomenological approach to the musical analysis that aligns well with the present study. The steps proposed by De Backer and Wigram involve:

- Step 1: Overview of improvisations in a session
- Step 2: Selection of representative musical characteristics
- Step 3: Verification of chosen excerpts
- Step 4: Selection of video fragments for analysis
- Step 5: Notation of scores
- Step 6: Structure of the musical analysis
- Step 7: Method for the presentation of results
- Step 8: Description of non-musical aspects of the selected video excerpts.

(De Backer & Wigram, 2007)

These steps were followed for each extract and the transcript and commentary is presented below. The analysis of the musical structure (step 6) has been described in the commentary rather than marked on the scores since it seemed more appropriate to include this aspect as part of the narrative, especially given the short duration of the extracts, which generally did not allow big structures to emerge.

Selection of extracts and transcription

The extracts for this analysis were selected from the six sessions used for the meso level analysis. One characteristic exemplar was chosen from each of the sessions. Instead of transcribing an entire improvisation, which was outside the scope of this phase of the analysis, short extracts of 20 to 30 seconds of an improvisation were selected in each case. No software was used to aid with the transcription.

The selection of the extracts, both in terms of which improvisation as well as which short fragment, was purposeful – following similar criteria to the selection of the sessions for the meso level presented earlier – and was carried out in order to illustrate a particular process or kind of interaction as will be detailed later when commenting each of the transcriptions.

The table below (Table 5.5) shows the selection of extracts:

Table 5.5: Audio extracts selection

	Group	Session	Attendance	Participants	Title (provided by the therapist for identification)
Extract 1	GVI	7	3	P2, P3 and P4	Soundscape
Extract 2	GVI	12	3	P2, P4 and P5	Syllables in harmony
Extract 3	GVI	18	5	P1, P2, P3, P4 and P5	Sound and gesture
Extract 4	GMT	2	4	P6, P7, P9 and P10	Transition
Extract 5	GMT	9	3	P6, P7 and P8	Poem
Extract 6	GMT	18	3	P6, P8 and P10	Alternation

The process of transcribing was at points difficult due to different instruments and voices sounding similar or overlapping. An effort has been made to portray the musical features of each participant's contributions as accurately as possible. Brief articulation and dynamic notations have been included in the transcripts when these were particularly contrasting in order to give the reader a sense of those differences. The transcripts for each extract are presented here and the audio files will be provided with the submitted thesis.

Extract 1: Soundscape

This first extract is from session 7 in the GVI group where three participants were present (P2, 3 and 4). The chosen extract (Figure 5.8) is from the last musical activity of the session, which took place halfway through the session (as can be seen in the meso level diagram) and was followed by a long and invested conversation around participants' experience during the improvisation.

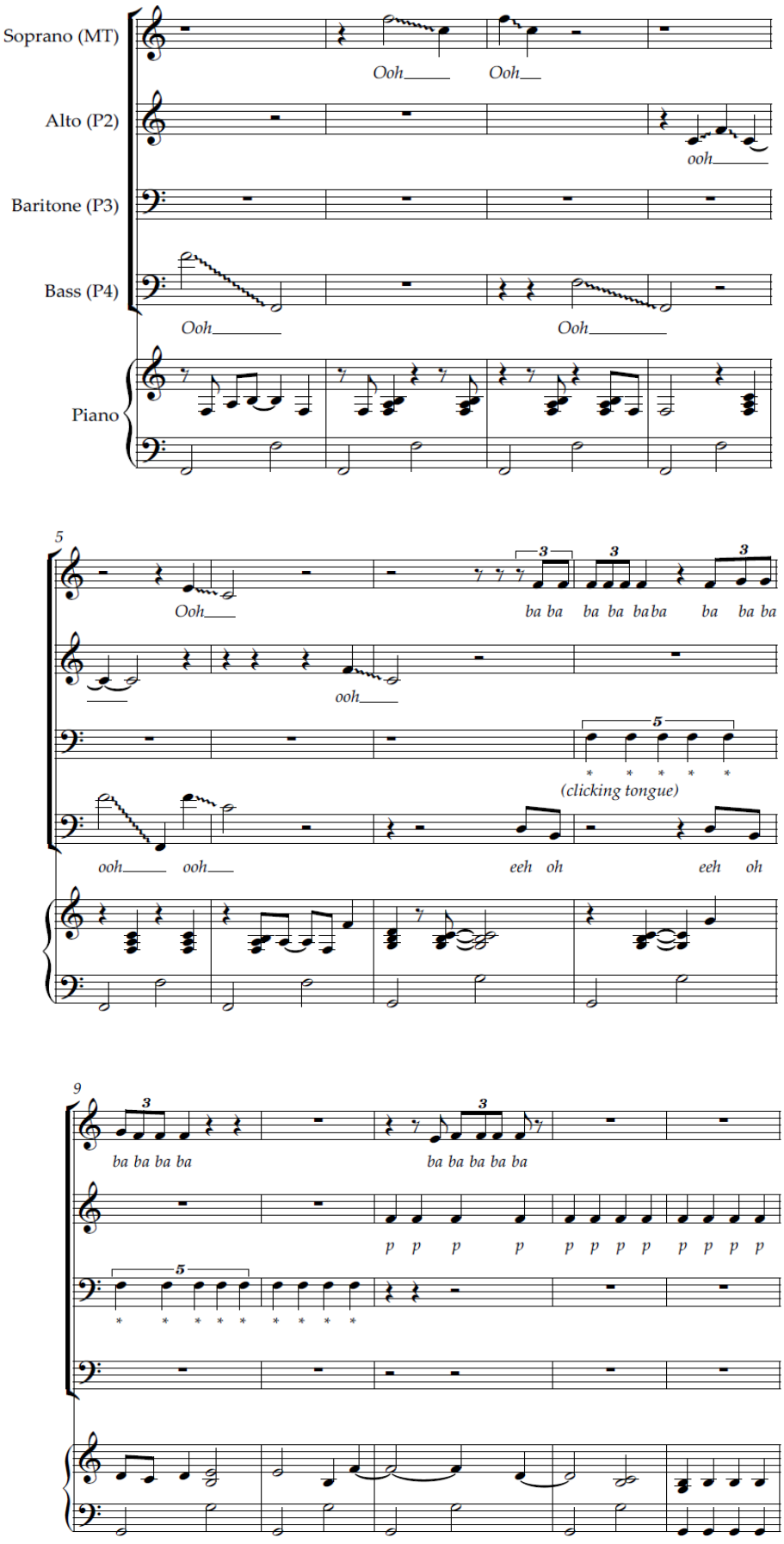
At the beginning of the session, two breathing exercises followed the physical warm-up. This activity was suggested by the therapist in order to continue to make use of the breath and explore the range of sounds that could be made just through modifying the breath. The use of the microphones was an important element of this activity since the reverb in the amplifiers allowed participants to play with different effects. The premise of the activity was to construct a 'soundscape' (or landscape of sounds) through the different vocal effects.

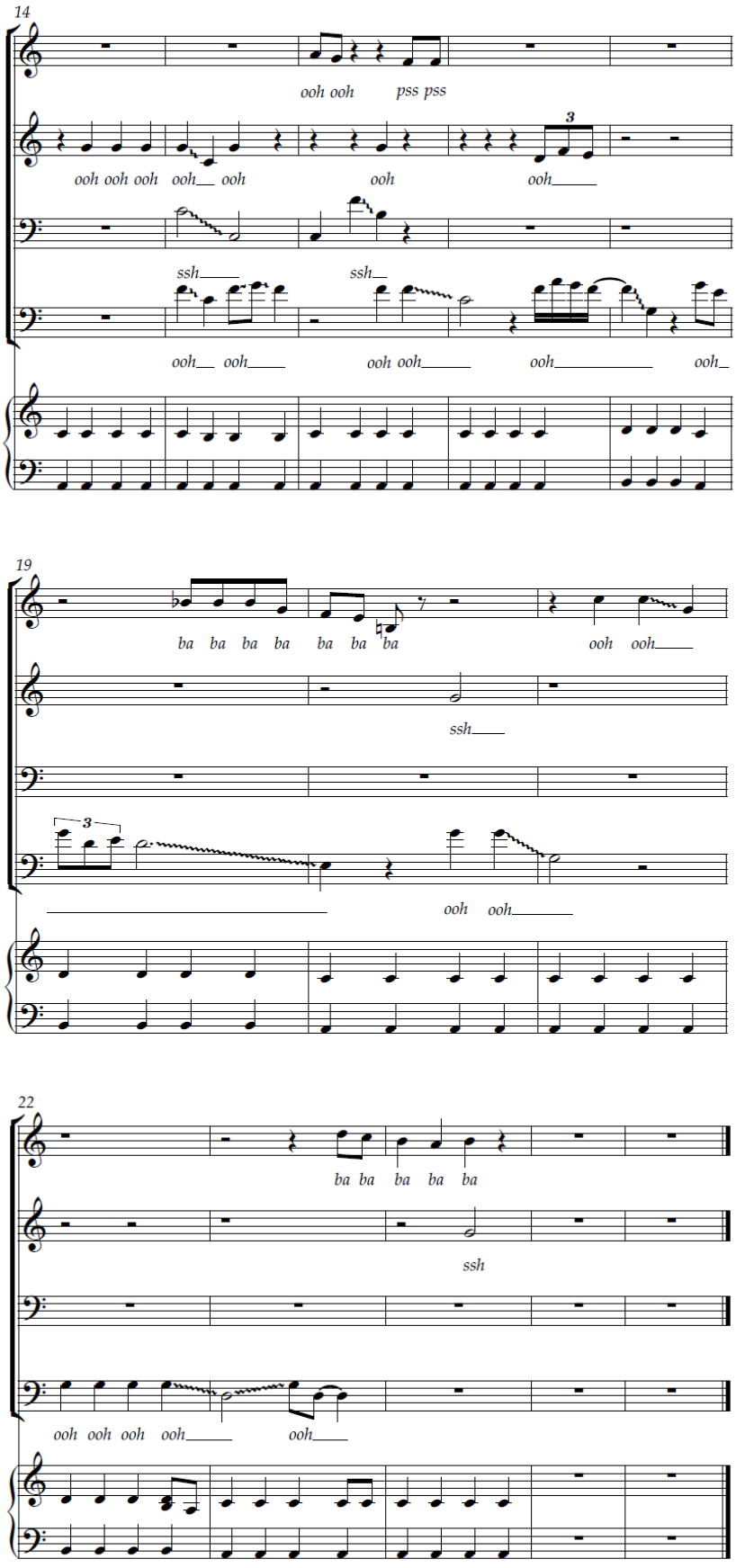
The piece started by just playing with the sounds of different consonants such as ‘sh’, ‘s’, ‘f’. Then the therapist started to introduce shorter more percussive sounds such as ‘ch-ch-ch’, ‘ps-ps-ps’, ‘t-t-t’, which some of the participants imitated and started to play with. All of this was accompanied at the piano by the therapist in open chords as a support for the improvisation, featuring alternating octaves in the left hand. The transcribed extract is from a few minutes into the improvisation, where the therapist had started to introduce the idea that there might be some animals in our soundscape and modelled some sounds such as the ‘ooh-ooh’ that can be seen at the beginning of the transcript.

The extract starts with mirroring of glissandi on and ‘ooh’ sounds between the therapist and two of the participants. Here, participant 4 appears to be exploring his whole vocal range through the glissandi, whereas participant 2 concentrates on exploring a narrower middle range of her voice. In response, the therapist, who was initially matching P4 by using her higher range, goes down to the middle range as well.

In bar 7, the therapist moves to a new tonal centre and this seems to start a different section in the improvisation where new sounds are explored by each one of the participants as well as the therapist. The first one to start a new sound is P4, who seems to introduce a new creature in the landscape, by imitating a donkey sound, which he repeats twice. This is a much more clearly rhythmically defined motif than the ‘oohs’ that preceded. The therapist also starts a more rhythmical motif on ‘ba-ba-ba’ and P3 starts to produce a sound by clicking tongue against the palate in a regular rhythm that goes against the vague tempo established in the piano. In bar 10 P2 copies the idea of the repeated percussive sounds, in her case on a ‘p’ sound sung very close to the microphone, which seemed to emulate a drum. This rhythm was picked up by the therapist who starts to play repeated notes from bar 13, in contrast to the more open tempo that was marked by the preceding alternating octaves.

Figure 5.8: *Transcript extract 1: GVI - Soundscape*




14
ooh ooh
pss pss
ooh ooh ooh
ooh ooh
ooh
ooh
3
ssh
ssh
ooh ooh
ooh ooh
ooh
ooh
19
ba ba ba ba
ba ba ba
ooh ooh
ssh
3
ooh ooh
22
ba ba
ba ba ba
ssh
ooh ooh ooh
ooh
ooh

This change in the piano accompaniment appears to mark a new shift in the piece and the 'ooh' sounds came back, this time showing greater pitch variability. In bar 15, P3 joins in again by using some of the 'sh' sounds from the beginning of the piece. The therapist responds to this by introducing some of the earlier sounds in bar 15.

This is an example of one of the pieces that was most similar in format to a 'free improvisation' like the ones in the GMT as it had little structure or instructions from the therapist. This improvisation took place after the group had had opportunities in previous sessions to improvise with humming and vowels, although this had been in more structured formats, such as call and response.

Although this piece lasted for about 8.5 minutes, there were several instances where the participants had stopped singing and the therapist had implicitly encouraged them to join in again by keeping the accompaniment going and starting to vocalise again. This is a good example to show how at times it was difficult for the participants to sustain the vocal activities, although it is possible to see in this extract that they were able to engage in the activity when the space was held open.

The piece continued and the therapist suggested introducing new sounds, perhaps the sounds that a baby might make before learning to talk. The therapist again modelled some sounds and the participants started to copy some of them with some prompting but again it was difficult to sustain. Afterwards, when the therapist invited the participants to comment on their experience of that activity there was quite a strong reaction from P4, who said the idea of the 'baby sounds' had been quite an uncomfortable one for him. The group reflected on the impact of having introduced the idea of a baby which felt quite vulnerable and difficult to engage with. An interesting discussion followed where some of the participants shared some of their childhood experiences.

Both P2 and P4 commented on how they had felt comfortable with the improvisation using non-verbal vocalisations and they felt able to relate to the idea of the sounds in a landscape and animal sounds, but that when the therapist suggested making the sound of a baby this had felt too much. This piece then became known as the 'baby sounds' whenever any of the group members referred back to it. This happened relatively often throughout the course of the remaining sessions and the group often reflected on the

impact that this activity had had in the group. It was often cited as an example of something that had been challenging to engage with although P2 often remarked that she had found it quite interesting and playful. P4 also mentioned that through having talked about it he felt it had been useful to learn more about the developmental function of the non-verbal vocalisations that babies produce and that adults mirror. This had been discussed when he asked the therapist why people talk to babies by making silly sounds instead of talking to them with verbal language, which he thought would be more beneficial for the baby in order to learn to talk. He acknowledged that he did not like it to see adults do this as he felt like they looked stupid and he talked about feeling stupid when making the baby sounds as well. This aspect of the regressive aspect of non-verbal vocalising will be further explored in the discussion section.

In contrast to this, P3 reported struggling with a different aspect of this activity, although he agreed with the fact that bringing the 'notion' of a baby in the session had been triggering a sense of vulnerability, which he linked to his traumatic upbringing. His first issue though was that since the activity was done with the use of microphones he had found it difficult to cope with the sensory dissociation of not knowing where the different sounds were coming from. He perceived the new sounds from the soundscape as very sudden and unpredictable, which links with the lack of structure of this particular activity.

This improvisation appeared to mark a significant moment for the GVI group and made an important impact on the participants' experience –as reported in the interviews –, hence why it was chosen for this analysis. This was the first time in the group where a free improvisation activity was introduced and some changes in how the therapist thought about different musical activities followed in response to the participants' feedback of it having been a little overwhelming. One of the changes was that the microphones were used less frequently after this and almost not at all towards the last phase of the group as people felt OK to sing without them. Another change was that the suggested activities tended to be more structured in order to make them more accessible. At this point there was a question around the participants' ability not only to engage but to be creative and sustain their contributions in the activities, since this activity in particular but others before had felt very tentative and had not allowed people to be playful and creative with how they used their voice.

Extract 2: Syllables in harmony

This activity has been described before in the 'macro' analysis section. This represents an example of the changes that were introduced following the experience of the 'soundscape' which has been explored in the previous section.

This extract (Figure 5.9) is from session 12, where there were three participants again, this time participants 2, 4 and 5. The group had first experimented with this activity in the previous session, so they were familiar with the structure. The activity originated from the song that the therapist taught to the group in session 9, just before the break. The group wanted to work more on the song coming back from the one-week break in session 10, where some possibilities for harmonising the main melody were introduced. Then in session 11 the therapist suggested the syllables in harmony activity for the first time, by saying that we could make our own song based on the one that we had learned, using the same chords and simple 'lyrics' without any particular meaning.

As has been briefly pointed out before, the idea around this activity was to provide an accessible enough structure which would limit some of the dimensions for the improvisation, in order to support the participants in being more autonomous and creative during the vocal improvisation. This came from the therapist's realisation that in the GMT group participants could choose between instruments which had several dimensions to play with such as the piano, the cello or the guitar or instruments that had a more limited range, such as drums and other percussion instruments where the main dimensions that they could improvise with would be mainly rhythm. Instead in the vocal group there were a lot of choices to be made: pitch or range, melodic contour, rhythm, harmony in relation to others, timbre, what to sing (consonants, vowels, words, etc.). Therefore, by giving participants a clear rhythm and syllables to pronounce as well as a simple and predictable harmonic context, the aim was to focus their range of choices so that they might feel more able to improvise with the remaining dimensions in the improvisation.

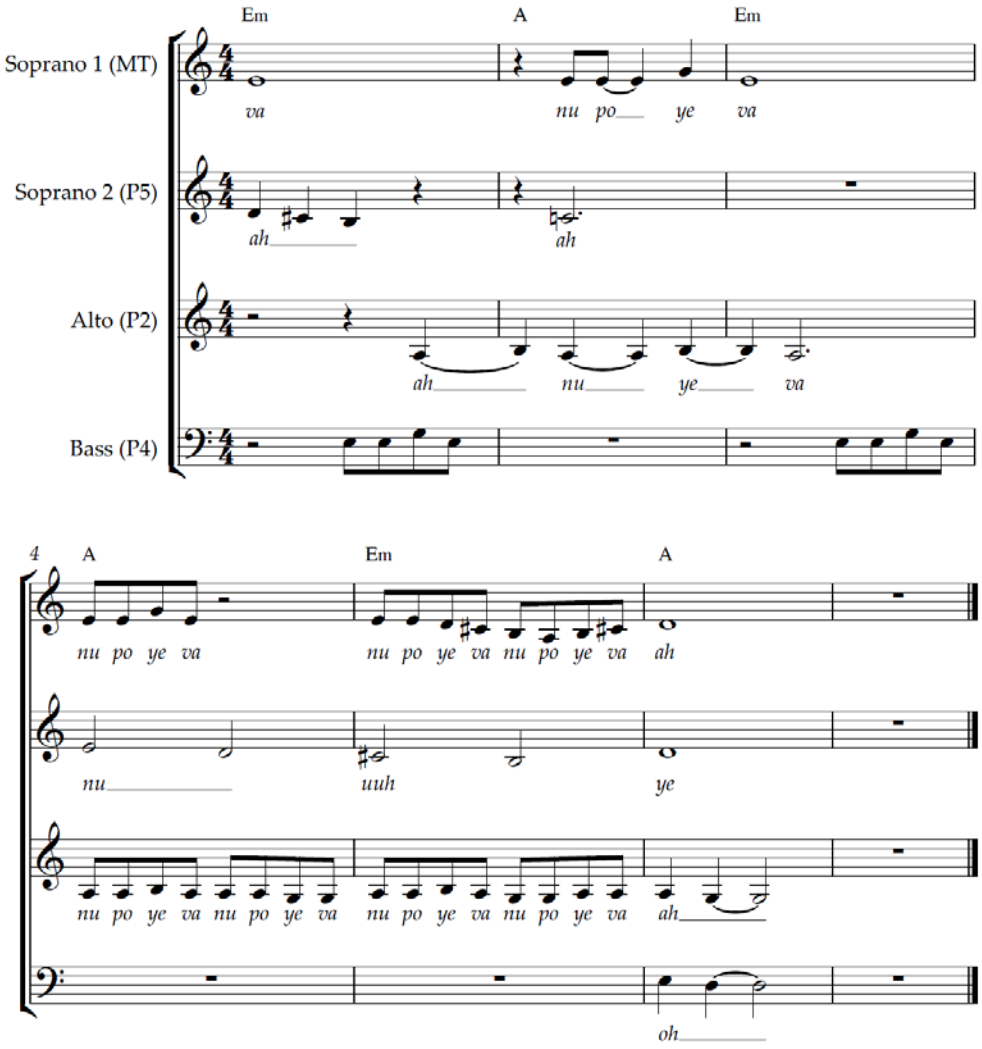
This was the aspect of the activity that was pre-designed by the therapist for a specific purpose, as well as the idea of helping participants to maintain their melodic lines independently from each other. The remaining aspects of how the activity evolved and

developed were improvised in the session in response to the participants' engagement with the activity.

As was described before, the activity consisted of choosing random syllables to form two 'words', which in this case were 'nupo yeva'. No specific meaning was attributed to these, but they served as the phonetic basis for the activity. After having practised the exercise in the previous week and having introduced different more or less prescriptive ways of singing the words, such as with long notes and short notes, in this session participants were encouraged to make use of the different ways of singing the words within the harmonic structure in the way they wanted. This meant that they would be singing the syllables at their own pace and that whilst one person was singing 'nu' someone else might be singing 'va' for example. We started practising this with the same chords as the previous week and then one of the participants suggested changing the chords. The extract selected came from the third repetition of the activity with the new chords.

In the transcribed extract it is possible to observe that the different participants were able to alternate different ways of using the words 'nupo yeva'. It can also be seen that the participants are able to maintain their own line and develop some motifs. Some imitation between them can also be seen for example when in bar 4 P2 imitates the melodic contour repeated twice by P4 in bars 1 and 3 (also copied by the therapist in bars 2 and 4). This extracts shows an example of participants being able to be creative in their use of the voice in a way that can resemble the level of playfulness and creativity seen in the GMT extracts in terms of having separate ideas and lines and being able weave them creatively in the group music making. The range of possibilities is more limited than in GMT where different people might be playing in ways that are more clearly separate and different from each other, but nevertheless this level of autonomy appeared significant in this group where the concept of improvising with others had not been easily accessible.

Figure 5.9: *Transcript extract 2: GVI – Syllables in harmony*



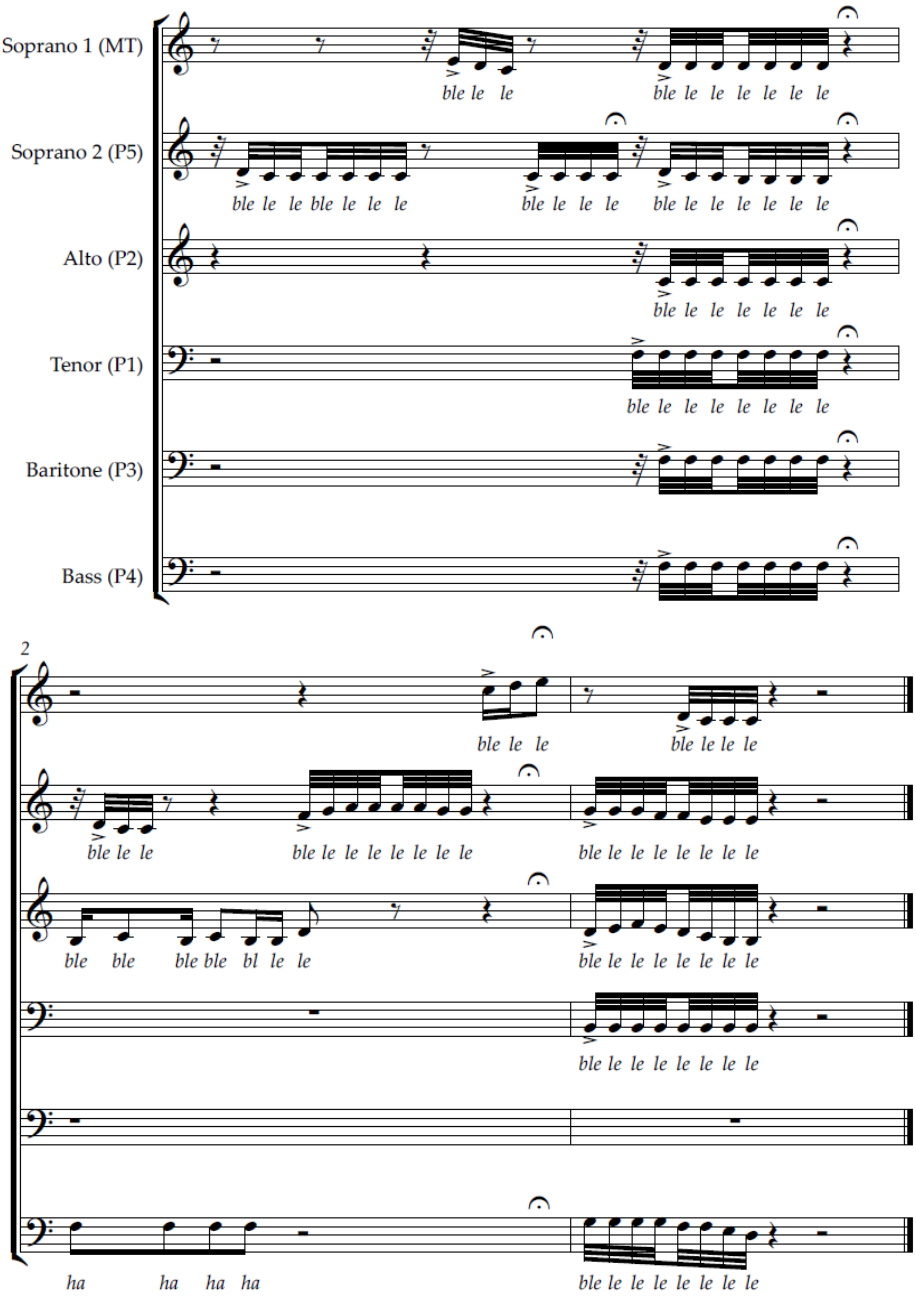
Extract 3: Sound and gesture

This extract (Figure 5.10), from session 18 and where all 5 participants were present, is once more from an activity that started to develop in the group during the previous week. On that occasion, the initial check in had been particularly long, perhaps due to this being the first session after the second one-week break of the group. For that reason, the warm- up only started around 40min into the session, which left little time for music making. After the warm-up the therapist went back to some of the themes from the group discussion where different members had been using gestures to describe their feelings, particularly P5. The therapist had noticed the gestures and brought them back at this point, suggesting that we might be able to use the remaining time of the session to experiment with the gestures and sounds, since people seemed to be quite lively and in touch with their bodies.

Although the idea had seemed rather alien at the beginning, the participants in that session responded quite well to the suggestion and engaged with this new element of adding movement with enthusiasm. One of the participants had said "we should have done this the last time when all of us were here!". For this reason, in the following week, when all the participants attended it was suggested that we go back to the gestures and sounds activity.

Initially the activity had consisted of taking turns where each participant would combine a sound and a gesture and the rest of the group would imitate it and repeat it several times. After we had gone around the circle twice the activity started to become less structured. At one point P5 suggested that we might stand up to explore the movements better. Shortly after the group had agreed and stood up there was some uncertainty as to how to proceed with the activity and people started to move and giggle. At some point within this transition, P5 did the initial motif transcribed in this extract as part of her own exploration of movement and sound shaking her hands and head as she produced the sound that has been transcribed as 'ble-le-le', which seemed to resonate with the giggling. This sound was produced by flicking the tongue back and forth through the upper front teeth and upper lip, similar to a sound that might accompany a children's grimace.

Figure 5.10: *Transcript extract 3: GVI – Sound and Gesture*



As can be seen in the transcript, the therapist immediately copied this, seeing it as an opportunity for the group to continue the activity, as it seemed to have lost the focus at that point. Very quickly, P5 repeated the sound again which functioned as implicit clue for the rest of the group to echo it. After the first echo, P2 imitates the sound in a different way and P5 responds by expanding her original sound and give it more direction, which the therapist in turn matches as well by expanding the register. The group echoes this once again with P4 also being more playful with the sound. What followed was a shared explosion of laughter.

It is interesting to note how in this particular activity P5 became a lot more assertive in her suggestions and use of music although she tended to adopt a follower role in the group, as was discussed during the meso analysis.

This extract was chosen to show a very different way of working by incorporating the body and movement. It also shows the spontaneity, playfulness and the range of sounds that could be part of GVI, which was very different from the clearly defined pieces from the GMT group. There was a sense of silliness and permission to regress to a more infantile way of being with movement and with voice that seemed to animate the participants in a different way, which was fun and different. This activity also seemed to add an element of intimacy that brought the group together in a different and perhaps more genuine way. After this session, the attendance remained high until the end of the sessions, which is not to say that this particular activity is what caused it, but may have contributed to bringing a more established sense of belonging to the group.

Extract 4: Transition

The first extract from the GMT group is from session 2, which was a significant session where tensions arose particularly between a new group member and the rest of the group. This improvisation followed the activity of the 'sound signatures', which was described in the 'macro' level analysis. Therefore, this was the first time that the participants were improvising together in the session, which given the fact that this was only the second session and two members attended for the first time, appeared as a very new and introductory piece. There were 4 participants in total.

The extract (Figure 5.11) shows a transition section where most participants progressively stopped as if the piece had reached the end. Participant 6 was the first and had stopped playing at the end of bar 1 from the transcript and P7 and 10 stopped at the downbeat of bar 4. However, instead of following that organic sense of ending that seemed to have culminated in the downbeat of bar 4, P9 continued to play the gato drum, which the therapist supported on the djembe by continuing to play as well.

P9 continued to play and the therapist supported it by mainly marking beats 1 and 3 as he continued to repeat the same rhythmic motif. The first participant to join in again

timidly on bar 7 and more full from bar 9 was P10 on the guitar. Participants 6 and 7 joined in as well on bar 10. The piece continued after this for a couple more minutes with all participants playing.

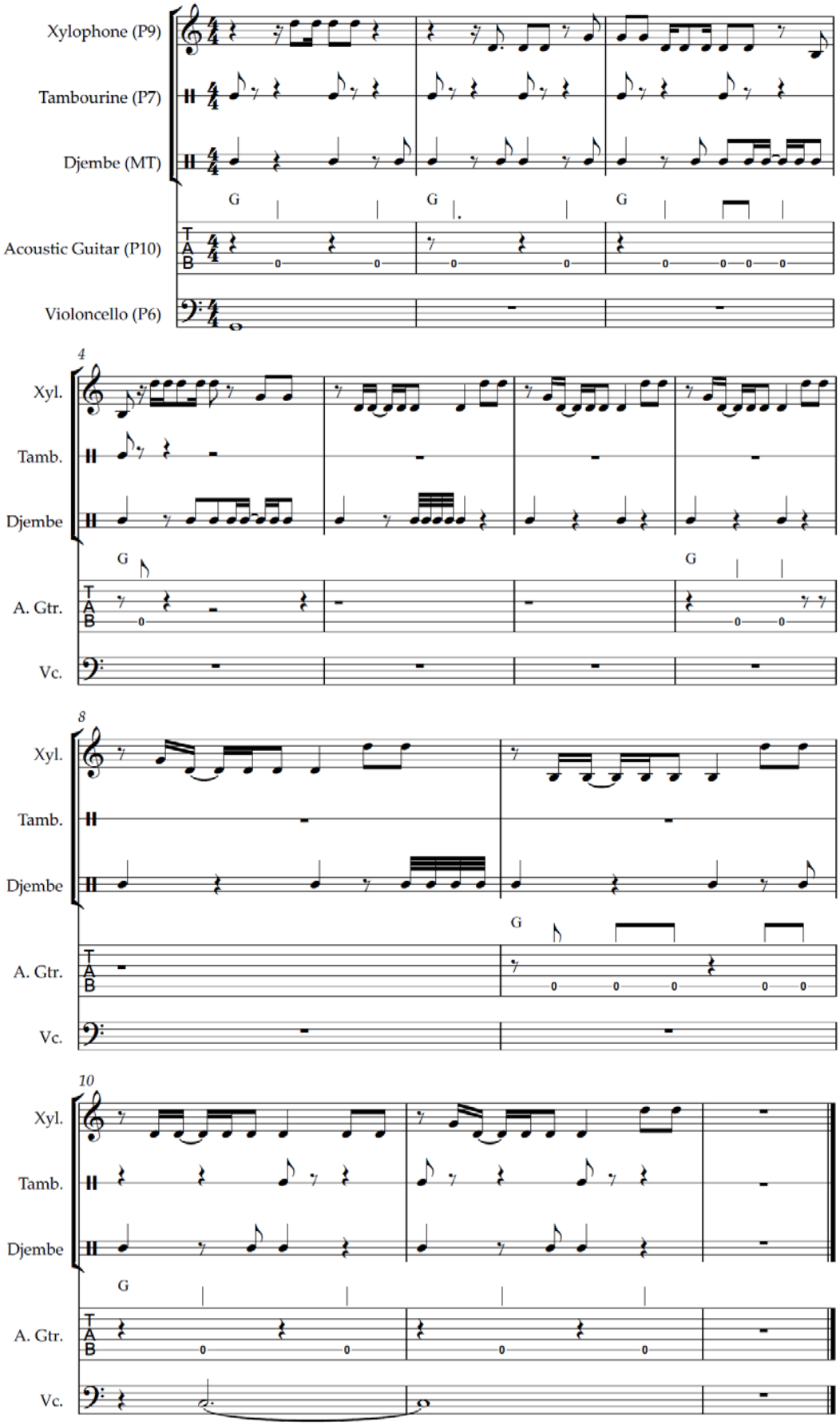
Music therapists who often use instrumental group improvisation in their sessions will be familiar with those transition fragments or 'false endings' where the group seems to have reached consensus that the piece is ending but either one of the participants or indeed the therapist decide to continue to play. These phenomena can occur for various reasons in different contexts. There might be someone who is self-absorbed in their own playing at such extend that they appear to be unaware that the rest of the group has stopped playing. This however, seemed more a case of relative 'defiance' from participant 9, who was clearly aware that the group had stopped and everyone was looking at him. He looked back at the group with a cheeky and playful smile and continued to play.

Afterwards, the therapist enquired about the participants' experience of the transition. P9 said that he was enjoying the playing and hence he continued, adding that when he did not enjoy it anymore that was when he stopped. From the remaining participants there were varied responses: whilst P7 said she found it fun and enjoyed listening to what others were creating, P10 talked about feeling anxious about not knowing what was going to come and P6 thought that for him it had felt tense, as if the therapist was waiting for P9 to eventually stop playing but continued to support him and no one made the decision to stop.

Given that P9 only attended another session 10 weeks later and considering the low GSRS scores for this session that will be presented in the next session, it appears as if the group dynamics that were enacted in this piece had an important impact on all the group members. Therefore, this extract shows how some of the tensions in interpersonal relationships can manifest musically, which is nothing new for music therapists.

Finally, this is also a good example of how, despite the variety of instruments that were used, many did not have a great range of dimensions or options to play with. Therefore, in many occasions the main creative element here was rhythm, even in the case of the guitar for example, which kept repeating the same chord in different rhythmical patterns.

Figure 5.11: *Transcript extract 4: GMT - Transition*



Extract 5: Poem

This extract (Figure 5.12) from session 9 was chosen to show a different group improvisation which included the use of text. As was explained in the macro and meso analysis, the text was a poem by P7, who agreed to bring copies of her work to the session. At the beginning of the session, the group had read and discussed the poem and afterwards the participants decided to do an improvisation 'about' the poem. In the discussion that followed P6 suggested to have the poem recited during the next improvisation. Since there were no other volunteers he offered to read it aloud, with the author's permission.

Participant 8 had mentioned that he liked the style (mainly the harmony and articulation) of the first improvisation and that we might want to stay in that style and develop it further in the following piece. The extract chosen is from that second improvisation. Everyone stayed in the same instrument and P6 added his voice to the playing of the djembe. The text at the end of the extract has not been transcribed for confidentiality reasons and has been substituted by the sign '#'.

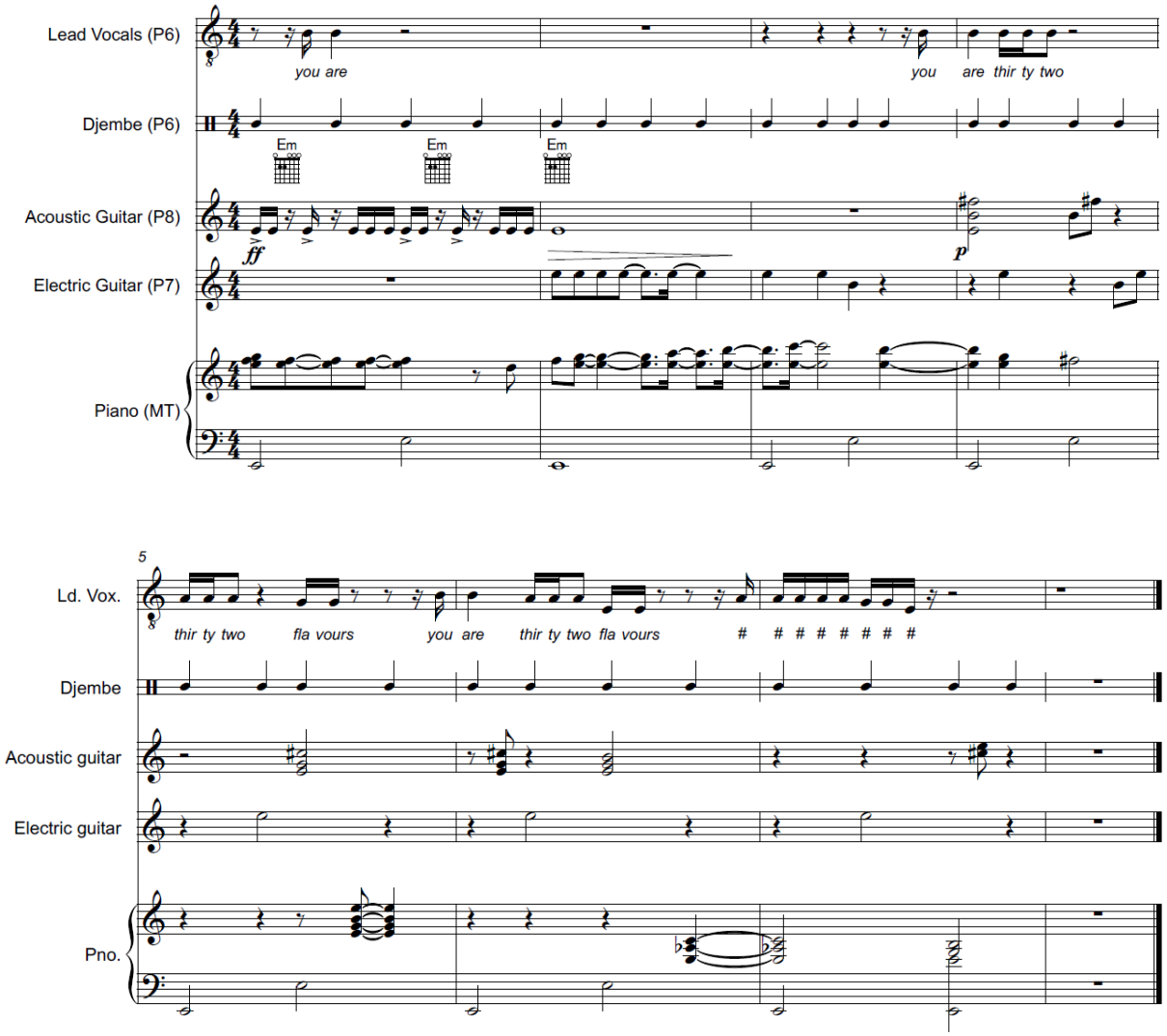
The use of the text seemed in this case to give the piece a sense of structure, direction and narrative, whilst the rest of the instruments contributed in more focused and purposeful ways compared to other improvisations, where there was a sense that the various instruments were playing in a way to sustain the music, leaving less spaces and playing in a more structural way. The 'external' element of the text, which in a way was imposed in the improvisation actually appeared to free the playing from the responsibility of structurally sustaining the music and keeping it going.

Although the group had used themes or references for the improvisations prior to this session, these had not appeared as present throughout the piece and often were perceived more as a starting point than a driver of the improvisation. In this case, instead, there was more of a sense of programmatic music, as if the improvisation was less abstract.

Similarly, the other function that the text seemed to provide was a more concrete way to talk about the music in the session, it seemed to give more ownership to the participants as to how they wanted to shape the music to go with the text. This was captured and

discussed in the meso analysis, where it was highlighted that the poem had also helped to bring focus to the session, as all three improvisations were in some way informed by the poem. It also served as an identifier for talking about the improvisation in other sessions.

Figure 5.12: Transcript extract 5: GMT - Poem



Extract 6: Alternation

This last extract (Figure 5.13) is from session 18 where three participants were present. At the beginning of the session P8 was particularly dominant in the conversation as was shown in the 'meso' analysis of the session. At this point, there had already been one improvisation in the session, which had been quite exploratory. In this improvisation all members, including the therapist, were playing percussion instruments. This selection of instruments gave the piece a particularly rhythmic focus that can be appreciated in the transcript.

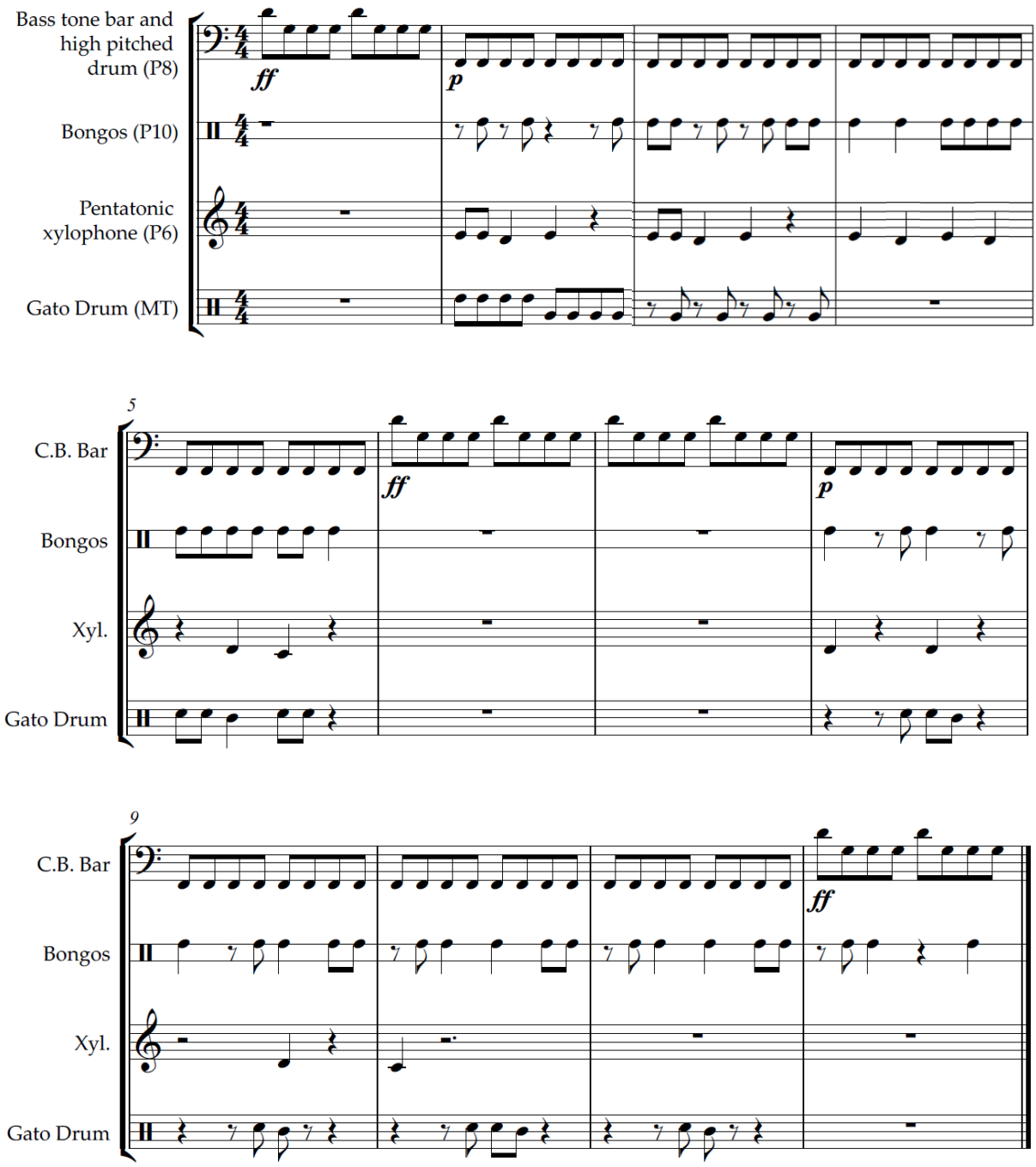
This particular fragment from the improvisation was chosen as it portrays a playful structure that emerged where P8 would change from his main instrument (the bass bar) to a drum where he would play a repeating motif four times (2 bars in the transcript). He alternated this with a repetitive playing on the bass tone bar for four bars. The transcript begins by showing the end of one of those 'solo breaks' which is followed by four bars where the whole group is playing before the next two bar break. In bar 8 the group comes back again for another four bars and the beginning of the following break is noted in bar 12.

P8 had been alternating between playing different instruments for some time before this structure emerged. Once the pattern began to form, the rest of the group seemed to recognise the structure and play along with it. This built a sense of anticipation going into the break as well as coming back to the piece. It felt a little like an implicit contract similar to that of certain jazz improvisation structures where the solos are divided in blocks of four bars and alternate. Participants 6 and 10 appeared able not only to follow the structure but also to play in a creative way within it by varying their motifs.

It is interesting to note how although P8 was dominating and in control of the structure of this section of the piece, in the fragments that followed the solo breaks he actually played relatively quietly, as has been indicated in the transcript and therefore in those segments the rest of the group became a lot more prominent and leading the musical landscape whilst he became a background support. The motifs played by P6 were particularly audible in those instances as well as the therapist. P8 had talked at different points throughout the sessions about a certain tension within his personality and character of having an impulse to dominate in a solo style whilst at the same time being

scared of that side – which he associated with his previous struggle with addiction – and wanting to be very supportive of others and collaborative. This extract seems to reflect this playful negotiation between the two sides.

Figure 5.13: Transcript extract 6: GMT -Alternation



This is another example of how some of the leadership roles during the conversations were reflected in the music making as well, but the reason that this was chosen was to provide an example of the greater control or autonomy that seemed accessible in the GMT group compared to the GVI group. The fact that such formal structures were able to emerge and be sustained within the improvisation denotes the possibility for the participants to be creative with their music making as well as remain aware of the overall piece structure and be playful with that as well. This thread will be further explored in the discussion section.

Conclusions

Having presented and described each of the extracts separately, as well as the commentary around how the activities emerged and how they impacted the sessions afterwards, several overall considerations are discussed here, which will be explored further in the discussion.

Four main ideas emerge at this point which characterise the musical activities of the groups. As a preliminary observation, it is important to highlight that these thoughts come from the particular account of the sessions that took place as part of this study and the following ideas might not be relevant or featuring in other groups. The aim here is not to generalise characteristics of GMT and GVI practice but to bring together observations from the comparative case study.

The first idea to highlight is something that was already mentioned briefly in the 'macro' level analysis, and which has been explored here in more detail, concerning the musical variety in each of the groups. The transcripts of the extracts show how the ways in which the participants engaged with the music making were more consistent across sessions in the GMT than in the GVI group, although the variety between participants in each of the sessions was greater in the GMT group than in the GVI group. In other words, the GMT group featured more diverse ways of playing within a piece with people being able to choose an instrument with little expressive possibilities, such as the tambourine, or another one with a wider range of options such as the guitar. In the selected pieces, those different musical roles could coexist in the same improvisation and gave the pieces a varied timbral, textural and structural frame. However, the same possibilities and frame

appeared to apply in all of the improvisations across sessions, from session 2 until session 18. Meanwhile, in the GVI group the ways in which participants made use of the voice were relatively similar between participants in each of the pieces, although there was a somewhat greater variety in the Soundscape example where percussive sounds were combined with more melodic lines for instance. However, what was clearly noticeable was the difference in the use of voice between pieces, which changed not only in format and structure but also in the vocal resources used in each.

The second idea, which relates to this first one and has also been discussed previously in the macro and meso levels, refers to the degree of autonomy and capacity to sustain the music making. As seen particularly with the last extract where an alternating structure emerged through the course of the improvisation, the music making in the GMT group appeared to afford more opportunities to be playful with the structure of improvisations. This was also the case in the other two extracts, where there were a variety of textures which influenced the musical form. This phenomenon appeared to the therapist as linked to a greater autonomy from the participants, perhaps due to the narrower range of dimensions that they could be creative with. This autonomy or agency seemed to manifest as allowing a certain distance between the music making produced by the improviser and their subjective experience of the group´s music. As has been mentioned, the closer link with the body in the vocal production of sound seemed to reduce that distance, which seemed to impact on the participant´s capacity to sustain the music making and to be more autonomous in using their musical contributions in order to create a structure in the piece. It is for this reason that more restrictive or pre-determined structures were incorporated in the GVI group, which made the musical activities more directive.

The third idea to consider concerns the continuity of the musical activities across sessions. It has been shown how all of the portrayed formats or activities from the GVI group had been built up through the course of the sessions. The soundscape had been the next step after the humming and the breathing exercises that had preceded. The syllables activity had been designed in response to the soundscape and had started with singing a pre-composed song and then making a similar one in the group. The different ways of pronouncing the syllables had been practised separately and progressively in the course of two sessions and then it continued to evolve. Finally, the sound and gesture activity, although initially took place spontaneously, in the following session participants

wanted to go back to it. This phenomenon gave some continuity to the sessions as well as a sense of narrative or progression and development of the musical activities.

Instead, in the GMT this was not the case, and even when some particular activities such as the sound signatures repeated over a number of weeks there did not seem to be a sense of linking the content of the activity to that of the previous week, it felt like we were just taking the same format to do something different. Sometimes there was a sense of narrative between the different pieces in a session. This has been described for the session when we made use of the poem to build the different improvisations. In a similar way, in several other sessions sometimes the participants or the therapist would refer to the previous piece when thinking about the next improvisation. For example, in one case P6 wanted to do a piece that was contrasting with the previous one.

Finally, the fourth and last idea of this section relates to the use of pre-composed material and how this was combined with the improvisations. This was most apparent in the GVI group where some of the activities were mainly concerned with pre-composed music, although it is possible to argue that there is an element of improvisation even when reproducing a well-known song in the group. What is most relevant here is to think about the function of singing of pre-composed songs for a group where the main task was to engage in group vocal improvisation. On one hand, on some occasions the experience of singing well-known songs served to familiarise participants with their own singing voice and with singing together in the group. In that sense it functioned as a preparation for improvisation. On the other hand, however, the pre-composed songs also had different purposes, such as sharing cultural references at the beginning, where the participants were getting to know each other. For example, when they had to reach consensus of what song they would like to sing together and they exchanged views on songs they liked and knew. Another function was to use the lyrics of songs in order to discuss them, in this sense the emotional content of the lyrics might have served as a starting point for the participants to open up about their own emotional world. As described in the literature review, this function of reproduction techniques as increasing social relationships and decreasing interpersonal problems is described in the study by Mössler (2012). Similarly, in the songwriting activities, participants were making use of both verbal and non-verbal creative expressions to share their experiences and express themselves.

We have also seen how using a pre-composed text as a basis for an improvisation in the GMT group affected both the music making, the structure of the session and the ways in which activities were negotiated. In the discussion section, it will be interesting to reflect on the different aspects of the therapeutic encounter and how these were affected by the use of pre-composed material, since the present analysis appears to show an important influence in how the sessions were shaped.

5.2 RQ2 – THERAPEUTIC PROCESSES

Research question 2: What therapeutic processes emerge when using GVI and GMT?

Following the first research question concerning the interactions that took place in the GVI and GMT groups, this section presents the findings from the second research question. Here the focus is on the therapeutic processes emerging in the groups. As explained in the methodology and methods chapters, one parameter of psychotherapy processes, therapeutic alliance, was chosen as the main measurement, given its important role in different therapy modalities and its strong correlation with therapeutic outcomes (Ardito and Rabellino, 2011; Arnow *et al.*, 2013). Therapeutic alliance was assessed through the weekly data from the Group Session Rating Scale (GSRS) questionnaires. Added to this, a review of the attendance of the two groups is also presented in order to provide another level of description of the groups' development and processes. Both the scores from the GSRS and the records of attendance are analysed through descriptive statistics.

5.2.1 Attendance analysis

Overall, the attendance of both groups is similar and shows similar trends and characteristics. In both groups the attendance was relatively high for this client group (Lefforge, Donohue & Strada, 2007). Only one participant dropped out. He did not provide a clear reason for this and in fact when contacted to enquire about his absence he repeatedly said he was planning to attend the next available session. The following sections detail the calculation of the attendance from different angles.

Calculation method

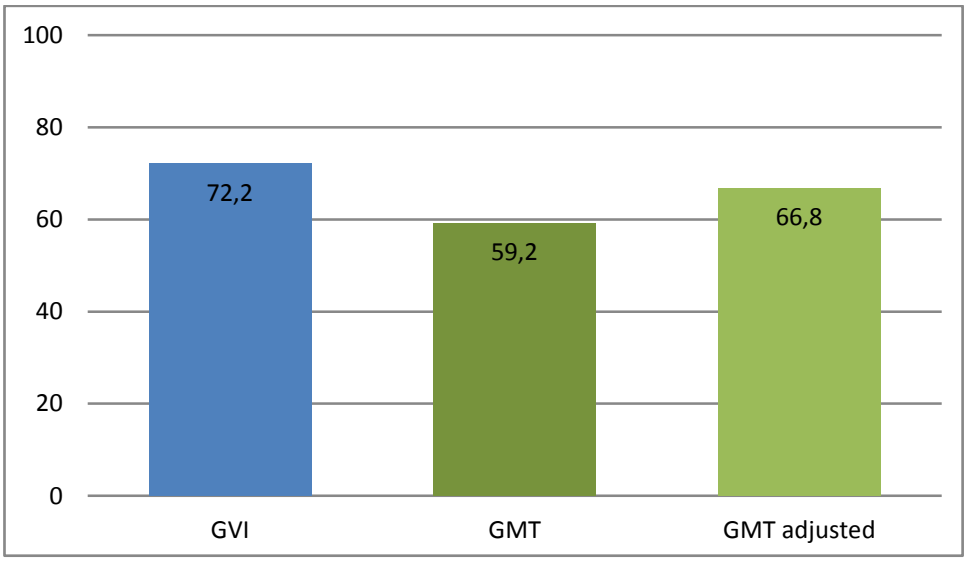
Both the GVI and the GMT groups had a membership of 5 participants per group. In the GVI group all members stayed until the end of the study and completed the interview and follow up individual clinical session to discuss discharge. In the GMT group one patient (P9) dropped out and only attended 2 sessions in total. For this reason, when calculating the attendance percentages the GMT group has 2 values, one for the absolute figures of attendance based on the initial 5 participants (intention to treat analysis, ITT) and an 'adjusted' value to calculate the percentages based on the evolving actual membership of the group (on treatment analysis). For this 'adjusted' value, the total membership of the group has been considered 5 until session 11, which was the last one attended by the participant who dropped out and, 4 from then on.

Both groups first started with a confirmed membership of only 4 for different reasons. In the GMT group, one of the participants (P10) had had to delay one of the assessment sessions, which meant that on the first day of the group he still had his last assessment session and he joined the group from the following week (week 2). Instead, in the GVI group, one participant (P5) had completed the assessment but at the time of the start of the group was overseas. She only joined the group on the 8th session. In both cases the percentage of attendance has been adjusted to a total membership of 4 until each of the participants joined their respective groups, at which point the percentage is calculated in proportion to a full membership of 5. This happens in session 2 for the GMT group and in session 8 for the GVI.

Attendance analysis: macro

The global analysis of the attendance figures showed a very similar percentage of overall attendance, particularly when using the adjusted value for the GMT, despite a slightly higher attendance in the GVI group. The GVI had a general attendance across the 23 sessions of the group of 72.2% and the GMT group showed a 66.8% attendance (59.2% in the intention to treat analysis) as shown in Figure 5.14.

Figure 5.14: Overall attendance



These figures show the averages of percentage of attendance per session, meaning that the percentage of attendance has been calculated separately for each session (i.e. if

there were 4 out of 5 participants present a value of 80% attendance is given to that session).

Another way to look at the groups' attendance is by looking at the average attendance of each participant. This has been calculated in the table below, showing an average number of 15.6 sessions attended in the GVI and 16.5 in the GMT group (13.6 in the ITT analysis), which again shows great similarly between groups.

Table 5.6: *Individual attendance per groups*

Individual attendance GVI			**Individual attendance GMT**		
GVI	**Number of sessions (out of 23)**	**%**	**GMT**	**Number of sessions (out of 23)**	**%**
P1	10	**43.5**	P6	19	**82.6**
P2	14	**60.9**	P7	14	**60.9**
P3	17	**73.9**	P8	19	**82.6**
P4	22	**95.7**	P9	2	**8.7**
P5	15	**65.2**	P10	14	**60.9**
Average GVI	15.6	**67.8**	Average GMT	13.6	**59.1**
			Average GMT adjusted	16.5	**71.7**

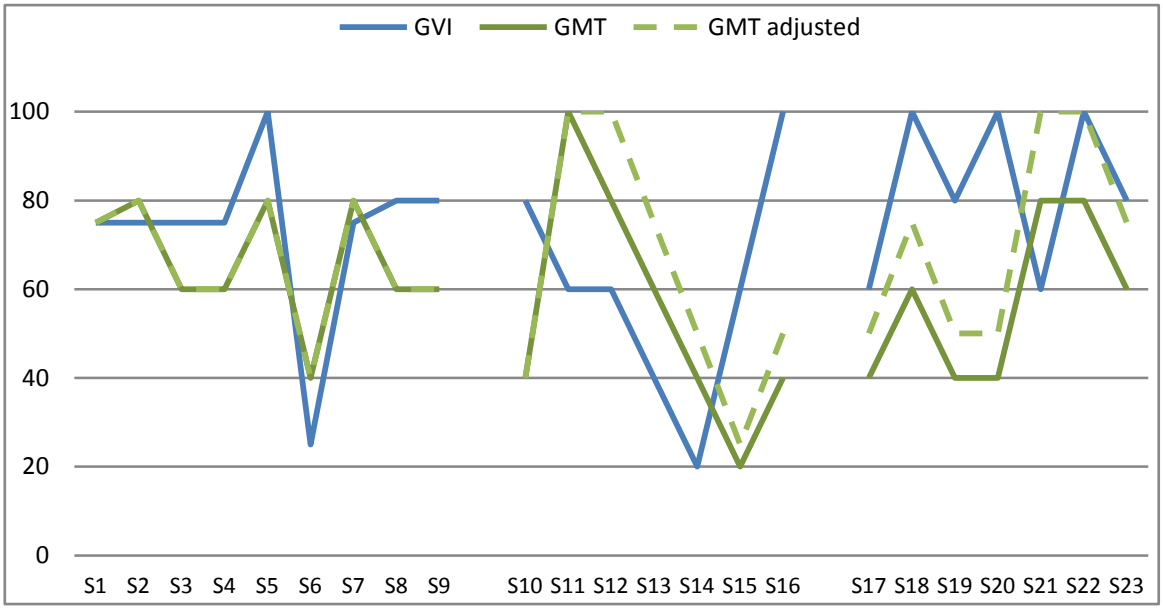
The above table (Table 5.6) starts to show the individual differences in attendance, which will be described below in the 'Micro' section in more detail. However, an average of around 16 sessions out of 23 attended by participants in both groups (around 70% of the sessions) is a relatively high figure for a client group where absences and drop outs from services tend to be a characteristic feature (Lefforge, Donohue & Strada, 2007; Sharf, 2009) given the difficulties clients face in their different diagnosis, which might make it difficult to maintain a consistent attendance.

Attendance analysis: meso

Looking at the attendance values per session to have a more longitudinal perspective similar figures and trends can be observed. Figure 5.15 shows the fluctuations in attendance throughout the 23 sessions. It is interesting to notice the marked similarities in increases and decreases in attendance in both groups. The two one week breaks have

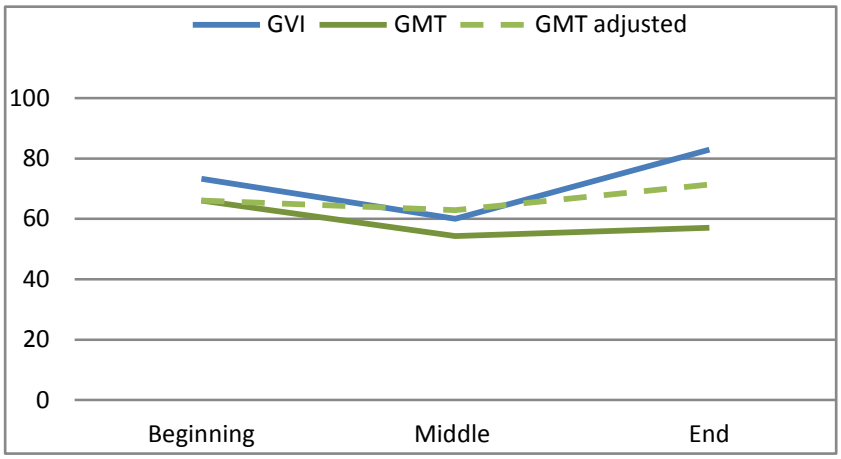
been shown with empty segments in order to be able to appreciate the potential effect of the breaks in the groups processes and the impact these had on the attendance. Other factors also influenced the participants' attendance, such as an intense heat wave on session 6, which might have contributed to the low attendance on that week.

Figure 5.15: Group attendance per session



Looking at the average attendance per group for each of the three phases of the group (beginning, middle and end) in Figure 5.16 it is possible to appreciate the expected initial drop and final raise typical of therapeutic processes (Charman, 2004). The increased attendance in the last phase of the group is particularly evident in the GVI group, where in the last phase there was an average attendance of 82.9% of participants, which is a significantly high attendance figure, which was clearly above the initial attendance value, whereas the GMT group also increased in attendance in the last phase but remained in a similar region as the initial attendance.

Figure 5.16: Group attendance per phase



Attendance analysis: micro

Finally, it is worth examining the individual attendance figures in the light of explanatory background information. The number of sessions attended by each participant has been shown in the table in the previous 'macro' section, where it is possible to see for example that participant 1 only attended 10 sessions. In his case, rather than being an ongoing fragmented attendance, this was the result of him missing 9 consecutive sessions towards the middle of the 6 months. This did not seem related to an episode or relapse in mental health but rather of practicalities that got in the way linked with housing and benefits for that participant. He reported feeling too exhausted and unable to attend due to those circumstances. Similar cases of this happened for participant 2 who was on holiday and then physically unwell for a few weeks. As discussed at the beginning of the attendance analysis section, participant 5 also missed a number of consecutive weeks at the beginning of the project as she was overseas and only joined the group by week 8, which explains the relatively low number of sessions attended in her case. There was one case in the GMT group as well, where participant 7 was offered a professional internship that clashed with the time of the group. She missed six sessions due to this in between the second and third phases of the group.

There were other types of absence that were more specifically related to a relapse for example for participant 10, who missed a few sessions due to this. Similarly, for patient 2, she was recovering from a previous episode that had taken place between the assessment sessions and the beginning of the group sessions. For this reason, she missed the first three sessions of the group.

Finally, it is worth thinking about absences of participants who considered leaving the project. For example, participant 3 did not attend for four consecutive weeks during the second phase of the group. In his case he was considering leaving the group at that point, as he found it stressful to continue to attend. An individual session was offered where we were able to discuss this and he decided to continue to attend eventually and was appreciative for that individual support later on. Individual sessions were available for participants if they felt that there was anything that they wanted to address separately, but no one else requested this although they had been informed of that possibility.

Participant 3 was the only participant, apart from participant 9 in the GMT group, who considered leaving the project during the course of the sessions. As explained previously, participant 9 only attended 2 sessions and later on decided to leave the project. It was

possible to discuss this over the phone and a discharge plan was agreed back to the CMHT where he was able to sustain some engagement with a newly allocated care coordinator.

Final considerations about attendance

Overall it is possible to say that the attendance in both groups was similar and relatively high. Due to the small sample size and exploratory nature of the study no statistical tests were used. However, it is possible to notice a higher attendance for the GVI group particularly in the final phase of the group, as has been shown in figures 5.15 and 5.16 in previous sections.

This will be revisited when considering the group processes that took place and the analysis of the scores of the Group Session Rating Scale questionnaire. There is a sense of growth and consolidation for the GVI group that these attendance figures start to point towards and which will be further explored.

5.2.2 Analysis of GSRS questionnaire

This section addresses the descriptive statistical analysis of the Group Session Rating Scale scores. As described earlier, this questionnaire is a validated measure of therapeutic alliance and was used in this study to examine one aspect of group processes in order to explore differences and similarities between the two groups. The questionnaires were filled in by all participants at the end of each session and, mirroring the analysis of research question 1, the analysis of the ratings is presented here in three levels: macro, meso and micro.

Calculation method

The scores of the Group session rating scale (GSRS) questionnaires were calculated using a standard ruler as per the measure's protocol, and entered into a table after each session. Each questionnaire contained four scores out of 10, one for each of the four parameters measured by the questionnaire. Each parameter is scored by putting a mark somewhere along a horizontal line which measures 10 cm in total. At either side of the line there is the same statement worded in a negative way (i.e. 'I did not feel understood') on the left hand side and in a positive way (i.e. 'I felt understood'). The

score is taken by measuring the space between the beginning of the line on the left hand side and the participant's mark.

The different parameters of the GSRS questionnaire focus on:

- Relationship: asking the participant to rate the extent to which they felt "understood, respected and accepted by the leader and the group".
- Goals and Topics: asking the participant to rate the extent to which they felt that "we worked on and talked about what I wanted to work on and talk about".
- Approach or Method: asking the participant to rate the extent to which they felt "the leader and the group's approach is a good fit for me".
- Overall: asking the participant to rate the extent to which they felt that "overall, today's group was right for me – I felt a part of the group".

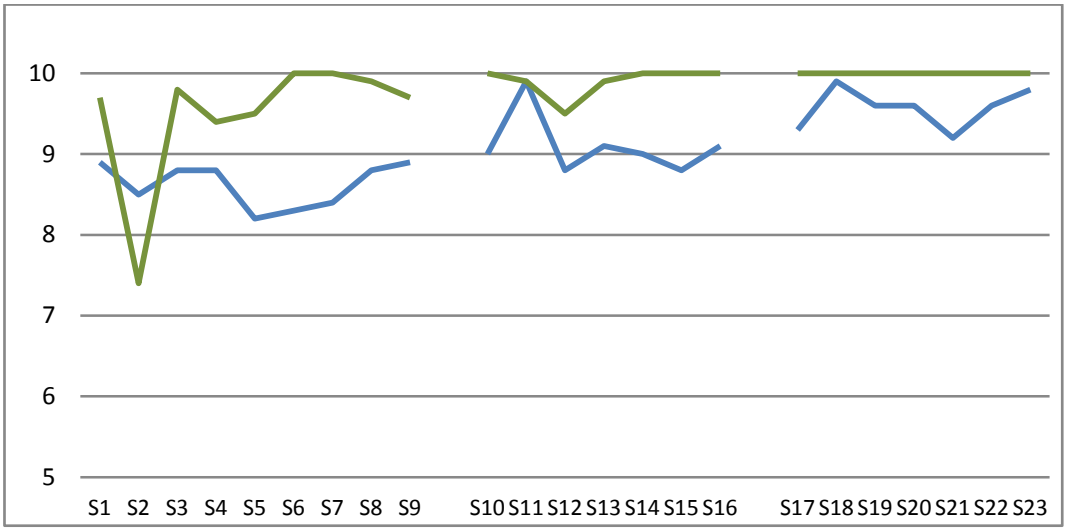
The calculations in the following sessions are the average result of all the scores from the participants who attended each session.

GSRS analysis: macro

In a first global analysis of the GSRS scores for each group a clear difference between the two groups is immediately visible, where the GMT group's scores are systematically higher than those of the GVI group almost in all sessions (Figure 5.17). Both groups show a similar trend of increasing scores as the groups progressed, with the GMT group reaching a point about half way through where the scores remain on the maximum value until the end, reaching ceiling effect (Austin, 2002). Instead, the GVI group scores also reach high figures towards the end, but these remain variable within the area between the 9 and the 10 score value.

Some of the points where the scores deviate drastically from the progressive trend line seem to be closely related to specific events in the sessions. For example, the significant drop in scores for the GMT group in session two appeared to link with a certain tension which arose between a new participant and the rest of the group. This will be further explored later on as this was one of the themes of this group. Similarly, the sudden increase in scores for the GVI group in session 11 seemed to relate to a new vocal improvisation activity that was introduced in that session for the first time. This will also be described in subsequent sections in more detail as this seemed to be an important moment for the group. Link it with the RQ1.

Figure 5.17: *Synthesis of GSRS scores per session*



GSRS analysis: meso

Focusing the attention on more discrete analysis of the different parameters measured in each group (Figures 5.18 and 5.19), it is possible to appreciate how each of the parameters appears closely linked with the others, although there are some subtle differences as well. In order to highlight these, a chart showing the comparison between groups of each separate parameter is shown separately (Figure 5.20).

This analysis reveals that the most variable scores are those for the 'overall' category, where the participants were rating how much they felt the group was 'right' for them and how much they felt part of the group. Instead, the 'approach or method' scores were the most stable for both groups, suggesting that the therapeutic stance and frame for the sessions format was perceived as consistent even when the tasks or group conversations were more variably rated.

The GVI group shows greater variability between different parameters, which might suggest a more mixed experience from the sessions, whereas the GMT group's scores for the different parameters are more closely linked to each other. This might also probably relate to the scoring 'style' of each participant and therefore, both in overall value and in differentiation of the different aspect of the session's experience. This will be explored further in the following section, which will allow a more detailed look at the individual participants' scores.

Figure 5.18: *GSRS parametric scores in GMT group*

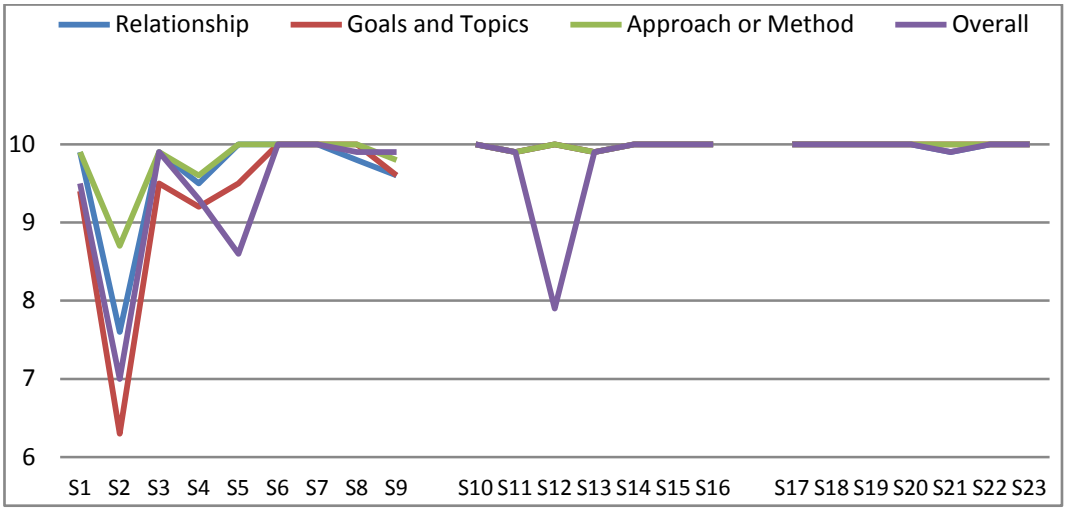


Figure 5.19: *GSRS parametric scores in GVI group*

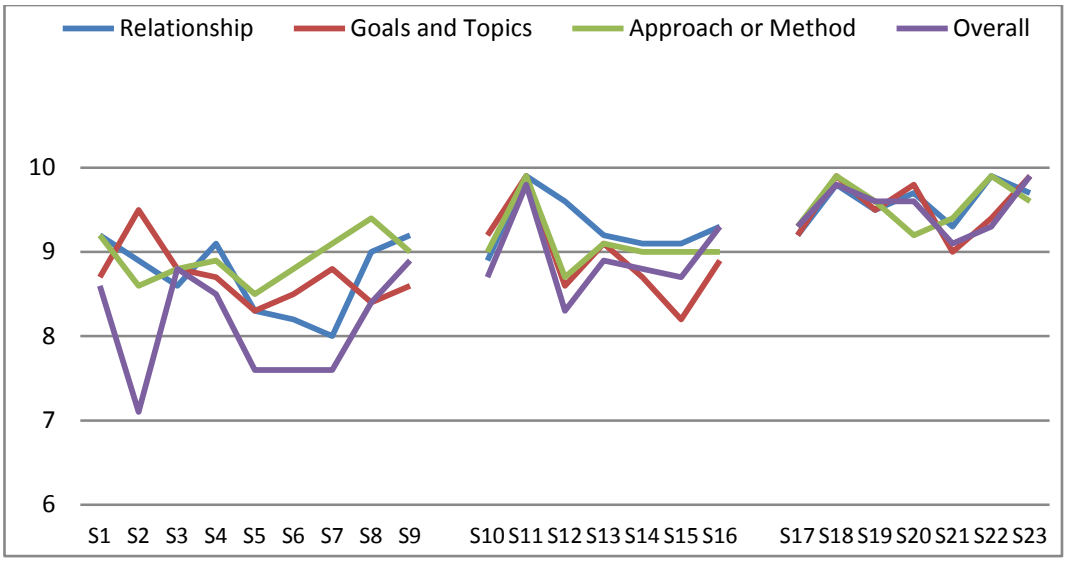
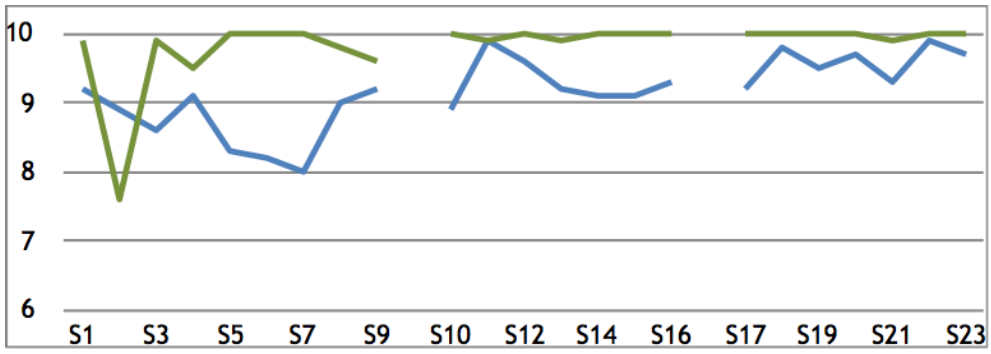
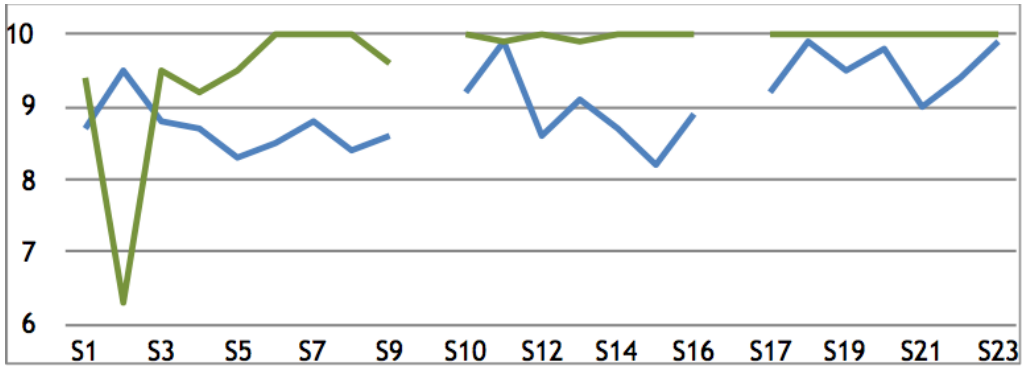


Figure 5.20: *GSRS Parametric scores comparison (GVI – GMT)*

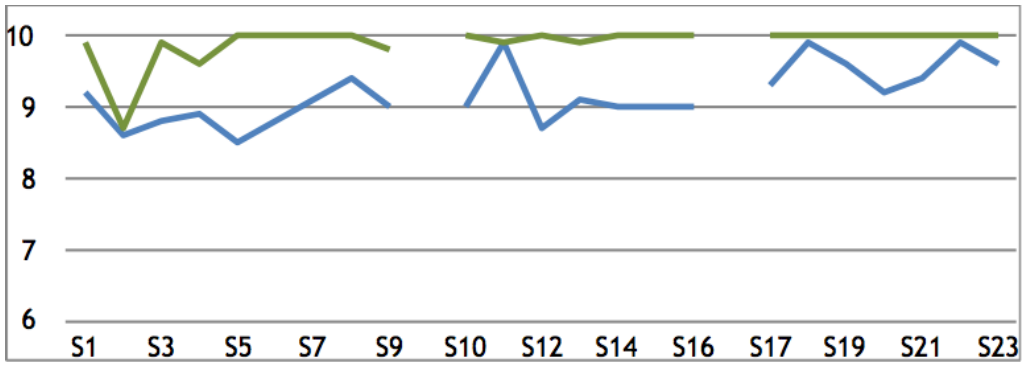
Relationship (GVI blue, GMT green)



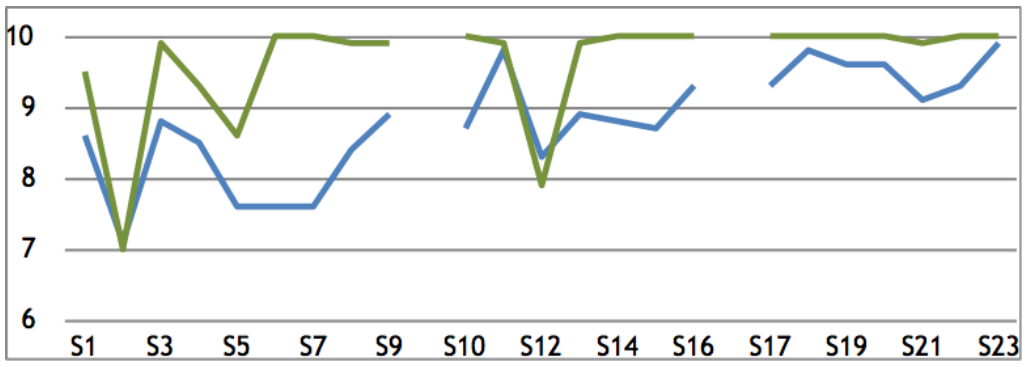
Goals and Topics (GVI blue, GMT green)



Approach or Method (GVI blue, GMT green)



Overall (GVI blue, GMT green)



GSRS analysis: micro

Participants showed different 'styles' of rating the questionnaires. Since there are no specific categories or values clearly described in the scale, each participant seemed to have a range of the spectrum or line that they used, which varied from the whole of the line to using just the upper third for example as there were no indications of the extent of what each extreme of the line meant.

For this reason, a further analysis of each individual's scores was done in order to look at the relative changes within individual participants' scores rather than averages of absolute values amongst different participants. For this purpose, a Table with all of the individual scores is presented (Table 5.7 for GVI scores, Table 5.8 for GMT scores), where individual variations have been marked in yellow when there is a relative decrease in the score of the same parameter compared to the last score available for that participant in that parameter. A change in the opposite direction has been marked in green to highlight the increases and orange has been used for the occasional instances where there is a very significant drop in a particular score.

This analysis shows that participants 1 and 5 from the GVI group and 7, 8 and 10 from the GMT group tended to score all the parameters from each session similarly and that they also tended to provide consistently high scores for all sessions. Therefore, for these participants more subtle changes in scores have been highlighted. Instead the remaining participants showed a greater score variability between sessions and between parameters, which means that only more substantial changes have been highlighted.

Although there were participants with both 'styles' in each group, it is worth noting that three out of the four main participants for the GMT group scored the questionnaires in the consistent style, which was the case for only two of the five participants in the GVI group, which seems to have importantly influenced the overall scores for the group.

When looking at the individual scores it is also possible to see a more accurate reflection of what they commented on in the session, as well as in the final interviews, in regard to their experiences of the different tasks and conversations in the groups. For example, for participant 4 there was one particular session (session 7) where he reported finding the vocal improvisation activity that occupied most of the session quite uncomfortable to engage with. This was then reflected in his GSRS scores, although only in the parameters concerning 'relationship' and 'overall', which have been marked in orange in Tables 5.7 and 5.8. Instead, the remaining parameters, of 'goals and topics' and 'approach or

method' were still rated significantly high. This is again an example of how this participant had a highly variable scoring 'style'.

Another example of the scores being directly related to specific tasks can be seen on session 6 for participant 3, where he reported that he specifically struggled with one of the more 'experimental' vocal activities, where participants were encouraged to improvise an 'imaginary language'. Finally, participant 5 reported that the songwriting activity that was the focus of session 21 had felt too difficult cognitively and this is also reflected in her scores for that session, although she tended towards the 'consistent style' of scoring, as has been described previously.

In the GMT group there were fewer instances of this phenomenon, although as briefly discussed before, a clear example took place in session 2 where tensions arose between the different members of the group. The only other clear instance took place in session 12, where participants 6 and 8 provided unusually lower scores in the 'overall' category, although they did not report anything specifically during the session. It is interesting, however, that the therapist's session summary notes also reported a sense that the session felt 'less achieved' than in the past and that something felt a little 'stuck' throughout the session. Since this was the session following the one where participant 9 attended for the second and last time, it is worth taking this into account when reflecting on the group's process. The impact of the presence and absence of this participant seemed to have a profound impact of the overall process of the GMT group, which was particularly emphasised in the final interviews by all participants.

Further discussion of the different activities and how they were experienced by the participants as well as group processes was presented in the analysis of the audio recording and will be explored in the analysis of the interviews.

Table 5.7: GVI individual GSRS scores
R: Relationship, G: Goals and Topics, A: Approach or method, O: Overall

	P1				P2				P3				P4				P5			
	R	G	A	O	R	G	A	O	R	G	A	O	R	G	A	O	R	G	A	O
S1	9,9	9,9	10	9,6					8,7	7,2	8,5	8,3	9,1	9,1	9,1	7,9				
S2	10	10	10	10					8,5	8,6	8,6	7,1	8,1	9,9	7,1	4,2				
S3	10	10	10	10					9,1	8,8	9,5	9	6,7	7,6	6,8	7,5				
S4					9,8	7,4	9,5	9,4	9,1	9	9	8,1	8,4	9,6	8,1	8				
S5	10	10	10	10	8,3	6,6	9,7	6,4	8,4	8,3	8,1	6	6,3	8,2	6,1	8				
S6													9,8	9,8	9,8	9,8				
S7					9,9	9,8	8,6	8,6	9,3	7,5	9,5	9,6	4,8	9,1	9,1	4,6				
S8					9,8	9,4	10	10	8,4	8	9	7,9	8,7	7,2	8,4	7,4	9,1	9	10	8,3
S9					9,8	8,5	8,4	9,1	8,4	8,3	8,9	9	8,4	7,5	8,3	7,3	10	10	10	10
S10					10	10	10	10	8,2	7,6	8,4	8,9	8,3	9,8	8,2	6,5	9,1	9,2	9,3	9,2
S11					10	10	10	10					9,7	9,7	9,7	9,5	10	10	10	10
S12					9,9	7,8	7,7	6,6					8,8	8,1	8,3	8,2	10	10	10	10
S13													9,8	9,8	9,9	9,8	8,5	8,4	8,3	7,9
S14																				
S15	9,7	6,4	9,4	9,6					9,4	9,4	9,6	8,1	8,3	8,7	8	8,4				
S16	9,6	9,4	10	10	10	10	9,3	10	9,6	7,1	7,9	8,2	7,2	7,9	7,6	8,3	10	10	10	10
S17									9,2	9,8	9,3	10	8,5	7,8	8,5	7,8	10	10	10	10
S18	10	10	10	10	10	10	10	10	9,4	9,6	9,6	9,4	9,8	9,8	9,8	9,7	10	10	10	10
S19					10	10	10	10	8,9	9,5	9,4	9,7	9,1	8,5	8,9	8,5	10	10	10	10
S20	10	10	10	10	10	10	8,2	9	9,6	9,6	9,5	9,6	8,7	9,2	8,6	9,3	10	10	9,9	9,9
S21					10	10	10	10					9,3	8,8	9,8	8,9	8,6	8,3	8,5	8,5
S22	10	10	10	10	10	10	10	10	9,8	9,8	9,8	9,6	9,8	7,2	9,6	6,9	10	10	10	10
S23	10	10	10	10					10	10	10	10	8,6	9,5	8,2	9,4	10	10	10	10

Table 5.8: GMT individual GSRS scores
R: Relationship, G: Goals and Topics, A: Approach or method, O: Overall

	P6				P7				P8				P9				P10			
	R	G	A	O	R	G	A	O	R	G	A	O	R	G	A	O	R	G	A	O
S1	10	10	10	8,7	10	10	9,9	10	9,8	8,4	9,7	9,7								
S2	8,8	4,9	6,9	1,8	9,9	9,8	9,4	9,3					1.8	0,6	8,5		10	9,8	9,9	9,9
S3					10	10	10	10	10	8,7	9,9	9,9					9,8	9,7	9,7	9,7
S4	8,6	7,7	8,8	7,8					10	10	10	10					10	10	10	10
S5	10	9,3	10	9,2	10	10	10	9,6	10	8,6	10	8,9					10	10	10	6,5
S6	10	10	10	10					10	10	10	10								
S7	10	10	10	10	10	10	10	10	10	10	10	10					10	10	10	10
S8	10	10	10	10	9,6	10	10	9,6	10	10	10	10								
S9	9,2	9,3	9,4	10	9,7	9,5	10	9,6	10	10	10	10								
S10					10	10	10	10									10	10	10	10
S11	10	10	10	10	9,7	9,7	9,7	9,7	10	10	10	10	9,7	9,7	9,7	9,7	10	10	10	10
S12	10	10	10	2,8	10	10	10	10	10	10	10	8,6					10	10	10	10
S13	10	10	10	10	9,8	9,7	9,8	9,6	10	10	10	10								
S14	10		10	10													10	10	10	10
S15																				
S16	10	10	10	10					10	10	10	10								
S17	10	10	10	10					10	10	10	10								
S18	10	10	10	10					10	10	10	10					10	10	10	10
S19									10	10	10	10					10	10	10	10
S20					10	10	10	10	10	10	10	10								
S21	10	10	10	10	9,8	10	10	9,8	10	10	10	10					10	10	10	10
S22	10	10	10	10	10	10	10	10	10	10	10	10					10	10	10	10
S23	10	10	10	10					10	10	10	10					10	10	10	10

GSRS analysis: final considerations

As is shown in the section on the audio recording analysis (section 5.1.1), one of the features of the GVI group was that the musical tasks of the group were more varied than in the GMT group. For example, there were activities ranging from singing pre-composed songs to improvising with words, improvising without words, songwriting, activities involving sound and gesture, etc. For this reason, it is also worth considering the possibility that the variety in the group's tasks might have also contributed to a more variable range of scores in the GVI group when compared to the GMT scores, which remained more stable, in the same way that the musical activities remained more similar as well.

This is relevant both to the differences in scores between different sessions (as described in the previous paragraph) as well as between participants, since there were instances in the GVI group where some participants had particularly enjoyed a specific task which had been uncomfortable for others.

There will be an opportunity in the discussion section to review the appropriateness and usefulness of the different data collection methods used in the study, where there will be a more extensive reflection on the relevance of the information gathered through distributing the GSRS questionnaire weekly after each session. For now, it seems important to highlight that some of the main events which contributed to the global groups processes were captured by this measuring tool. It has also allowed some reflection and nuance on the differences in the nature of the groups' tasks and the impact this had on the participants' experience of the sessions.

An analysis comparing the attendance levels and the GSRS scores was done by superposing the charts presented in this section with those of the attendance analysis in order to see if there were any signs of possible correlations. This did not appear to provide any further insights apart from what has been discussed in each separate analysis already. For this reason, those charts have not been included here for discussion as the figures are already available separately.

Finally, the relatively small number of participants per group might have influenced the evolution and degree of engagement with the interventions. The techniques themselves would probably have been adapted to suit larger formats. However, given that this group size of five is not unusual in similar music therapy settings, the present findings appear relevant to small closed music therapy groups.

5.3 RQ3: CHANGE MECHANISMS

Research question 3: How do patients and therapist experience GVI and GMT?

This section presents the findings from the post therapy interviews conducted with all participants. These were aimed at providing some insights for research question 3, which enquired about the change mechanisms involved in the practices of GVI and GMT. This follows the more exploratory enquiry from research question 1 about the interactions in the groups and the considerations around group processes generated from them in research question 2. Here the reflections aim at a deeper and more nuanced exploration of the accounts from the participants.

The interviews were conducted in the same music therapy room as the initial individual assessment sessions. The interviews were transcribed manually from the audio recordings. The transcriptions included both verbatim textual content and some important non-verbal aspects of communication such as gestures, from the therapist's memory.

Two levels of analysis of the data, thematic analysis and Interpretative Phenomenological Analysis (IPA) are combined strategically, as will be described in the sections below, in order to provide a full exploration of the participants and therapist's experiences of the practices of GVI and GMT.

5.3.1 Thematic Analysis

The thematic analysis conducted on the transcripts from the interviews served different purposes. Firstly, it was an initial step in getting familiar with the data and mapping it out with first impressions. Secondly, it served to analyse one of the main parts of the interview which consisted in identifying and rating changes from before and after the therapy. Thirdly, it was a way of selecting the fragments of data mainly concerning the experiences around the music making and the therapeutic framework. These would be analysed in the more in-depth IPA analysis, along with the remaining fragments that related to other aspects of the sessions, such as the experience of the research methods or the social aspect of the group. The thematic analysis was conducted following the model and steps suggested by Clarke, Braun and Hayfield (2015), which involve:

familiarization, coding, 'searching' for themes, reviewing themes and defining and naming themes.

As described in the methodology section, the method used for the interviews was the client change interview (Elliott, Slatick, & Urman, 2001), the outline of which can be seen in Appendix G. An important section in this interview format asks the participants to identify any changes that they have noticed in their lives and to rate how expected those were, how likely it was that they would have occurred without having attended the therapy, how important they felt the change was and to reflect on what they thought had contributed to that change. The semi-structured interview also included questions around the positive and challenging aspects of the sessions as well as significant moments and the participants' perception of the research aspects involved in the research. The first analysis presented here will address the changes identified by the participants in each of the groups and later on the remaining views from them that were not included in the IPA analysis will also be presented.

Analysis of reported changes

In this part of the analysis the changes have not been explored in depth due to the fact that those that are more relevant to the questions have been explored in the IPA analysis. In addition to this, the changes did not have to be directly related to the therapy sessions and therefore in a way some are more clinically relevant than concerning the object of the study. However, what is provided here is a content analysis (Wilkinson, 2015) of the changes organised in categories and a numeric way of portraying the different categories' prevalence in order to explore if there were any important differences between the two groups and to look for any trends.

The different categories for the changes emerged from a coding and classification of the data and aim to map out different dimensions of the therapeutic work that a music therapist might be considering when running this kind of group. The same categories were applied to both groups. The categories of changes were:

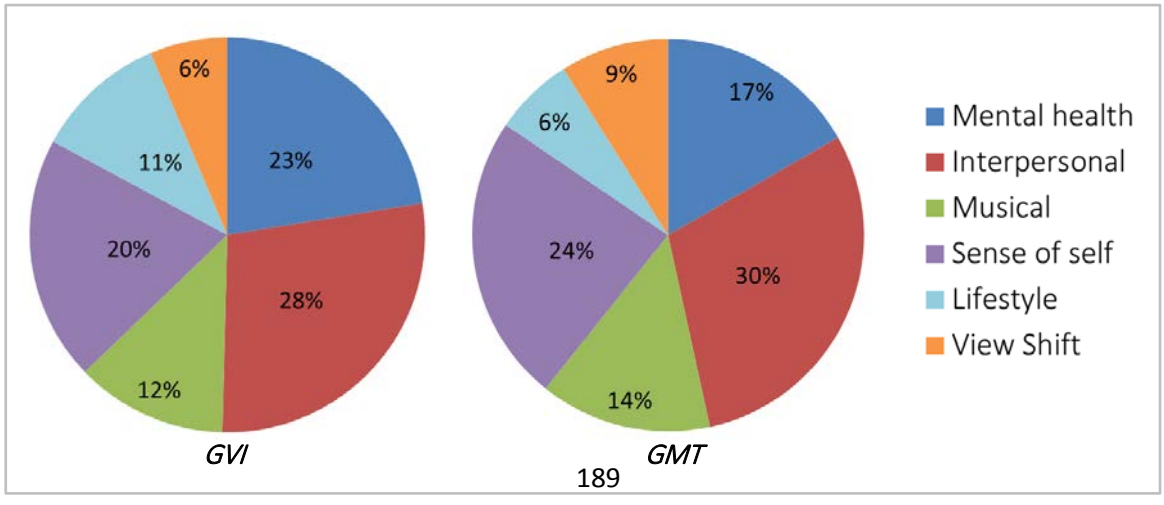
- Mental health: changes in clinical symptoms and changes in medication
- Interpersonal: changes in participants' experiences in relating to others

- Musical: changes in musical activities outside the music therapy sessions
- Sense of Self: changes in individuals' perceptions of themselves (not clinical symptoms)
- Lifestyle: pragmatic changes in various aspects of lifestyle
- View shift: changes in perspective around mental health or psychotherapy

After identifying each of the changes and exploring them briefly, the participants then rated each change on the dimensions presented above on a scale of 1 to 5 (how expected, likely and important they felt the changes were). Table 5.9 shows all the changes with their ratings for each group organised in the different categories and Figure 5.21 shows the overall significance of the changes per categories in percentages. The reason that it has been shown in percentages was that there were five participants who did the interviews for the GVI group and only four for the GMT group and therefore absolute values would not have provided comparable figures. Also, since this is not a quantitative analysis of the impact one each group, it appears reasonable to focus more on the distribution of changes than on their actual value.

As Figure 5.21 shows, the distributions of changes were very similar in both groups, both showing the highest scoring for the changes relating to the 'interpersonal' changes, followed by changes in 'mental health' and in 'sense of self', although in slightly different proportions between the groups. Then in both cases the 'musical' changes follow and the last two categories are 'pragmatic' and 'view shift', although again in inverted proportions.

Figure 5.21: Changes distribution in GVI and GMT groups



In this sense, it is possible to assume that both forms of music therapy practice, GMT and GVI, seemed to overall address similar overall therapeutic dimensions. It seems fitting that the largest area of change for both groups was the interpersonal category, since both the group experiences and the reflections on these are a crucial aspect of this format of therapy.

The category that seems to vary the most between the two groups is the changes in lifestyle from the 'pragmatic' category, which in the GVI group are almost a double of the percentage of those in the GMT group. Looking in detail at the changes in this category it can be seen that three of the participants reported changes in lifestyle that link to bodily experiences: P1 feeling more able to resist cravings and eating healthier, P2 not feeling like needing a cigarette after the sessions, and P4 exercising more. It is possible to see these changes as concerning a greater awareness of or healthier relationship with the body. This is interesting if considering the voice's closer link with the body. This will be a theme that will be explored in the IPA analysis too.

Table 5.9: Summary of changes and ratings

	GVI					GMT				
CATEGORY OF CHANGE		Change	Expected	Likely	Important		Change	Expected	Likely	Important
Mental Health	P1	less intense memory restoration process	4	4	3	P6	being more accepting of mental health condition, greater psychological flexibility	5	5	5
	P1	gradual improvement in a general feeling in your mind and your body	2	3	4	P6	being a bit more hopeful	4	1	4
	P1	a strengthened ability to think about bittersweet memories through releasing difficult emotions	4	5	4	P8	feeling more stable	2	5	5
	P1	feeling a development in your capability to work and normalising that, going into a more normal way of capacity to work	3	3	5	P8	managing your disassociation episodes better	4	4	4
	P2	more relaxed	4	4	5	P10	change in medication	4	1	3
	P3	feeling better after the sessions than before coming into the sessions and	4	5	5					
	P4	not having violent thoughts anymore	2	1	4					
	P4	reducing medication	1	1	5					
	85		24	26	35	56		19	16	21
Interpersonal	P1	new and more positive experience of being around other mental health service users	5	3	4	P6	greater tolerance for uncomfortable feelings in interpersonal relationships	4	5	5
	P2	easier with strangers	4	3	5	P6	'stuff' is less of an issue (i.e. relationship with your CMHT)	4	4	4
	P3	feeling listened to and perceiving a healthy interest from others, feeling safe to share	5	5	4	P6	experience of non-rocky supportive relationship	5	5	5
	P3	some hope in the capacity to meet different people and feel safe and respected	4	5	4	P7	slightly less co-dependent with your relationship with your mother	4	4	5
	P3	discovering a new aspect of personality (i.e. having a good sense of humour)	5	4	4	P7	having more perspective in romantic relationships	5	4	3
	P4	learning to remain calm and give other people space to talk	4	5	4	P8	reinforced experience of being part of a group	1	1	5
	P5	realisation that there are people who care and a feeling of belonging	5	5	5	P8	close relationships noticing that you are more easy to be around	5	5	5
	P5	encouragement to perhaps see other people in the community instead of not wanting to go out	5	5	4	P10	positive curiosity towards noticing oneself and others rather than ruminating	4	4	4
	106		37	35	34	100		32	32	36

Musical	P1	enjoying singing more on my own now	4	5	4	P6	feeling more able to improvise with than expected	5	4	3.5
	P1	joining a choir 3-4 months ago	4	3	3	P6	possible to have fun and enjoy playing music with others	1	2	4
	P2	enjoying making music with others	1	5	4	P8	using music as a form of expressing and processing feelings at home	4	5	5
	P5	motivation with the wish to engage more in music making	5	5	4	P10	some hope of being able to engage in music in the future	5	5	4
	47		14	18	15	47.5		15	16	16.5
Sense of Self	P1	Relative perceiving you as more relaxed and more your old self	2	4	4	P6	feeling more present in the moment, linked to a capacity to meditate and focus	4	2	4
	P3	feeling in the now	3	5	5	P7	feeling more confident professionally and personally	5	4	5
	P4	discovering old ways and bringing back the old self	2	5	4	P7	feeling more adult, more long-term perspective and taking more responsibility	2	2	4
	P5	feeling able to achieve something with voice and able to learn	5	5	5	P7	more self-aware than self-conscious and developing more reflective and curious stance	2	3.5	4
	P5	feeling more important and confident to respect yourself	4	4	5	P7	overcoming fear of getting around and less confusion with directions	5	2	5
	P5	having space and time for oneself in the group	4	5	5	P10	challenging internal feelings, becoming aware of how music therapy has brought up emotions	5	4	4
						P10	ability to be less detached, in touch with real self	4	4	5
	76		20	28	28	79.5		27	21.5	31
Lifestyle	P4	quit smoking	1	1	5	P6	career rethinking	4	4	4
	P4	more exercising	1	2	4	P7	quit smoking	5	2	3
	P1	eating healthier, being able to resist the cravings more	5	3	4					
	P2	not feeling like wanting a cigarette after the sessions	5	5	5					
	41		12	11	18	22		9	6	7
View shift	P1	appreciation of psychotherapy as an important ingredient in treating mental health	3	4	3	P6	shift from a biomedical to a biopsychosocial model: more compassionate, empowering and agency	5	5	5
	P5	realising that mental health patients can be bright	5	5	4	P10	realising that group therapy can be helpful	5	5	5
	24		8	9	7	30		10	10	10
TOTAL	379					335				

Main themes

Apart from the reported changes, the rest of the main themes from the thematic analysis of the transcripts of the interviews – excluding those from the IPA analysis – are listed below and mainly concern the social element of the groups, which did not depend on the type of technique used, the experience of the research aspect of the sessions and some considerations around the beginning of the groups.

Initial scepticism

Some participants mentioned an initial scepticism at the beginning or before the groups started. In P1's case this was due to previous experiences: "at the beginning I was quite sceptical […] I've been to other [music groups] that weren't very good', whereas for others this was more related to the idea of meeting new people in the group and making music with them: 'in the beginning I didn't know really if it was for me or if I would fit in […] I was wondering whether I could relax, whether we could sing together, whether we could share… but as time went on, and it didn't take very long, it was absolutely wonderful" (P2), "before I started I didn't know what to expect and I was very anxious of meeting other people and it was all about the voice and how am I going to sing my horrible voice and I was feeling shy, and then when I attended maybe the second time I felt very comfortable" (P5). Similarly, P7 also mentioned that "I was really sceptical about joining I must say, I did it initially because my doctor seemed to think it was a really good idea".

Social aspect

Most of the participants, from both groups, talked about the positive experience of being with other people in the group. These are some examples of generic comments: "enjoyed meeting different people" (P6), "they were all good and supportive" (P5), "people were nice" (P1), "got on well with everyone" (P7). Some other participants were more explicit in describing how they found this helpful. For example, P2 mentioned that "sharing experiences makes you feel less alone and can be quite supportive […] you're not the only one", and P10 talked about the need for him to socialise "it's a social thing too, which is something I massively need, to get away from detachment and disassociation, so combining that sort of thing [music] with a social aspect is also another very good idea […] it's the aspect of being with others and that feeling inside of it".

P4 also pointed out another aspect of the benefit of the social aspect of the sessions: "being amongst others my personality has come out […] when you are on your own you

don't know what type of person you become because you are not interacting with people, but when you meet people and interact you can gauge yourself […] I'm feeling good about myself, I think the group did help me and it will stay with me for a little while […] it was one of the best things about it, that's what made music therapy, that there was other people there".

Some participants also placed importance on meeting other mental health service users and sharing experiences with them in a safe space: "meeting new people, people that I've never met before, who have suffered, who share the same misfortune as me" (P4), "nice to get to know others with mental health" (P6). P1 also emphasised the importance of being able to support each other: "it's not nice to see people suffering […] you have been there […] what was very helpful was expressing positive emotions to each other".

As seen from the comments presented here, this side of the groups did not appear to depend on the modality used. Instead this seemed to be a constant between the two groups, which makes sense since the format of the groups was the same in both.

However, it is important to highlight that some participants (P6, P7 and P8) from the GMT group also commented on the instability of the group membership which they perceived as generated from the ambivalent disengagement of one of the participants (P9).

Research

The last area to cover in this analysis is the participants' experience of the research methods that affected the sessions, such as the use of the GSRS questionnaires and the interview at the end. Most participants alluded to a sense of not noticing the research aspect as being intrusive, which was the aim of the naturalistic approach to the research. For example, P2 talked about not feeling part of an 'experiment': "I didn't feel you were doing any research. It didn't feel like it, because you weren't always asking questions or seeming like a medical person wanting to do an experiment, so that is what would imagine for research, some sort of experiment, which could all have been, but it didn't feel like it, and research… I didn't even know what you were researching because it didn't feel like research".

Similarly, P4 and P6 talked about feeling like it was a routine clinical group: "I just thought it was music therapy, I never noticed… you never gave us tests or asked questions" (P4), "it didn't feel like I had been involved in research cause […] it seemed very analogous to what we would have done clinically […] from what I understood of the research that it

was more observational almost, […] it's kind of 'what happens if we do this?' […] it didn't feel anything especially weird" (P6).

Some participants also touched on enjoying the possibility to contribute to research and its potential findings: "I'm very happy if I could be useful for you to do your research" (P5), "I really enjoyed it, I'm into research […] I like curiosity and I like the idea of contributing to something that could become bigger" (P7), "I'm just really grateful to be part of it […] I think it can benefit lots of people, it think it can be far reaching" (P8), "it's the only way to learn about things, isn't it? And improve on and I'm always OK with sort of research" (P10).

When asked directly about their experience of having to answer questionnaires every week at the end of the sessions the reactions varied but they tended convey a sense of it feeling rather non-eventful and not intrusive as well as perhaps not very meaningful, due to feeling that the answers were the same every week, as P7 said: "I pretty much answered the same thing every week, because it generally felt the same every week".

Here are some other examples from other participants: "that was soft interrogation it wasn't forced like nothing was forced upon, if anything it was relaxing, I found it relaxing […] I never had any problems about it" (P4), "you can just imagine someone doing that as a weekly benchmark" (P6), "The questionnaires were pointless weren't they? Well to me […] it was always fine. I can only speak for myself, but I don't think we needed to do it every week" (P8), "they're very good. The only thing for me, I thought it was always good so my thing would always be very good […] I would tick higher up all the time, I think I mentioned it to you before that it's just going to be the same again because it's always been good" (P10).

Participants 2 and 5 shared similar views but added the importance of the questionnaires in being able to give feedback: "it was ok, I thought it was part of the work that we had to do […] it was boring but it was very quick! I knew it was part of your work, we have to give something back to your work so you can correct maybe things in your work you know about what to do, it gives you an idea" (P5), "it was so easy, it was just almost at the end [of the lines] for each one each time because as far as I was concerned […] I found everything went so well most of the time […] I would have done [the questionnaires] even if it hadn't been research because feedback is important" (P2),

In contrast with the views on the questionnaires, when discussing the experience of the interview, participants reported a sense of finding it quite useful in order to reflect on the impact of the sessions. Particularly for P2 and P6, the interview seemed to have been important in gaining awareness and formulating their experience in a sense: "it helped me realise things I hadn't thought of, a lot of the things that you've brought up today, so it's made me realise the benefits […] I think I got this fuzziness tone to music therapy, feeling it's nice but without you asking specific questions I couldn't have pin pointed all the different angles and perspectives about how it's nice, where it's nice and why, but I think it's done that for me […] it's made me realise the benefits that I've had over the weeks" (P2), "I think this reflection has been helpful cause I think I didn't see what it has done, I think it's like a shift that's happened in my head probably. I think sometimes I was wondering like, what is this doing? Cause I think it's more subtle that other therapies […] I think this session is helpful to think about what impact it has actually made" (P6). Both participants suggested that the interview became part of any music therapy work.

It is worth also noting, however, that the interview lasted for about an hour and a half and P1 mentioned that 'it's also tiring because you need to think about a long period'.

Conclusions

This part of the analysis, which has looked at generic aspects of the music therapy sessions, not directly related to the use of one practice or the other, shows strong support for thinking about the two groups as a similar kind of intervention, at least on some levels. The narratives that shown here point to a shared sense of the experience of the overall features of the group music therapy format, particularly looking at the changes distribution.

Some characteristic features of each of the groups have started to appear already however, and the more detailed experience of the music making and of the therapeutic frame will be explored in the IPA analysis sections where the focus will be instead on examining the nuances and differences between the experiences of the participants' in both groups. The balance between similar and distinct aspects of the two groups will be then fully explored in the discussion section.

5.3.2 Interpretative Phenomenological Analysis

Following the thematic analysis, fragments from the interview transcripts that concerned the music making through the use of voice or instruments specifically were selected for a second analysis to focus on participants' experiences in more depth. The objective here was to leave out the data captured already by the thematic analysis and to provide an opportunity to consider the experiential accounts from the participants' views of the sessions in order to get closer to the psychological phenomena that the participants highlighted and described.

As well as selecting the fragments that related to what it was like to engage musically in the sessions, the sections where participants talked about their sense of the therapeutic frame were also included in the IPA as this has been a relevant feature throughout the planning and conducting of the study as well as a significant aspect of the analysis so far.

Coding and clustering process

The process of coding and clustering themes followed the guidance provided in Smith (2015). An initial coding of the selected material from each interview was done separately, keeping close to the text of the transcripts. The themes from each interview were initially grouped into provisional clusters, which then developed further as the themes from all the interviews came together. This process was done separately for the two groups until the final table of themes was obtained for each of them. Later, the clusters were ordered starting from the most subjective and inner experience to the most narrative and social for both groups and the two lists were put in parallel as can be seen in Table 5.10.

Although having the two lists in parallel helps to compare them, the aim is to consider the overall narratives running through each of the groups against each other, rather than to compare each of the themes or even each of the clusters individually, which would not relevant in this analysis.

Table 5.10: Overall clusters for GVI and GMT groups

GVI	P1	P2	P3	P4	P5	GMT	P6	P7	P8	P10
Sensory aspect of singing	X	X		X	X	Music's impact on emotions	X	X	X	X
Something from inside out and accessing something very 'inner'				X	X	Importance of the expressivity on the instruments	X		X	X
Accessing a different mental space through singing	X	X	X	X	X	Dissonance and consonance in and out of music	X	X	X	X
Experience of intersubjectivity	X	X	X	X	X	Relating personal traits with music traits	X	X	X	X
Discovery of new things: accessibility to new experiences	X	X	X	X	X	Fun, motivating	X	X	X	X
Balance in the frame and therapist management (frame GVI)	X	X	X	X	X	Sharing the space and therapist management (frame GMT)	X		X	X
Difficulty around the technique (GVI)	X	X	X	X	X	Difficulty around the technique (GMT)	X	X		X

As will be shown, each of the groups has seven clusters of themes. The first five clusters in each group refer to the most salient features of the participants´ experience of the music making in each group and, as explained in the previous section a cluster has been allocated in each group for their experience of the framework or format of the sessions. Finally, a seventh cluster has also been allocated to both groups concerning challenges with the instrumental or vocal techniques in each group. It seemed important to pay particular attention to what was perceived as difficult in each group in order to get a better understanding of the practice.

Appendix K indicates which participants mention each of the themes and clusters. Although specific attention will not be drawn to the mentions of each theme for each participant, selected illustrative examples will be discussed in depth by showing extracts from the original transcripts. Under each of the following sections dedicated to particular clusters a table with the themes that make up the cluster will be provided. These are extracted from the general Appendix K. As discussed in previous sections, P9 from the GMT group dropped out and therefore did not take part in the final interview. Hence why only P6, 7, 8 and 10 are shown in this analysis.

GVI themes

The list of clusters for the IPA analysis of the GVI interviews, shown in Table 5.10, starts with two clusters which have to do with the subjective experience of singing as experienced in an embodied manner. The narratives around have been particularly

interesting for this study since the sensory and bodily aspect of singing is a very relevant theme, particularly when compared with the use of instruments, which employ a different kind of embodiment. For this reason, this topic has been separated into two clusters, given its relevance to the current research.

The following two clusters from the list refer to the experience of singing at a higher level of abstraction that relates to the concept of the self and self in relation to others. Finally, the fifth cluster refers to a more social consideration around the activity of singing. As mentioned already the last two clusters are similar for both groups and refer to the frame and the challenges of each of the techniques.

Sensory aspect of singing

Table 5.11: Sensory aspect of singing - themes	P1	P2	P3	P4	P5
Chest filled with joyful sensation. Invigorating. Euphoria, exhilarating.		X		X	
Physical exercise linked with singing and breathing (expanding lungs).				X	
Different breathing. Link between anxiety and breath.		X			X
Shift of the attention to the body.	X				

The first cluster of themes for the GVI group has been given the title of ´sensory aspect of singing' as it brings together different themes around bodily and sensory experiences mentioned by most of the participants from the group. Table 5.11 gives more detail of such themes and of which participants mentioned them. Here it is possible to see that two of those themes refer to the breath either directly, by pointing at the differences experienced in the breathing technique when singing, or indirectly, by talking about feeling motivated to do more exercise to 'expand the lungs' as a form of preparation for the sessions (P4).

This is how P2 described the difference in the breathing: "Singing is a different sort of breathing to the ordinary everyday walking about doing my shopping, when I don't think about it. I think about my breathing when I sing". This points to a greater awareness of the body when singing and also a sustained awareness of its benefits when outside therapy.

The other two themes refer to a sensory experience but in a less mechanistic detail. On one hand there is the statement by P1 when he talks about a generic shift towards the

external world through the body: “I think it’s very important to have some external form. If you’re just in your own mind it’s just not really healthy, you need to relax a lot for your body to keep up”. There is a sense here of shifting the attention outwards rather than staying in an inward focus. In this sense, thinking about the body as a middle ground or membrane between the external world and the internal ‘mental’ world is a powerful image of how experiences in the body can shape the narratives of the relationship with our environment.

Finally, the first listed theme in this cluster refers to the physical sensation described by P2 and P4 as experienced during some of the singing activities. They talked about a sense of aliveness inside, which P2 referred to as a “joyful feeling that filled my chest”. When I enquired about this feeling she said “It was like a more-than-usually big breath of very pure air that made me feel quite [inspires] well. A feeling like proudness but it wasn’t proudness, but that feeling of you could actually put your shoulders down and stick your chest out and feel confident, you know?”. This account even suggests a certain posture or way of being which seems to reflect a sense of presence within the body.

P4 talked about a perhaps similar sensation which he defined at different points through the interview as ‘euphoria’ and as an ‘exhilarating’ and ‘invigorating’ feeling. When I enquired further about this feeling he said: “you know when you’re singing your hair starts to… [gestures with hands] when someone sings, I got that. [Therapist:] Do you mean like goose bumps? [P4:] Yes, yes, goose bumps, so it was like feelings that I might not have experienced and maybe them feelings changed my overall outlook on life, because it’s the experienced it you know, who knows… only you know that, I don’t really know”.

This passage seems to not only link with the sensorial experience of goose bumps, but also connects this experiential component to how this might affect the way in which he makes sense of the world. He seems to feel a little lost towards the end of this quotation around how to put into words this complex phenomenon, which seems understandable.

It is interesting to note here that P3 was the only one not to report any such sensory experiences. He was diagnosed with Asperger’s syndrome and often talked about his high sensitivity to sounds in general. In fact this was one of the obstacles he had to overcome at points in the group (described in a later section). He appeared to be hyper-attuned to the sounds in the room (including traffic coming from the road, the sound of the wind or rainfall, etc.) and was constantly monitoring and adjusting to the sound levels, hence why

perhaps the singing sometimes added to this, but did not appear to him as more or differently sensory focused than other activities.

Something going from the inside out

Table 5.12: Something from inside out - themes	P1	P2	P3	P4	P5
Old lively side/self that is inside could come out and be expressed in the singing				X	X
Getting something out fluently				X	
It touched the 'inner self'				X	
Seeing something of a persons' inside – link with personal mental health narrative					X

The second cluster for the GVI group is a mixture of elements from the category of the previous cluster, relating to something in the body, and of a higher level concept of self. As explained earlier, this has been categorized as a separate cluster due to the importance to detail in this area relating the use of voice and experience of singing to a sense of embodied awareness and narratives derived from this.

In this case, only two participants alluded to this phenomenon of having a sense that whilst singing one has an experience of a process of getting something out from within. Given the mechanics and physiology of producing vocal sounds – where the sound is produced inside the body and travels towards out of the body – and the relevance of the accounts for the narratives of mental health of the participants that mentioned them it was considered opportune to treat this as a separate cluster.

Table 5.12 shows the four themes that come into this cluster. The following extract from the interview with P4 illustrates two of the themes: "I felt that these music therapy sessions did work, you know it speeded my recovery up, it made me fluent and expressive and back to jolly old me for a good old laugh […] I wasn't stuttering, everything came out of my mouth fluently". Firstly, considering the element of being able to be expressive and fluent, this was relevant for this participant, who in the past had experienced stuttering, particularly when talking to others in a position of power. The way in which he describes it as "everything came out of my mouth fluently" contains quite literally the sense of something from within that comes out through the voice.

Secondly, within that same statement, he also refers another theme within this cluster, the sense of being in touch with a previous sense of self from his past, his "jolly old me". Later on in the interview he described this notion in more detail: "I raised my voice and made it sound funny. That was just to get a laugh out of everyone else, you know, that's the old me. […] Discovering old ways, old habits in me". This seems to indicate that this association with his old self has specific vocal qualities that he clearly identifies. This idea of a livelier sense of a vocal sense resonates with something that came up in the interview with P5, who talked about it when discussing her particular confidence and expressivity during the 'sound and gesture' vocal activity, which has been described in the macro analysis. She talks about her experience during that particular activity in the passage below:

> *"It just came out with that moment, you know, sometimes it's like this [clicks fingers]. When I was happy in school I used to do lots of things like that with my friends, I thought 'Ah, still it's there!', you know it can come out with the things you do […] when I feel comfortable I can be the other person that I was, the one, the real one… moving, happy, laughing, making jokes…"*

Again, here it is shown how she talks about this side, which she later referred to as 'bubbly', in terms of 'coming out' of her in the way she used her voice in the sound and gesture activity. She had mentioned in the past, mainly in the individual assessment, a sense of having a different and livelier side of her from when she was younger that she felt she had lost.

Within this similar narrative she also talked about a sense of having had the opportunity to 'see' something about the inside of P1 through the way in which he sang in a particular occasion, suggesting a sense that the voice can be a way into someone's internal world:

> *"I was really amazed about (P1) when he sang. I was shocked! The voice that had been hiding from us! And again It proved me I was very wrong. So I was thinking he's very quiet he doesn't always bring his voice, he hides and in the end wow! The sparkling star, ooh! I thought Oh my god! What is that? […] And then the positive feeling that mental health people can be very bright, they can have something hiding but it so difficult sometimes to bring it up and to show it, so I was really amazed and again very, very positive thinking. […] I think how we feel sometimes it could feel like being under a big cover like a dark curtain, I can't see what is beyond and I believe 'no, no, no I'm not good I'm not good',*

and then I thought oh no, each person has something hidden, yes I was really amaze about (P1), honestly, how beautiful he sounded. It is very important because you can believe […] that you are nothing, you know all those negative thoughts, but actually it might be something really deep down that has never been out, you have to find it, because it never came out."

It is interesting how she talks about a place that's very deep down into someone, almost inaccessible, and how she feels that she has been able to grasp something quite profound about P1, which she then links with her own narrative of her two sides. Interestingly, shortly after discussing this, she went back to this issue of her two sides and reflected on another one of her usual narratives around her experiences of mental health, which related to a painful feeling of having something kicking her from the inside of her stomach. In the individual assessment she had put significant emphasis on her suffering from this and often described it in a sense of it being something nasty that wanted to hurt her and she always ended the account by frustratingly wondering 'what is it? What does it want from me?'. On this instance the narrative was slightly different:

"I was thinking when I told you, you know, there's that human sitting there and kicking me with the foot really hard and like, I was thinking 'what does it want from me?' Is there anything there that wants to come out and I'm not allowing it? Like there's some positive thing, it's been there sitting, sitting and becoming human and beating me up and please take me, show me, let me out!"

This was a significant shift in the narrative, where she started to wonder, this time from a more curious rather than frustrated stance, whether what was sitting inside of her might be something positive, something that wanted to be shown to others, perhaps that livelier side of herself.

Finally, within this cluster another theme emerges which refers to the use of voice being able to address something that is deep within oneself, from P4. It is important to mention here that he had experienced individual music therapy sessions with another therapist in the past, where he had an experience of playing instruments:

"I preferred to be in the singing group, than the musical instruments […] just playing instruments you're not really giving your inner self a chance, you're just making the instruments [sound] […] There was less of it [the inner self] in the

[instrumental] experience and it was more of an experience going to the vocal group".

Here he seems to imply that in his experience there had been a greater involvement of the inner self in the voice work than with playing the instruments, although when the therapist enquired further about this different experience, his response was to highlight how in the vocal group he had learned how to put vowels and consonants together, adding that "may be you don't sound good on your own but you sound good with other people, I enjoyed it". This idea will be revisited in a different section; however, this has been brought up here to provide some context as to what he might have meant about the inner self experience. It might be the case that he was referring to a sense of having a more concrete activity where he felt more involved. It is also important to highlight that his previous experience of music therapy had been in an individual format and therefore the group element might also have significantly influenced his experience of the sessions.

Accessing a different mental space through singing

The following cluster refers to the notion of being in a different mental space when singing, which each participant described in slightly different ways, as shown in Table 5.13. For example, P1 talked about feeling relaxed and turning his mind off and feeling relaxed: "it wasn't hard and it made me switch off nicely, it was like when you don't feel you need to rush and do this and that, you can just relax and think about things". This was similar to P3, who talked about deserving a break from his constant anxiety for an hour and to have fun. However, in his case, this allowed him rather than to feel like his mind was switched off, to be more present, to be 'in the now', which he said he really struggled with in his daily life, where he had to constantly manage the stress related to his diagnosis of Asperger's syndrome. Again in that sense of accessing something different, he described this as feeling motivated to step out of his comfort zone and 'leave the bubble'. Meanwhile, for P5 instead the singing seemed to help her to go into a bubble as she described feeling 'lost in the music', 'it takes me away, like I'm flying'.

Table 5.13: Accessing a different mental space through singing - themes	P1	P2	P3	P4	P5
Creative stimulation: writing a poem, 'good images in my head'	X	X			
Turning mind 'off' and being relaxed: no rushing	X				
Getting lost in the music: it takes me away, like I'm flying					X
Being in the now			X		
I want to have fun, I deserve a break. Put the anxiety on hold for an hour.			X		
Motivation to 'leave the bubble' and push one's boundaries			X		
Importance of singing when comparing with a previous approach to MT				X	X
'It's given me a full range of emotions'				X	

Despite the different images evoked by the participants, what seems to be in common in all of these experiences is a sense of being in a different space, mentally, than in their day to day lives, accessing a different way of being, a different realm of experience or a different kind of awareness. For two of the participants (P1 and 2) this different space was specifically coloured at times with creative stimulation. P1 for example described that in a particular occasion, which he could not specifically recall, "it made me think about writing a poem". For P2, instead, this was a more visual type of stimulation during the activity of the soundscape (described earlier in the macro level audio analysis): "it just made me have images in my head, which were good images".

Finally, two more themes came under this cluster. One specifically relates to something that was described before, where P4 talked about the singing being the element that differentiated the two modes of music therapy that he had experienced. Previously that extract was taken as an example of how the singing was experienced as something more 'inner' than the instruments. Here, instead the focus is on the fact that the singing appeared to be perceived as a distinctly different type of experience than the music therapy with instruments, therefore suggesting that it addressed a slightly different dimension of experience. P5, who had a brief experience of group music therapy with instruments with a different therapist, described it as: "This is very new because you have different techniques, singing together and the different work you do than __ (previous therapist). What he was doing in the past, it was introducing us with the equipment not with using our voice, so it was different."

The other last theme was about the sessions having given P4 a 'full range of emotions'. This was a generic comment towards the end of the interview which seems to indicate

that he had felt like the sessions had allowed him to explore different emotional registers and had given him access to experience himself differently in different situations. This will be explored further in the section regarding the frame.

Experience of intersubjectivity

Table 5.14: Experience of intersubjectivity - themes	P1	P2	P3	P4	P5
Therapist meeting and matching vocally					X
Improvised harmonising as a unique experience		X			
Collective result greater than individual sound		X		X	X
Sense of being part of society					X
Connection with others, in and out of the singing	X	X	X		X
Sense of familiarity whilst singing 'syllables in harmony'				X	
Music as a kind of wrapping to appreciate more, to facilitate communication			X		
You feel you exist behind the music, you can touch others through the music.			X		
Feeling listened to. Feeling safe and respected.			X		

As shown in Table 5.14, this cluster brings together a range of experiences described by the participants where there seemed to be an emphasis on the dialectic between self and other through singing, hence why overall cluster uses the term intersubjectivity in order to act as an umbrella term. Intersubjectivity here is used in the sense expressed by Malloch and Trevarthen (2009) of coordinating one's actions with others.

On this note, it seems appropriate to start with the themes mentioned by three of the participants around their individual experience of the vocal improvisation. P5 talked about her experience of improvising specifically with the therapist, although she mentioned that she had felt this in the group as well. She describes a sense of 'forming and being formed by' that she calls matching and following each other:

> *"When we sang I didn't have like mistakes, it was like we were matching, I don't know how to put the words like… we were good me and you! I was following you, you were following me, does it make sense? Like we were matching […] I felt like me and you were matching the melody and how we raise up and go down and me and you were meeting our voice I don't know very… nicely, I don't know."*

This idea of the voices meeting during the improvisation and this resulting in her feeling like there are no mistakes because we follow each other seems particularly powerful. It might remind the reader of the accounts of 'communicative musicality' and coordinated rhythms of intersubjectivity of the developing infant as presented by Malloch and Trevarthen (2009).

The following two themes refer particularly to the activity called 'syllables in harmony', which has been described in the audio analysis. The following extract from the interview with P2 is particularly rich in giving an account of how that activity was experienced by her. It is worth pointing out that she had played a single line melodic instrument when she was young (hence why she talks about doing music alone) and had sung in her school choir as well.

> *"I'd always imagined you would write like a poem or the lyrics and then you'd find chords to go with it and then you'd find a tune, something was thinking would be very difficult… but doing it the way we did, we had a song in minutes. I thought it was brilliant, it really gave me a lift. And everyone joining in! And I suppose I'd been alone for so long, and the last time I did music with anyone was when I was at school […] So as an adult, if I have done any music, which hasn't been for a long time, it's always been alone. So just being with people making music was fantastic! […] It was fascinating making it and a really big burst that it was so easy and quick, but the biggest buzz of all was that I wasn't alone making it, that people were sharing and it was like communicating and boosting each other out really and relaxing. […] The harmony particularly, I found that when I harmonised, even though I thought I was out of tune, I was enjoying harmonising, because I haven't done that… ever. I had done it at school but that was really learning from a page of music that was pre-prepared, I did no improvisation at school, so improvising harmony was a new one for me, I enjoyed it and felt I could do it. […] [Improvising] took more imagination and it was more difficult, I was somehow individual, it wasn't'… no one else was doing it. It wasn't there written down like choirs […], it was a new unique experience. […] It took cleverness with my ears, which don't hear very well, but because we were all so close to each other in the room and I could hear what other people were doing I had the confidence to try what I wanted to do to make it sound nice. I feel it often, not always, but it often worked and it was just very pleasing for me, just the musicality of it."*

This extract contains a number of themes, some of which will be discussed later. At this point, the main theme to discuss is around how the improvised harmonising was experienced as a unique experience and one that involved a certain sense of back and forth between the different members, which she describes as boosting each other out. It is interesting to notice how in her account the reference to her individual experience (i.e. 'it took cleverness', 'no one else was doing it') and her sense of the contact with others (i.e. 'people were sharing, it was like communicating') constantly intercalate. In her description of the experience she also brings together a range of dimensions from an aesthetic appreciation to a cognitive effort as well as the element of social interaction which appear to all be mixed in and combined in her overall rich and 'fascinating' experience. Another important aspect highlighted in this quotation is how the activity was presented in an accessible way. This is significant in terms of GVI not being exclusive or reinforcing musical elitism.

P4 also talks about his experience of this activity (which he calls 'Nupo Yeva'), which was the first one he mentioned when the therapist enquired about any significant moments in the interview. He talked about a sense of familiarity with the song, although it was improvised:

> *"Nupo Yeva, that one sticks in my head. It sounded like something that I'd listened to before but I can't remember the song, so it was just the memory you know. It reminded me of a song, not of a specific time in my life but it reminded me of a song that I'd heard and I just couldn't remember the song but I could remember the melody with Nupo Yeva."*

Since in this activity there was no pre-determined melody and participants were encouraged to improvise in singing the words from the beginning, it is interesting that he felt that he recognized the song. On one hand, this might have been due to the simple harmonic accompaniment on the guitar where the therapist was initially playing chords I – IV – V – I, which is a very common harmonic structure that might have reminded him of another song that had a similar harmonic profile. On the other hand, it is also possible that from those chords or the melodies sang by the therapist or other members of the group he remembered a specific song or melodic motif that he felt able to sing and 'fit' within the structure of the activity. Whatever the exact reference to the sense of familiarity, this account from P4 reflects the affordances of this activity, where it was possible to relate to it as something that sounded familiar and therefore potentially safe

and accessible, even though all the singing was improvised. This might have given him a sense of confidence or control when approaching the activity as it was something that he somehow recognised.

Having looked at these initial three themes concerning a more individual experience, the following six remaining themes refer to a sense of connection with others in various ways. One theme that three participants described in a rather similar way was this idea that the collective result was bigger or prioritised over the sound of the individual in the sessions.

We already saw an example of this in the previous extract from P2, where she said "even though I thought I was out of tune, I was enjoying harmonising". In a different point in the interview, she also mentioned that: "I got the confidence from that, not with my own voice but doing it all together. I'd never have confidence to sing alone, I didn't like it when we did that, but together, where I could be a bit quieter and less noticeable, and just see people trying to do things together and making a lovely sound". Similarly, with P4 it was already shown how he expressed that "it may be you don't sound good on your own but you sound with other people. I enjoyed it". Finally, P5 also referred to this by stating that "we shared though we didn't maybe like our voice but we were doing something. Some like connection like this… bring us like this [gesture of hands coming together]."

In all of these accounts there is a sense of contributing to an overall sound that is pleasing despite expressing a certain negative appreciation of their own individual voice. In P5 it is also possible to start to identify a sense of connection between the participants, which was captured in a separate theme. P5 expanded on this by talking about a sense of 'embracing' others through the singing: "when we sang and we were like sitting next to each other like embracing […] you know with the song, because we're singing the same thing, we feel the same, we are doing something together and we are sharing and we are sort of connected to each other".

It was interesting to notice how both P2 and 3 talked about this sense of connection as being felt in and out of the music making. P2 puts it like this: "sharing experiences makes you feel less alone. I just liked the fact that we could all be there in a separate little bubble, in our own lives and share something … words, experiences, harmony". P3 describes a sense of combining different aspects of the relationships in the group: "I think

it was the combination, you know the equation of music and this kind of bonding, you know, with people."

He (P3) then added a sense that the singing was some sort of extra layer that enveloped the relationships in a way that facilitated that connection to emerge:

> *"we talk at the moment but nothing is echoing, so [music] it's a kind of wrapping thing to appreciate more, to appreciate more, you know, to facilitate the communication. It's a kind of wrapping, you know, I don't know what you call that in English, but you know it was for me… when you have something nice and you put this kind of paper silk inside to make you appreciate more."*

When discussing this, in order to illustrate what he meant, P3 talked about previous experiences in his life where he was a DJ and explained that "for me it was a way to communicate and probably to exist, you feel you exist behind it [the music]". This notion seems to connect with a statement from P5, who said that for her being able to join in the singing and attend the sessions felt like taking place in society: "it was a really pleasing thing… like taking place in society but in a place where they were understanding my mental health problems".

Finally, the last theme here, which continues this thread of a sense of being seen by others, comes from P3 who emphasised at different points during the interview that one of the main aspects of his experience in the group had been to feel safe, respected and listened to:

> *"I never had this kind of opportunity to have people to listen to me, cause there's a difference between hearing and listening. But you could see the real interest, healthy interest and that's helped me to open up. I'm quite introvert in a way, I don't necessarily like to talk about me. I prefer to observe and listen to people, but that encouraged me to do something a bit different, which is to feel safe enough to talk a bit more about what I experience […] Feeling in a safe setting and clear exposure of respect, not having to justify myself, that was certainly fuelling my frail motivation to leave my bubble and push my boundaries".*

Discovery of new things

Table 5.15: Discovery of new things - themes	P1	P2	P3	P4	P5
Cognitive productive aspect: it gave me an idea to use my mind		X		X	X
It is possible to acquire skills: there is some learning possible in singing					X
Initial dislike of own voice: process of relating to it		X			X
Community activities more accessible. Greater confidence in socialising.	X	X		X	X
Link with previous musical experiences: reconnection and building a musical self	X	X	X		
Music always felt inaccessible in the past					X
Enjoyed or valued the carol singing	X		X	X	X
Emotional resonance with pre-composed songs	X				
Sense of enlightenment and self-help				X	

This cluster focuses on the phenomenon of experiencing something new, a sense of discovery and opening new doors through a range of themes shown in Table 5.15. A particularly important theme here is the fact that several participants mentioned that they had experienced an increased confidence in their capacity to socialise and work with others collaboratively. P2 put it in a very illustrative way: "I thought if these people can do that with me, other people also might be able to do something with me, even if it's not music." This is particularly relevant in her case as socialisation was not something that she particularly had difficulties with and had mentioned that she had a good social network of friends and family. Yet, her account appears to convey a sense that new possibilities had opened for her. In fact, after the interview, in the follow up session, I had suggested that a next step for her might be to join a community choir which she initially was sceptical as she assumed that there would be auditions and she was not confident that she would pass them. I mentioned the idea that most community choirs might not have entry auditions and this seemed to encourage her to try it. She tried a local community choir the following week and phoned the team to let the therapist know that she had enjoyed the rehearsal very much and that she was planning on continuing to attend.

Another member of the group, P1, had recently also joined a community choir before the group finished and mentioned in the interview that "I'm sure I felt much more comfortable singing that I was doing before […] I just gelled into the choir […] it feels good to be part of something". P4 also talked about feeling motivated to engage in more activities following the end of the music therapy group: "After such a positive and

productive last 6 months for a day on the week, maybe I can do two different things in two different days a week next year. Thanks for the social re-building skills." Finally, P5 also mentioned that "I was really scared to meet people from other races and now it proved me wrong, sometimes if you get to know the people I think we are all the same, our needs are the same. We can make friends, we can talk, we can do things together, no matter how you look like. So sometimes it is worth to try rather thinking and stepping back and you know isolating yourself." In her case, contrarily to P2 this was significant because she did tend to isolate herself and avoided social activities or encounters.

For her, music in itself had been something very new as she felt that it was inaccessible to her: "I love music but always I believed that I can't do it". Meanwhile, for other participants the musical activities in the group were narratively connected to their previous activities of music making and this appeared as a reflection around how the music that they made in the group contributed to expand their 'musical selves'. It has been shown how P3 talked about his previous experience as a DJ and how P2 talked about her experiences singing in the school choir and a single line instrument.

One activity that most participants discussed in the interviews was the carol singing in the last session. For example, P1 mentioned that "it was also good to sing songs, you would never have had the opportunity to otherwise […] It was really good to sing Christmas songs", which points at the importance of providing a space where to sing pre-composed songs for people who felt like they did not have access to other opportunities to do so. He also highlighted the emotional resonance with the lyrics of songs. In this case he talks about the time when the group decided to sing 'Let it be' by the Beatles: "When we sung sort of more difficult songs in content like 'Let it be', I just realised what a great thing it is and that other people have suffered problems or perceived problems quite well, and some other artist they're just not, like the regular boring group […], so you can find very interesting things in songs."

These comments show the variety of functions that the pre-composed songs played in the GVI group, from providing a space to share cultural references in a normalizing way, like singing carols for people who felt they did not have another context to sing them, to reflecting on particular emotions contained in song's lyrics. This has already been mentioned before and will be picked up again in the discussion.

Another aspect that some participants alluded to in terms of new discoveries was a certain cognitive effort and process of learning that was valued as stimulating. It has

already been shown how P2 talked about the 'cleverness' and 'imagination' that she felt was required during the vocal improvisation activities. P5 mentioned directly how she felt that the songwriting activities in particular were an opportunity to use the mind:

> *"when we were discussing how to do things it helped me to think, to push myself, to bring the words and the sentences, I said 'oh that's good! So I can use my mind as well at the same time!' It gives you a chance, it's easy as well, I don't know you were there saying 'come on think about very little things' so that helped you to think […] You have to interact with the group which is very good you know? Yes, so I loved that as well. It gave me an idea to use my mind."*

In this extract there seems to be an element of surprise that she felt she could use her mind 'as well', as if she had not expected it to be part of the sessions. When at the end she says that it gave her an idea to use her mind, this seems to indicate that she found the experience stimulating. Equally, she talked about being surprised when realizing that there was an element of learning the practice of singing, implying that she previously thought that it was 'about the voice', meaning that you either 'have' a voice or not, but that it is not something that one learns: "I was thinking it's about the voice but actually I thought you can learn how to like [gain] experience to use your voice, surprisingly, because when you don't have any technique or any knowledge you think it's only about the voice, but it's not just the voice, and that was really encouraging for me […] [you can] use the technique, learn how to use your voice".

We have already seen before how P4 talked about having learned about putting consonants and vowels together. He also talked about feeling that "it enlightened me, it was like self-help, although it was like structured, I thought I self-helped myself by getting emotions out". Here once again there is a notion of learning something new and accessing new experiences, as well as GVI being something that is owned and self-directed, despite the earlier considerations around the directiveness from the therapist.

The last theme from this cluster relates to discovering a new perspective of one's voice, particularly for P2 and P5, who often talked about not liking their voice. They described a process of relating to their opinion of their voice in a more positive way. For example, P2 mentioned that she regretted having lost the 'lovely' voice that she used to have when she was young. As the following extract shows, she had certain expectations to do with her vocal skills that the sessions did not meet. This will be discussed in more detail in the following cluster, where different challenges will be explored. Here, however, she talks

about her dislike of her voice: “it didn’t sound in tune to me. It didn’t sound good to me […] the realisation that my voice is broken. I thought I’d be able to fix it… and that’s sad”. However, later on she mentions that her confidence grew throughout the six months and that towards the end “I felt confident enough, but earlier on in the sessions I didn’t have that confidence”. Similarly, P5 talks about how she felt at the beginning of the group “I don’t believe I can sing and I feel embarrassed that someone is going to hear my voice, I was terrified of that. I didn’t believe that people can like my voice”.

Balance in the frame and therapist management (frame GVI)

Table 5.16: Balance in the frame and therapist management (frame GVI) - themes	P1	P2	P3	P4	P5
Variety of activities		X		X	
Balance between talking and singing	X	X	X		
No pressure to achieve. Felt in control.	X		X		X
It was safe			X		X
Easy and accessible	X	X			X
Therapist playing piano felt as calming and trustful			X		
Importance of musical quality	X				
Well managed and controlled process	X				

As explained before, a cluster dedicated to the participants’ experience of the frame was also included alongside the previous clusters on the experience of the music making as this is an important aspect to consider in the present study where the impact of the difference in the technique seems to have impacted the therapeutic frame. Here the different considerations from the participants in regards to different aspects of the frame, such as balance, directiveness and variety of activities are brought together, as shown in Table 5.16.

The variety of activities is something that was already discussed in the analysis of the audio recordings in research question 1. Here, it can be seen that two of the participants alluded to this variety: “it was different each week” (P2); “the different stuff we were doing every week, sometimes it was carrying on from the last week” (P4). In the last comment, P4 refers not only to the different activities but also on how sometimes these

had a continuation with previous weeks, which was another phenomenon that took place in the GVI and which was discussed earlier.

Another aspect that various participants touched on was the balance in the structure of the sessions, including the balance between the 'talking' and the 'singing'. Here, where P1 talks about this balance, the fact that the therapist was able to control and manage the group seems to contribute to the balanced result:

> *"it was well organised so the people weren't doing anything they wanted next to each other, so there was a harmony and also helped that you were balanced and calm and able to hold the group well together and that you were able to find a balance between our social interactions and singing, that was very nice as well. So you didn't let it not to be about music therapy but you also let it to be a social dealing therapy as well because we were allowed to communicate our problems, how we are […] it was controlled, it was very nice, like a music session should be".*

At the end of this extract from the interview, it is possible to start to see P1's relatively rigid sense of what a proper music session should look like in his view. Throughout the interview he conveyed a view that some types of music are objectively more beneficial than others. Often he mentioned this when comparing the GVI sessions with a previous experience that he had had of music sessions based on electronic music, which he described as 'extremely noisy' and "drum and bass coming and everything mixed together it was very bad […] nobody likes it, even people without mental health problems can't listen to it, and that they think it's good for people scares me". In contrast, he valued that "it was very nice that you are a real musician and we are not just banging and doing stuff, […] it was harmonic […] there's so many relaxing types of music which is good for the mind!." These statements offer a certain view of the music as being the object that is at the centre of the therapy. This resonates with his view, presented earlier which valued the pre-composed music used in the sessions.

In regards to the balance between the 'social interactions' and the 'singing' mentioned by P1, P3 seemed to have a similar view: "you could see people wanted to communicate probably sometimes much more than to sing, that's the way I felt too, so it was balanced, but it was good for me on the other hand the way each time you tried to readjust, not to try to be too structured about this and you could feel the need of different sessions, different people extended and facilitated". Here, as well as the balance, P3 touches on

how this negotiated between the participants' needs and the therapist's 'readjustment' in a way that he seemed to find helpful.

This tendency to dedicate more time to the talking at times in the group was also mentioned by P2, who talks about a development in her view of this: "if we had been singing a lot rather than talking a lot I was even happier, although towards the end I wanted that, the talking, because I'd got to know people a bit". This shift in her position towards accepting and even valuing the talking moments in the group as the sessions progressed seems in her case to be closely linked to a closer relationship with the other group members that grew over time.

This balance seemed to be complemented by a sense of there being no pressure to achieve in the group, which is quite relevant in terms of therapeutic frame, particularly considering the more directive approach adopted by the therapist in the GVI group. P1 for example highlighted the fact that it felt acceptable to just participate, without further expectations: "it's very important that you feel it was nice just to participate and that you weren't expected to do things or not to do things, you didn't feel it was a compulsory thing, you felt it was more like a bonus, that it was not something you had to do, it was something you can enjoy doing and there's no, no anticipation at the end". It was also shown earlier how P5 talked similarly about the fact that there was 'no pressure'.

P3 offers a similar view, adding a nuance in relation to feeling in control and how this was shared between the therapist and the participants: "I never felt pushed… challenged maybe but in a very respectful way: if you don't want to sing you don't have to sing. […] in a way you are in control but we are in control as well. That was kind of thing that can create, to help the bonding and feeling safe, not under pressure". At the same time it brings back the idea of feeling safe in the group, which was also mentioned by other participants. Similarly, various comments have been shown previously where participants commented on the activities being easy and accessible, like P2 "it was so easy and quick!", when she was talking about her experience of the 'syllables in harmony' activity. However, this will be put into perspective with the following section which will be dedicated to the more challenging aspects of the music making.

Before moving on to that, one last theme to do with the impact of the piano from P3, who found it an important part of the sessions: "music doesn't lie, so when you see someone playing piano you see authenticity […] you know I'm not a natural verbal person and music talks on its own […] listening to, the piano was something calming". He seems

to refer to a certain authenticity linked to non-verbal aspect of the music played by the therapist. In a more generic way this might also refer to a sense of feeling grounded by the supportive accompaniment by the therapist at the piano, which often provided a harmonic base for the improvisations.

Difficulty around the technique (GVI)

Table 5.17: Difficulty around the technique (GVI) - themes	P1	P2	P3	P4	P5
Singing as mimicking, sense of copying rather than finding own range.			X		
Wondering about own talent. Expectation of 'getting voice back'.		X	X		X
Singing felt chaotic, 'didn't know where to go'. Difficult following different people.			X		X
Improvisation and songwriting not very helpful: less involvement in improvisation.	X				
Difficulty with the non-verbal free improvisation.				X	
Sensory overload: too loud and too much light.			X		
Need for longer sessions.				X	X
Would have liked more technique and tuition.		X			
Too much talking at times.				X	
Feeling exposed.			X		

This final cluster for the GVI group is an important one, where the different challenging aspects reported by the participants have been brought together, as shown in Table 5.17 in order to provide a reflection on the difficulties experienced in the group in various aspects of the sessions.

The following themes relate specifically to the difficulties around vocal improvisation and tend to convey a sense of not knowing what to do or feeling confused as to how to contribute to the group's music. For example, P3 talks about a sense of feeling lost in the music when everyone was singing at the same time. The confusion around how to use the technique in this instance seems to relate with finding one's own line or 'range' rather than imitate what he heard from others. For this reason, as he mentions at the end of the quotation, activities that were done individually in turns felt easier for him:

> *"I think that was kind of me trying to mimic sometimes […] I don't know the potential of how to play with it, you know at one point I remember I asked you is it me who has to find your range to be on the same level or do I need to find my*

range, and I don't understand all of that technique […]it's always been like mimicking the tone and that's completely wrong cause probably I have a tone which is mine, but I never found it […] When everyone was singing at the same time I didn't know where to go […] it was a bit chaotic, cause it was too many people […] I much preferred at the time when each of us tried on our own […] I could be more receptive".

Despite this preference for activities that involved singing alone, P3 also mentioned that 'I was feeling embarrassed to let myself go and go into the thing and to be exposed', which was similar to P2's experience: "Singing alone, putting me on the spot [was uncomfortable], in the end I would have got there […] I felt confident enough, but earlier on in the sessions I didn't have that confidence […] there were points in which we were going to have to sing alone. I think once we did it, and mine was appalling and I felt so ashamed, another time […] I just backed out."

P5 talked about a similar phenomenon to the chaos experienced by P3, where she felt that following the group was difficult at times due to other group members being 'different': "I felt I can follow you easier than the group, cause sometimes some people was different". It is possible to assume that by this she refers to the fact that each of the other group members were singing different things, and this made it difficult for her to follow. She also mentions that following the therapist felt easier in comparison. It is difficult to know here if she means that it was easier to follow the therapist within the group, perhaps due to the therapist's voice being louder or more confident, or whether she refers to moments in the sessions where the therapist was modelling specific lines or call and response activities. She might have also been referring here to improvising with the therapist only during the individual assessments.

Whereas both P3 and P5 as has just been shown seemed to struggle with the concept of having their own vocal line and not feeling confused by what others were singing, P2 instead seemed to find the actual production of sounds difficult. In her case, having sung in a choir in the past, maintaining her own line which was different from others' did not appear to be an area of concern, but realising the sounds she imagined was more difficult and she felt she needed more input around vocal technique: "for me personally I would want a bit of musical tuition to feel more comfortable doing the therapy and I know I came from knowing a bit but it's so long ago, I would have liked to learn a bit more to feel more comfortable right from the beginning". However, she added that "I wanted more of

a musical lesson, [which] isn't therapy is it?" showing that she was aware of the difference.

The reason that she felt she needed more vocal technique was that at various points in the sessions she felt some discomfort in singing "like a tightness, like it wasn't relaxed, but I might have been trying to sing the wrong pitch for me, cause I think I probably got quite a narrow range now". She also felt her voice had a 'croakiness', which she associated with "I felt that was when I was out of tune". P2 talked a little about how she tried to work around this in the group: "I found if I sang very quietly my voice was better, which is why really I preferred the microphone, because I could sing so quietly but it could still be heard, because the croakiness doesn't happen when it's really quiet." A reflection around the use of the microphone will be presented in the discussion.

So far particular challenges in the act of singing have been explored and now some concerns around the format of certain activities are addressed. For example, in P4's case, as has been described before, he found the 'Soundscape' activity, or baby sounds as he called it, difficult. This seemed to be associated with the concept of the 'sounds of a baby' particularly, rather than the free improvisation, since he felt that 'it was just that I think people who make baby sounds sound stupid'. In that moment, it felt like the therapist had struck a nerve by proposing to make baby-like sounds: "you did strike nerves and that because you're dealing music and you're dealing with emotions". However, having discussed it in the group he added that "it was helpful in the long run".

Whereas for P4 this was a topic that was discussed in the sessions and he brought it up in the interview as well, in the case of P1 this was more subtle and the therapist had to enquire directly about certain activities such as the songwriting and the improvisation in the interview since he had exclusively mentioned the activities that involved the use of pre-composed songs so far. In his response he alluded to a sense that in those more improvisatory activities he felt less involved in it: "that didn't really work for me […] I don't know, it was nice but… not so sort of, you don't feel that you're always involved in it so much. I guess it just wasn't so interesting for me. But that doesn't mean that it was not very good. I saw it as very good for other people, it's just everybody is different". It was interesting that he still provided positive feedback both in the interview and in the GSRS questionnaires and that this only came up in the interview, where even there, he seems to want to minimize it by talking about how he felt those activities benefited others.

The songwriting in particular, which P1 did not find very interesting, was also one that P5 struggled with. In her case it was due to the difficulty in mixing the sentences together to decide on the lyrics of the song composed by the group. As she explains, this seems connected with her previous trauma of feeling unable to provide answers for a task: "that was very distracting for me […] I felt like I'm in school […] I was going really quiet and, you know when we were picking the words and matching them […]. Anything to do with things that I don't know brings back memories, it flashes back always, like how I was in school, so I think then I had a blockage there […] [It was] a little bit pushy for me, I didn't like that. I felt I was being forced like in school and I didn't have anything in my head to say so I was struggling". However, this contrasts with her comment on how she felt that it was a positive and accessible cognitive challenge, which was explored before.

We turn next to a different area of difficulty which had to do with struggling with one's own sense and expectations of their talent. This chapter has already covered before some participants' dislike of their voice and how they felt that in some aspects they gained some confidence in that respect. Here focus is put instead on the expectations of some participants of discovering or acquiring a talented voice through the sessions, as P3 expressed: "maybe I'm going to discover something about a potential you know, I have no idea whatsoever what is my potential at all […] I never knew if there is something there […] I thought if I could sing I would probably know by now, but on the other hand I was like 'oh, maybe you are wrong".

P2 had a similar expectation, although for her it was more a case of recuperating the vocal skills that she had when she was younger: "I had the wrong idea about music therapy, I thought the therapy for me would be getting my voice back and releasing my voice and singing really loud and melodically… of course that didn't happen because that would have been like magic. But I hadn't realised quite how bad it had got […] my voice was lovely then and I could sing loud and I could sing clearly and I could sing in tune, which I can do none of that now". This once again links with how she felt limited by the technique, which was covered earlier.

In the case of P5 she also wandered about her own talent, but rather than expect to find it in the sessions she emphasized in the interview how discovering that singing was something accessible had made her ask herself how her life might have been different had she learned music when she was younger: "I never had the chance, if I had the chance, would I have been able to do it, to understand? And how would it have changed

my life? […] I couldn't stop thinking that, each time I walked and when you played I said if I was sitting there playing, how would I be different person, to sing...".

The last themes in this section relate to difficulties around the format of the sessions, beyond the specific format of the activities, which has been covered before. For example, for P3, who struggled with sensory processing due to his diagnosis of Asperger's syndrome, he felt at times a certain sensory overload: 'the light, too much noise, the piano too strong', which seemed to be distracting for him, although he appreciated other for trying to accommodate his sensory needs.

Finally, P4 talked about feeling like "maybe we did a bit too much talking and never experienced the music full on", which contrasts with previous comments by other participants who found the combination as more balanced. This sense of not having enough time for the music was echoed by P5, who however suggested having longer sessions as she enjoyed the initial 'check in' time of talking: "if the time was longer […] I think totally it should be 2 hours altogether you know because you are checking up, that was fantastic, and then we start to do the song and then we sing and then it ends so quickly when we start to sing, you know, we didn't have time to enjoy."

GMT themes

The list of clusters for the GMT group, shown previously in Table 5.10, starts with the experiences of music having an impact on emotions. Then follow two clusters concerning the experiences of making music in the sessions where the participants reflect on their sense of the instruments' expressivity and how dissonance and consonance were negotiated in the sessions. Later, two more clusters relate to a more distanced position discussing how the use of music impacted the experience of the therapeutic process. Finally, the last two clusters, as has been explained before, are dedicated to the therapeutic frame and to the difficulties in the musical techniques used, like in the case of the GVI group.

Music's impact on emotions

In this first cluster it can be seen that different participants perceived the emotional impact of music in different ways as is shown on the list of themes on Table 5.18. Whilst P10 reported a deep affectation of music on his emotions, participants 6 and 8 talked

about the music being abstract and not easily relatable to emotional exploration: "getting me to explore emotions, I just think I struggled with it in music therapy because I think it's more abstract, because I think it's more subtle that other therapies" (P6); "there were times where it was completely kind of abstract, wasn't it, where everyone played their own thing" (P8).

Table 5.18: Music's impact on emotions - themes	P6	P7	P8	P10
MT was subtle and abstract, not easily relatable to emotions	X		X	
Deep emotional affectation from the music (in a good and safe way)				X
Particularly powerful mood change. Useful mood regulator at the beginning of the day.	X	X		
Playing with others more powerful than on your own. Instant connection in the music.				X
Impact on disassociation: overwhelming when it got loud. It touched something real.				X
Music as a healthy way to change how you feel and creative outlet for sensitivity			X	

This contrasts with P10 who emphasized throughout the interview how much music touched him. The following extract brings together different statements that he made at various points in the interview in order to convey the intensity of the experience that he communicated:

> *"[music] it hits me so emotionally, really kind of emotionally… rather than talking or something, music always affects me so deeply, so that's why it was kind of good for me and a challenge to even do it. […] in each session it was really like affecting me and stuff, in a good way and in a safe way, so that was really good […]. It touched me, it touched me so much… that I've never had with any like group therapy… […] it's hard to connect and get really into it, I guess that takes quite a while you know, but with the music I can instantly, if it's an uncomfortable feeling or whatever, it's instantly, from the first move, so that's what I kind of learned from within myself, the biggest thing that I kind of became aware of was how the musical form of therapy is…, compared to what I've done before, it has brought out stuff with me. […] Very surprising how much I was affected by that, cause I never though… and the feeling of it because I never thought about it until before I came, it was only when I was in the group I noticed 'Jeez, I'm feeling a lot!' […] I've gone through different things in life for*

over 40 years and nothing has touched me like that […] it's the only way that I've kind of touched something within me… which is real… […] for all my not feeling real it's touched the thing that is real."

This quotation shows the intensity of emotion and affect that P10 felt in regards to the music. This was particularly significant given the general flat affect and low mood that he generally presented with. As he points out, the music making was a distinctive element from the previous experiences of therapy he had in the past and one that was able to powerfully affect him.

More subtle changes of mood were also described by participants 6 and 7. P6 mentioned finding the sessions useful as a way to regulate his mood in the morning which helped to face the day: "sometimes I wake up in an emotional funk or something, I think it helped me get out of it". P7 reported a specific mood change from a particular session: "I was having a really bad day and I came in and felt so much better afterwards and it was really nice […] I remember I spoke to you afterwards and thanked you for the session, that was really great… because that was the only really bad day I had when I actually had music therapy on the same day and it really helped me".

In a similar way, P8 talked about music being a healthy way of changing how one feels. This was in the context of discussing his previous experience of treatment for his substance addiction in the past: "in addiction therapy you are very much encouraged to sit with your feelings, because it's something that no addict can do, you know they always want to change how they feel. So the idea of actually using music, you know to express […] I think the idea of changing the way you feel through music is really healthy". Later on, this will be discussed further in terms of what he then thought the music therapy sessions had motivated him to play at home.

Finally, within this cluster a couple more considerations from P10. The first one is that the impact on the emotions was not linked just to the musical 'object' but to the fact that this was done with others: "it's completely different and it's so much more powerful, because when I play guitar at home or whatever I had that feeling but when it's around people, when you're kind of connected it's so much more powerful, it's scary to me in a sense that... it isn't my natural self without being disassociated it's my realness, although I don't feel real and stuff I'm obviously real because I'm feeling it, so yes…"

The end of this quote shows the link with the last consideration which relates to the impact of music on the constant sense of disassociation from reality that was one of P10's main concerns. He talked about the sensation of knowing that he is real but not feeling real. During the enquiry on this question in the interview he reflected on this matter and arrived at the conclusion that although making music raised his anxiety levels, particularly when the music became louder, which tended to heighten his sense of disassociation, perhaps the sensation was particularly frightening because it was putting him in touch with something real rather than because he felt more disassociated:

> *"It's kind of freaky when it gets loud […] I'm generally pretty quiet, cause noise affects me and stuff. […] that was challenging… in a good sense you know, a fun way and in a scary way too. […] It was very uncomfortable… it was really different for me because even at home I wear earplugs and I have earphones to block everything out so being in that moment is very kind of surreal for me something really loud […] Although I'm kind of in the moment I'm still away from it, cause it probably scares me […] It could have been a bit of both, that I was kind of present but scared […] Maybe it's my natural self before I became unwell all those years ago and maybe what's so surreal about it […] how it was when I felt so, so called normal, and that's probably what scares me. […] Yes, the more I think about it, I was probably more there than I'm kind of describing […] Not being used to that feeling of being in that moment […] It could have felt like detachment but maybe it was being in the moment that was sort of hard. […] When it got really loud, that realness or connection it becomes too overwhelming, you know, I think that's the scary part of loudness and how… what's it going to do to my mind, you know? That scariness, cause all I've ever feared was going insane you know […] that fear of never coming back, the mind going and never coming back, that's what I've always… although I've never got it […] I haven't got there but it's felt like at times I'm getting there…"*

Once again a long quotation has been provided here in order to capture this complex and nuanced reflection on an experience of disassociation and how playing music in the group with others influenced it. This very rich description shows clear links with the direct experience of the music making, for example in regards to the volume of the music and how significant this was for him in increasing his affective state in a way that felt challenging and overwhelming at times, as it was associated with a fear of losing control of the mind.

Importance of the expressivity on the instruments

Table 5.19: Importance of the expressivity on the instruments - themes	P6	P7	P8	P10
Importance of being able to change instruments.	X			
Being able to play an instrument was important. Actually playing the instruments.			X	X
Feeling able to be expressive.	X			
Importance of sharing poem (text) as a different way of bonding.	X			
Push to play in a space where you are expected to.			X	
Wanting to stay invisible but be heard.				X

Here the focus is placed on how participants felt like they could be expressive through the use of the musical instruments as can be seen on the Table 5.19. P10 highlights the fact that the sessions involved 'actually playing instruments', which appears to emphasise the experiential aspect of music therapy. P8 adds that it felt useful to have a dedicated space where one is expected to play in order to be motivated to play: "even though music should be something that you want to do… I need to be pushed."

From his perspective, P6 highlighted the importance of being able to change between different instruments depending on how one felt: "having that flexibility when I wasn't feeling up for the cello to play something else […] I think if I had to be stuck with something and I couldn't do it, there would be frustration". This denotes that he felt able to be expressive in different ways through the different instruments: "just being able to be expressive was helpful". In a similar way, putting the emphasis on the different expressive affordances of different instruments, for P10, who tended to play in the background and often chose to play the bongo drums very quietly, highlighted how this allowed him to 'stay invisible but be heard'.

Finally, P6 also notices that making use of poetry felt like a 'different way of bonding' in the group compared to the usual use of instruments. This has already been discussed in the analysis of the audio recording for the session where the poem was used for an improvisation and will be brought back in the discussion.

Dissonance and consonance in and out of the music

Table 5.20: Dissonance and consonance in and out of music - themes	P6	P7	P8	P10
Negotiating dissonance and consonance in the group.	X			
Enjoyable even if non coherent music.	X			
Peaks of harmony as well as clashes. Emotional when it 'gels' together.			X	X
Importance of grinding sounds.			X	
Intersubjectivity and how the clashes can be overcome with humour.		X	X	

In this cluster the focus is the participants' experience of consonance and dissonance in the music and how this was an important part of their narratives around the dynamics in the group as the themes on Table 5.20 show. For P6, for example, "the only challenging thing was like wanting to be more cacophonous with the music and I think other people wanting something more melodic, but then I think I got my times to do that and I think I felt satisfied with that". This account appears to reflect a quest for the moments of cacophonous or dissonant music and a tolerance for other moments where he felt that others were aiming for a more melodious result. He described his experience that "even though it's not coherent music as it were it's still enjoyable and pleasant to listen to".

It is interesting to notice how for participants 8 and 10 the opposite seems to be true, where the moments of dissonance are seen almost as failed attempts at consonance, despite being tolerated and seen as valuable to a certain extent. For P8 "hitting those peaks of harmony […] it was just amazing! […]even clashing you are still part of a group, whatever you are doing it's still part of a group […]It felt ok because it was all part of our process… I knew that between us all that we could create something harmonic so the fact that we can do something unharmonic was fine too". It is interesting, however, to notice that later in the interview he talks about valuing the more 'grinding sounds'. P10 makes a similar point when he states that "the way when it all just gelled and we were sort of kind of together that was really kind of emotional for me, really good […] even if the music is just kind of all over the place it's still … there's still a connection."

Both P7 and P8 make an interesting observation about how this negotiation of consonance and dissonance took place through humour and looking at each other and laughing: "it's just fun when you get a tune and you are looking at everyone and you are laughing and it's a sense of a humour about playing that's very uplifting, it's like one of my favourite things" (P7). This phenomenon will be familiar to most therapists who run

similar kinds of groups, where sometimes there is a tentativeness that has a high intersubjective feeling.

Relating personal traits with music traits

Table 5.21: Relating personal traits with music traits - themes	P6	P7	P8	P10
Looking at and learning about oneself differently, 'in a way of music'.				X
Different kind of awareness during music making.	X			
Link between the different musical role of instruments and personal narrative.			X	
One instrument in particular felt enabling to channel emotions related to trauma.			X	
Noticing something in the music and being able to discuss it afterwards.			X	
Reflecting on the comments from the group.				X
Resonating with someone else, sensing these in the music		X		X

This cluster can be summed up beautifully by a quote from P10 in response to the initial opening question of the interview about what was it like to be in the group: "I liked it because it was a different way of looking at ourselves and … in a very different way rather than just talking about it. […] We were kind of learning more about ourselves in a way of music. […] I know general stuff about me but, but different… yes, I liked that aspect where it was within the music".

As can be seen in Table 5.21, the themes from this cluster revolve around the notion that some of the personal traits from the participants were reflected in the music making, which allowed discussions and reflections in the group around participants' experiences from their musical expressions. It is worth adding that whilst the music reflected some of those personal traits that participants knew about themselves, the musical form seemed to illuminate them in a way that allowed them to be looked at from a different light that seemed to offer a new perspective 'in a way of music' as P10 described. Similarly, P6 talked about having a different awareness of himself: "it's kind of nice to kind of meditate almost in a different way".

For one participant in particular, P8, there was a strong link between the characteristics of the instruments he played and how he thought about the fact that choosing one or the other was reflective of different personality traits of his that he chose to express at different times. He appeared very interested to reflect on how his way of playing certain instruments, like the piano or the guitar, was revealing something about himself:

"it is so easy for me to get self-obsessed and so self-conscious and so self-absorbed, and there were times where that happened especially with the piano […] I think I wanted to consign that aspect of me to history […] I like the idea of just being sort of solid, keeping the rhythm… […] how reflective that is of what I hope my personality is, you know, I've had all of that ego stuff […] playing music really loudly, that was all very kind of ego driven."

Often, his response to this was to play simpler instruments such as percussion instruments. Through the course of the sessions, he became increasingly interested in playing the bass tone bars, which he attributed a certain 'solid' role as he would use them to mark the beat of the group's music (as seen in the last audio extract). In the following quotation he (P8) talks about his sense of attachment to this particular instrument:

"I got really attached to the tone bars and it's kind of… I think sort of somehow banging something, I don't know it's something about that feeling and being able to let it flow through me like that… because what was great about it [was] I didn't have to think about I'm in in wrong key, I'm not playing the right string… so I kind of got quite attached to those, I remember."

Here, when he talks about letting a certain feeling flow, he was referring to thoughts and feelings around past traumatic experiences, which he called 'core issues' that he discussed in the sessions around abandonment and abuse. The image of letting those difficult emotions flow through him when playing the tone bars and being the base for the rest of the group is a powerful one and it is significant that he felt able to talk about his different modes of being in groups, more dominant or more collaborative, though his use of the instruments.

In this sense he mentioned the importance of group members noticing how he played and discussing it in the reflective conversations afterwards, as he points out: '[P6] remarked on something that I played because he remembered'. Here it seems important that P8 was able to notice that P6 had heard something about him and crucially had 'remembered' it and 'remarked' on it. The music making on the instruments therefore seems to afford ways of talking about a theory of mind concept of being able to see that the other has been able to see something about oneself, in other words that one can be held in mind by the other.

In a similar way, P10 talked about the importance of reflecting on the experiences he had in the group and what he noticed about others and vice versa:

> *"I've thought a lot about what […] was noticed of me or just noticing others […] I still think about the discussions we had. I've just thought a lot about things we had in the group […] it was probably a change in that, cause other things I won't kind of start thinking about […] It's good cause generally it's more of a ruminating thought over worry and concern about my mental health rather than good aspects and positive aspects of a therapy […] I never thought I'd be thinking of things about myself or others or what they found in the task or whatever or in the music."*

Here again it is shown how the thinking and reflecting around the music in the sessions in regards to what was noticed about oneself or about others was a significantly valued aspect and one that stayed with P10 beyond the space of the sessions. It is also possible to see a shift towards a more curious stance towards oneself and one's mental health that affords the possibility of considering positive aspects rather than remaining in a 'ruminating' way of thinking. This has some resonances with the case of P5 from the GVI group where a similar phenomenon of a shift in the narrative around difficulties associated with mental health.

Finally, within the same line of thought around noticing others in the music making, the last theme concerns the mentions of feeling able to emotionally resonate with another group member through the way in which they used the music. For example, P7 talked about feeling touched by P10's way of playing the guitar:

> *"being quite touched by (P10). I felt like a sort of like sadness about him and also like […] it just made me think a lot, […] it was quite special when he played his music and that was that day that I was having a really bad day, and he was playing the guitar and it was just a moment that stuck out to me and he didn't know anyone was listening to him".*

In a similar way, P10 commented on sensing a resonance between him and P8: "I could sense he struggled with anxiety and a lot of stuff but it was a brilliant part of the group because he kind of knew instantly a lot of the suffering I have been through".

This aspect of thinking about the music making in order to think about oneself and one's relationship with others is a very relevant matter in this study, as it links with the idea

that in using instruments rather than the voice there is greater potential for a reflective space to emerge between the improviser and the sounds contributed to the improvisation than in the use of voice due to the different level of body involvement. This will be explored further in the discussion section.

Fun and motivating

Table 5.22: Fun, motivating - themes	P6	P7	P8	P10
Fun and playful.	X	X		X
Enjoyable therapy.			X	
Something new and appealing due to love for music.			X	
Motivation to play more at home when needing to process difficult feelings.			X	
Wanting to learn an instrument.		X		

As is shown in Table 5.22, this cluster contains themes that report a sense of enjoyment, playfulness fun and motivation from the sessions. P6 for example talks about the 'fun' of the improvisatory element of the sessions: "it wasn't easy but it was accessible to kind of jam in a group as it were, so I think that I found quite nice and I think also just having fun […] it wasn't learning how to play a sheet piece of music it was more fun and I think because it wasn't like 'I'm doing it wrong, I'm doing it wrong, I'm doing it wrong', I enjoyed it a bit more. […] I think it was very important to have that weekly bit of fun". P7 also adds the notion of playfulness: "it was quite fun and playful".

P8 also highlighted the joyful aspect of the sessions at the beginning of the interview: "[it is] the most enjoyable therapy that I've ever done". In his case, it seemed like part of the enjoyment came from his passion for music therapy was particularly relevant given his passion for music, which had led him to start to learn how to play several instruments when he was younger: "it was something that was particularly pertinent to me […] I never got to master any instrument but I could tinkle… but it was more than that thought, it was being part of the group".

In his case, P8 reported that the sessions motivated him to play more at home, where he had instruments but was never using them: "we've got a keyboard at home, it's encouraging me to use music as a form of expression, which is something I hadn't done for many years, so that's really good". This seemed to serve two functions: on one hand, to reconnect with his passion of music, but also to process difficult emotions sometimes triggered by his work. He detailed an example where: "I could have gone to […] the

keyboard, sat and processed those feelings through the keyboard, through music". This seems to link back his idea of changing the way one feels through music, which was discussed before.

This sense of motivation to play music was also mentioned by P10, who sometimes was invited to 'jam' with others in a regular place where he used to go but never felt confident enough to play with them: "that's another thing I felt, maybe I could try and have a go… so that's one of the things, it could give me confidence, cause I would love to do it, you know stuff like that, just for fun".

Finally, P7 also mentioned a certain motivation to engage further with music making: "[it] makes me want to learn an instrument". This is significant given that she often felt limited in the use of instruments in the group, as will be explored in the challenges section.

Sharing the space and therapist management (frame GMT)

Table 5.23: Sharing the space and therapist management (frame GMT) - themes	P6	P7	P8	P10
Sense of balance in the frame (i.e. more talking towards the end).			X	
Therapist's soft authority: difficult things were contained, focused.	X			
Insightful therapist capable to manage the group.			X	X

As discussed before, this cluster was included in order to be able to reflect on the impact of the therapeutic frame for the participants, given that this seemed to be one of the aspects that was affected by the different techniques in the two groups. In this case, some of the participants alluded to the balance between talking and making music as well as the therapist's stance and management of the group.

As shown in Table 5.23, for P8 it was important that he felt there had been increasingly less music making in the sessions, which in fact was corroborated in the macro analysis of the audio analysis. When talking about this, he also makes a comment on the therapist non directive management of this balance: "progressively we did less music and more talking […] and I think you structured it really well. I just think it worked… it was never 'right, we are going to have less music now and more talking', it just happened organically."

P6 also touched on the generally non-directive aspect of the therapist's stance: "I think you've always maintained like… it's not a totalitarian control, you've got a very soft authority but it's not weak. […] It was like well facilitated, well guided but it was not a case of 'well now we are going to do this', apart from when you said let's make music, which I think helped".

Finally, a couple of participants mentioned the therapist's notice of both the group as well as of each individual, which seemed to link with the capacity to manage the group: "I think you are very insightful […] you've got a very good understanding of your clients, as a group but also individually. The skill of the therapist in managing the group." (P8); "you were aware of every individual, different things about each other, which was really good" (P10).

Difficulty around the technique (GMT)

This final cluster, as for the GVI group, brings together different considerations around the difficulties encountered by the participants in order to allow a reflection on the challenging experiences that took place in the group. The different themes are presented in Table 5.24.

Table 5.24: Difficulty around the technique (GMT) - themes	P6	P7	P8	P10
Doing the singing (in the assessment) was mortifying.		X		
Limiting expressiveness in the instruments.		X		
Uncomfortable to share the poem.		X		
Feeling exposed and embarrassed when therapist commented on individual playing.				X
Positive challenge when playing on one's own, but it got better.				X
Wanting more instruments.			X	
It would be good to have more information about music therapy at the beginning.	X			
Some people were too dominant.		X		

As has already been briefly mentioned earlier, P7 felt limited in her capacity to express herself musically, as she explained in the interview:

> *"[taking part in the music] was quite intimidating, I just felt I couldn't express myself the way I wanted to because I was limited musically […] it's a shame*

because it would be so great if I could do it. I would like play some songs and stuff and have a lot of fun… I mean I love music so much… it's like my greatest passion actually. […] So that's really sad for me actually, that I can't express myself musically."

This was contrasting with other creative activities such as writing where she felt a lot more at ease with. However, playing the instruments was not the only aspect that she found challenging. Sharing her poem in one of the sessions (which has been discussed in the 'macro analysis') was also something that "quite uncomfortable […] I thought I would really love it and I found it quite cringeworthy". In the interview she also brought back her experience of trying some singing during the individual assessment, before the allocation to the instrumental group. She really struggled with the idea of singing although she bravely tried it out: "when I had to do the signing sing it was absolutely mortifying, it was a low point".

Her experience contrasts with the views presented earlier, mainly from P6 and P8, who felt able to express themselves flexibly through the instruments, but other participants found other aspects of the sessions challenging. For example, for P10 playing on his own during the 'sound signatures' felt quite anxiety provoking although in retrospective he thought it was a positive challenge: "now I see it in a good way, then I was so fearful "oh no not me" […] That freaked me out […] because I get so nervous, because that little space is all on you […] I see it as a really good challenge, it was brilliant. I fear it even now, but it was good, I liked that". He also talked about feeling exposed when in one of the sessions the therapist mentioned something about how he tended to end his playing: "I was kind of sort of embarrassed […] or shy of it". It has been shown earlier however, how he thought that those kinds of observations initiated a curious enquiry about himself and others in him.

The final themes of this section relate to the frame or format of the sessions, from P7 feeling that some people were too dominant in the group, to P8 wishing there had been more instruments available: "maybe a slight disappointment would be that we could have had more instruments". The impact of the musical equipment will be explored further in the discussion.

Finally, P6 thought that the information about music therapy could have been more specific or accurate: "I think it took me a few sessions to get what music therapy was, because I never really knew what it was, […] I don't know anyone who has done it either,

so I think just perhaps to kind of level people's expectations and make them more aware of what's going on […] I think perhaps if there's a way of communicating as best you can what it was about". This seems to link with his sense of music therapy being subtle and abstract and will also be explored further in the discussion, during the review of the methods, since he talked about finding the interview very useful to reflect on his experience in a more explicit way.

Conclusions

The aim of this analysis was to show in more detail the voices of the participants and to be able to reflect about the nuances and complexities from their experiences. Their accounts have provided a rich picture of the GVI and GMT practices and they have shown a range of touching, confusing, exciting and challenging experiences, which reflect the realities of the naturalistic clinical work. The music therapist reader will probably have recognised many reactions from the participants as being similar to those of their own clients. The overall picture therefore becomes more layered and possibly asks more questions than it answers, which was the original purpose of this exploratory research. However, it feels important to provide some concluding thoughts that bring together the variety of presented experiential narratives, even if it necessarily involves a certain reductionist approach.

Having looked at each of the themes for the two groups, several observations follow before discussing the findings from the interviews alongside the rest of the analysis in the discussion section. First of all, going back to the original table (Table 5.10) which showed the clusters from the two groups in parallel, and now having looked at the clusters in more detail, it is possible to notice some trends.

As was explained before, the clusters were presented in order from those concerning the most inner or individual experiences to those about more external and social experiences. Going back to it, it seems that although both groups emerged as having five clusters – plus the ones around frame and challenges, which were in a way more categorically informed and imposed on the data – and they both were ordered in the same way, when looking across the two groups, the clusters from one group did not appear to match the ones from the other in terms of degree within the continuum from 'internal' to 'external'.

For this reason, it seems to make sense to think about these clusters in terms of Damasio's (1999) theory of consciousness, which identifies three levels of self based on their level of consciousness, and to position the clusters within those. This offers a way of actually thinking comparatively about both sets clusters. Damasio's three levels of consciousness, proto self, core self and autobiographical self, describe a model of cumulative stages. In this model the proto self is categorised as a pre-conscious stage which constitutes the most basic representation of self and is closely linked to the body and its responses to the environment. This level is concerned with emotions but does not require language or memory. The following stage is the core self, which is concerned with the present moment, where the individual recognises that the thoughts are his. At this point feelings emerge as noticing the changes that affect the bodily state or proto self. Finally, the last stage is the auto-biographical self or extended consciousness which moves beyond the here and now and where a sense of narrative is possible. In this theory each of the stages is correlated with certain brain regions and neural pathways. However, here the importance is placed on the overall organisation in different degrees of consciousness which resonates with the way of ordering the clusters for this analysis.

However, it is important to highlight that Damasio's categories are only borrowed as indicative of different degrees of what more informally can be called 'internal' and 'external' experience, but this is not aimed at claiming that the experiences described belong to certain neural functions as described by Damasio's model. The fact that the proto self is a described by Damasio as an unconscious level and that some clusters have been attributed to that category only confirms this, since in order to be perceived and described in the interviews, the experiences are by definition conscious. Despite this, it still seems pertinent to use the categories, even if from an 'intuitive' point of view, in order to differentiate discrete categories within the continuum from lower to higher levels of consciousness, as these stages seem to convey some of the characteristics of experience described in the clusters (i.e. experiences more linked to bodily functions can be easily relatable to the realm of experience described in the 'proto self' stage).

Table 5.25 shows the same lists of clusters in the same order as Table 5.10 (excluding the frame and challenges clusters for each group), but here they are distributed into the different levels of self described by Damasio. The decision to place the cluster in one category or the next has, as previously mentioned, been done as a speculative move with the aim of making sense of the data and not empirically. This classification has been based on whether the most prominent feature was an experience related to non-verbal,

affect and bodily sensations (proto self), emotions mainly related to the present moment (core self) or a sense of narrative (autobiographical self). The resulting table (Table 5.25) shows how the GVI group's clusters are distributed more towards the proto self, having two clusters in the initial two categories and only one in the last whereas the GMT group's clusters go more towards the autobiographical self, having only one cluster in the initial category and two in the subsequent ones.

Table 5.25: Distribution of clusters in levels of consciousness

	GVI	GMT
PROTO SELF	Sensory aspect of singing	Music's impact on emotions
	Something from inside out and accessing something very 'inner'	
CORE SELF	Accessing a different mental space through singing	Importance of the expressivity on the instruments
	Experience of intersubjectivity	Dissonance and consonance in and out of music
AUTOBIOGRAPHICAL SELF	Discovery of new things: accessibility to new experiences	Relating personal traits with music traits
		Fun, motivating

This suggests potentially a perceived greater emphasis of the GVI work on the lower levels of consciousness, specifically involving an emphasis on the body, whereas the GMT experiences appear to be perceived as having a greater influence on more elaborate and narrative levels of consciousness. This, as any part of this research is obviously not only influenced by the technique used but also heavily by the participants given the small sample of the study. Therefore, it might be the case that this tells us more about the level at which the participants were able to work than about the affordances of the techniques. Given the relatively important differences in independent functioning as well as severity and chronicity of diagnoses in the two groups (as discussed in the demographics analysis) this would appear to make sense.

Despite the clear impact and influence of this dimension of the clinical work in the two groups, there still seems to be a place for the logical argument, corroborated by the data discussed here as well as the therapist experience which will be discussed in the following section, that the voice work might have a clearer impact on a bodily level of consciousness given its strong embodied nature. This is particularly relevant as one might expect or predict the opposite argument, since the vocal work affords more easily to include a semantic element derived from the use of words. This could be seen as

potentially contributing more to the autobiographical level, which is more concerned with a narrative, social and cultural aspect. In that sense, because the GMT work could be seen as more abstract and less verbal one might hypothesise that it might be more suited for working at a non-verbal, bodily and affective level. However, this was not observed in the data from this study. In any case, either modality is dependent on the therapist's ability to tease out meaning making within any of those three realms. In this sense, it is possible to argue that GVI does not reduce the therapeutic options of working at those different levels.

Further reflections on the findings from the IPA analysis will be presented in the discussion section by relating them to the overall research questions for this study.

5.3.3 Therapist's experience

Although the therapist's experience has occasionally been mentioned in previous areas of the data analysis, this section addresses the experiences gathered through the session summary forms completed by the therapist after each session.

It is important to address the therapist's experiences alongside those of participants in order to both be transparent with the reader, particularly given highly qualitative nature of the research, but also to provide insights from the clinician's perspectives about what it was like to be running each of the groups. This also provides an opportunity to consider aspects of the practice that relate to the profession and discipline dimensions to the music therapy work, which will be important to include in the discussion.

Session summaries

The session summary forms were a short form of between one and two pages completed by the therapist after each session, which was different from the individual progress notes written for the clinical records of the patients. A separate document was compiled for each of the groups which provided a reflective space for the therapist to capture the thoughts and impressions of the session both at a clinical and research level.

The first section of the document listed in chronological order the various events, activities and interventions that took place in the session and had a column for thoughts or reflections on the dynamics in the group. The second section contained some guiding process questions that aimed at stimulating overall reflection around the session. This section afforded for both clinical and research concerns, thoughts and ideas to emerge.

The following sections provide an outline of the main themes that emerged from the session summary forms. This section of this analysis has been kept purposefully relatively succinct since the discussion section will provide a richer analysis of the therapist/researcher's reflections and experiences from a broader therapeutic perspective.

Timing in the GVI group

A recurrent theme from the GVI sessions was a sense of not having enough time for the singing, which as seen in the IPA analysis was a perception echoed by several participants from the group as well. This often was accompanied with a sense of having to maintain the momentum when we started the singing in order to sustain the singing. This felt a little frustrating at times since there was a greater sense of responsibility in guiding and giving direction to the sessions than in the GMT group. Having seen the fragmented nature of the musical activities in the GVI group in the macro analysis of the audio recordings, this experience seems to be grounded in an actual difference in the timing distribution of the music making.

Having presented this, it is also true that when a certain activity seemed to work and the participants mentioned that they wanted to come back to it this felt more encouraging for the therapist as there was more of a dynamic of following greater autonomy of the participants in deciding how they wanted to use the sessions. However, even on those occasions it often felt like the therapist's responsibility to focus participants away from the verbal discussions and towards the singing. For that reason, especially when it felt difficult to cut short the initial check in discussion the singing tended to feel rushed, particularly towards the end of the session, when it seemed like the participants were starting to get more engaged in the activities.

Therefore, in order to balance the issue about timing the therapist felt pushed to being more directive in suggesting and initiating the activities, which were more directive in themselves, as discussed before, given their more structured approach. Adopting this more directive role felt rather subversive given the clinical tradition the therapist was coming from, in which music psychotherapy was understood as psychodynamically focused and the non-directive stance was valued as one of the fundamental elements of the practice.

This meant that the therapist felt at times self-conscious about bringing in a different stance from that of the tradition she had so far been part of and there was often a sense of stepping into a more ambiguous teacher-like territory. Whilst those feelings might have also been a result of the interpersonal dynamics and of transference processes with the group members, there seemed to be a distinctive sense of adopting a slightly different therapeutic framework linked to the use of structure in the music and to adopting a more directive role in engaging the participants.

Designing new activities in the GVI group

Another aspect that appeared often in the session summaries was an impulse to come up with different activities or interventions in order to resolve or overcome technical difficulties in how the participants were able to make use of their voices in improvisation. One of the main issues in this respect was that most of the participants struggled to maintain their line of singing amongst other members'. For some of the participants (P3, 4 and 5) this seemed particularly related to not having experienced it before, whereas for others (P1 and P2) it appeared less related to the concept of the task and more to self-consciousness, lack of confidence and vocal technique, as described by the participants themselves in the interviews. Therefore, it felt like there was a need not only to 'sensitise' the larynx but the ear as well.

Although these obstacles had been anticipated as a potential difficulty, they sparked a need to design new activities in response to the specific needs and strengths of the participants. This at points felt like a constant reactive attitude to the group in coming up with solutions, which could feel a little distracting from the clinical work and thinking about the group dynamics, since there were technical difficulties to attend to. This problem solving approach once more felt very alien to the more reflective stance in thinking about the group that the therapist was more used to. However, it was precisely because of this that the group was also more present in the therapist's mind and was perhaps less taken for granted, in the sense that there was a need to be creative in between sessions in order to provide something on the following week that might make it easier for people to engage with the singing activities. This contributed maintaining a 'fresh' sense of enquiry from the therapist's point of view, which is quite a healthy therapeutic skill.

In this sense, the whole six months felt more like a process of finding out how to work with the participants in the non-verbal medium of the therapy rather than having this notion established more or less from the beginning and working on reflecting with the participants on the use they made of the music making, like in the GMT group. It is interesting to notice how these different evolving developments of a shared way of working seems to be reflected on the scorings of the GSRS questionnaires, which have been analysed and discussed earlier. This suggests a shared notion in both the therapist and the participants of being jointly involved in trying to find out how to work together in

a more concrete way than in the GMT group, which probably contributed to reinforce the cohesion in the group despite the vocal challenges.

However, this required a proactive effort from the therapist in trying different things out in the sessions. One example of this was the 'syllables in harmony' activity which, as has been described before, was a partly pre-meditated intervention that was specifically designed to structure and support the context for vocal improvisation.

Membership management in the GMT group

In the session summaries from the GMT group, one of the main issues revolved around how to manage the membership of the group, particularly in regards to P9, who frequently missed sessions but when contacted to enquire about his absence showed willingness to attend and argued that he was having a busy period at work as he was going through a major transformation in the business that he owned. Alongside the uncertainty around his attendance there was a certain insecurity as to how to approach the situation when explaining it to the other group members as his very inconsistent attendance appeared to destabilise the group membership.

Although this was discussed in the sessions and sometimes appeared to offer useful insights into how the different participants felt about the issue, this nevertheless had an obvious impact on the levels of attendance and therefore other participants' experience of the group.

With the groups being closed and having the added research component it felt difficult to recruit another participant, also as it only became clear that P9 would not engage over half way into the sessions, given his recurrent manifested intention to attend the sessions. This was also destabilising for the therapist as it came as a disappointment when he did not attend after having been in touch and agreed that he would be attending.

The membership of the group was further disrupted when P7 did not attend for six weeks in a row due to an internship that she did which clashed with the time of the sessions and at the same time P10 had a brief relapse and could not attend for several weeks as well. At this time, which was towards the end of the second phase of the group, there was a sense of potential disintegration of the group, which felt difficult to stay with.

Variety and stuckness in GMT group

Another generic theme around which some of the considerations from the session summaries revolved around was the musical content of the improvisations. On one side this seemed to flow relatively easily in the group and most participants appeared able to relate to the instruments and were able to reflect on their playing. The variety of instruments afforded interesting, contrasting and creative combinations of sounds in the improvisations and the pieces seemed to navigate different atmospheres. In this sense, the music appeared varied and rich, allowing the different participants to interact in different ways, for example by choosing different instruments in different pieces or sessions. This was also true for the therapist who felt able to adopt more or less dominant roles by choosing to play different instruments depending on the context.

However, over time the therapist started to notice a sense of stuckness in the music. Some participants (for example P7 and P10) tended to be less explorative in their choice of instruments and in the way they played and since the range of instruments remained the same throughout the six months, there was a sense of an established practice and sound world that did not appear to grow or go in a particular direction.

Although the conversations evolved with the group members getting to know each other, the music seemed to have reached a level of saturation where not many new experiences emerged. The therapist wondered about the possibility of introducing new formats, but at a stage where it was quite close to the end and there was a sense of inertia where some participants seemed to feel comfortable (P6 and P8) and able to continue exploring different creative possibilities and therefore it felt difficult to introduce new structures at that point. Probably the threat on the group membership, explored in the previous section, also was a contributing factor on the therapist's feelings of insecurity in regards to introducing changes at such a delicate moment.

Concluding thoughts

The themes presented in this section seem to echo some of the participants' experiences which have been explored in the IPA analysis. More in-depth considerations of the therapist's experiences will be presented in the discussion, but here it is possible to begin to see a certain tension or challenge around the therapeutic framework and stance and how this was influenced by the musical content and format of the sessions in each of the groups. These themes were brought to both clinical and academic supervision across the course of the project in order to reflect on their therapeutic and research implications.

6. DISCUSSION

The aim of this chapter is to provide a synthesis of the findings from the different sections of analysis presented so far separately and to provide some lines of thought to answer the questions originally proposed. The following sections will therefore develop the main considerations around the similarities, differences, nuances and complexities in the comparison between the use of instruments in GMT and the use of voice in GVI. There will also be an opportunity to go back to the initial questions and thoughts presented in the initial chapters, as well as to the reviewed literature and the considerations that emerged from that.

After having explored the findings of the study from a comparative point of view there will be two sections dedicated to GVI specifically as this is the main focus of the core enquiry that stimulated the research in the first place, but also because there is a lot more specific theory from a range of sources available around the use of the practice broadly referred here to as GMT. In this sense, on one hand there will be a discussion of the theoretical framework for GVI as approached in this study and, on the other, some recommendations or guidance for using GVI will be presented.

Following these sections, a reflection around the use of the chosen methods will also be explored, given that although these were not the main focus of the research, the present study has served to use some of them in the field of music therapy for the first time – as far as the literature review has found – and it seems important to dedicate some space to reflect on the usefulness of these.

Finally, the discussion chapter will conclude with some considerations around the main challenges and the limitations of this study in order to provide some boundaries and context for the findings of the research.

6.1 Synthesis of findings

The sections below provide a synthesis of the results presented in the previous chapter in order to answer the initial research questions and to provide a basis for the discussion. The findings have purposefully been presented in bullet points in order to focus the thinking and provide a more precise and clear overview of the results obtained in the

data analysis, when compared with the more narrative account from the previous chapter.

6.1.1 RQ1 - Interactions

This section presents a summary of the findings from the macro, meso and micro analyses of the audio recordings, which were the data analyses designed to answer the initial research question of the study. This question looked into what kinds of interactions took place in GVI and GMT practices and in what ways these were similar or different. This question looked mainly at the music that took place in the groups although, as described in the methodology there was also attention dedicated to the verbal interactions, which were examined mainly in the meso level of the analyses.

The bullet points below provide a synthesis of the findings:

- There were clear differences in the kinds of music that the two groups produced and in how the musical activities were distributed in the sessions, as could be seen mainly in the macro and micro analyses.

- A greater variety of kinds of musical activities was observed in the GVI group whilst at the same time there was a greater variety of individual styles within each piece in the GMT group.

- The variety of musical activities in the GVI group included use of pre-composed material in various forms (including songwriting) alongside improvisation, whereas GMT focused exclusively on the use of improvisation.

- The use of pre-composed material appeared to have different functions in the GVI group, such as familiarising the participants with the experience of singing, getting used to singing in the group, as a preparation for improvisation, as a way of sharing cultural references, as a way of talking about emotions from the lyrics and as a way of moving to more familiar material after experimenting with improvisation.

- The use of pre-composed text as a reference for a group improvisation impacted on the music making, the structure of the session and the negotiation of tasks in the GMT group.

- The GVI showed a more fragmented distribution of the musical activities, with shorter but more frequent instances of music making than the GMT group.

- The shorter vocal activities often involved repetitions of activities which offered possibilities to revisit ways of engaging with the activities within the session and to revisit material from previous sessions, which was not a phenomenon that occurred in the GMT group.

- The shorter activities in the GVI group seemed to reflect a difficulty to sustain the singing for the participants. Instead, the GMT showed participants as having greater autonomy in their use of the music.

- The improvisations in the GVI had a higher level of structure than the GMT group. This was directed and supported by the therapist in order to frame the piece and restrict the musical possibilities to allow participants to engage and be creative in the improvisation.

- The GVI included more preparatory activities (such as the warm-ups) in each session whereas the GMT featured some preparatory activities towards the beginning of the groups but these decreased as the sessions progressed.

- Although the therapist appeared similarly leading and directive in suggesting and negotiating tasks in both groups, the GVI groups showed that in between short musical activities the therapist became particularly directive, more so than between improvisations in the GMT group.

We can conclude that the musical interactions in particular showed differences between the two groups mainly in terms of timing, distribution and degree of use of improvisation versus pre-composed material. The greater level of structure in the improvisations for the GVI group was another feature, which influenced the individual musical variety of the participants. The verbal interactions showed some subtle differences but overall the two groups showed a similar way of negotiating the group's tasks in the sessions.

6.1.2 RQ2 - Therapeutic processes

For the second research question the analysis focused on looking at the weekly ratings of therapeutic alliance as measured by the GSRS questionnaire. The records of attendance also helped to provide a picture of the therapeutic processes the two groups underwent.

The bullet points below provide a synthesis of the findings:

- Both groups were clinically successful in terms of the subjective experience provided by the participants through the GSRS, with both achieving very high ratings which reflects acceptance of the interventions and identification with the group.

- This indicates that both practices are possible to conduct as techniques of group music therapy and were accessible and helpful for the participants.

- The analysis of the GSRS provided similar descriptive trends for the ratings in both groups, showing a progressive tendency towards the highest ratings in the questionnaire.

- The GMT group reached those ratings sooner than the GVI group, however. The GVI group showed more variability of scores for longer and it was hypothesised whether this might be related to the greater variety of activities, to which participants showed different preferences.

- The GVI group showed greater attendance, even when adjusting for the participant who dropped out from the GMT. This was particularly clear during the last phase of the sessions.

- This could be associated with the slower process of finding a way of working together in the group (as reflected on the GSRS scores) in the sense that a greater or more active joined effort between therapist and participants in the GVI group could have contributed to the higher attendance levels towards the end.

Here, it is possible to conclude that the therapeutic processes did not show major differences, since the overall trends of the GSRS questionnaires and attendance were comparable. However, the GMT showed globally higher GSRS scores and achieved high

and stable scores more quickly than the GVI group. At the same time, GVI showed higher attendance and this was particularly contrasting with the GMT group in the last phase.

6.1.3 RQ3 - Change mechanisms

Finally, attention was turned to the accounts of participants and therapist of their significant, positive and challenging experiences in both groups in order to gain a greater understanding of the change mechanisms at work for each group. For this, an initial and more generic thematic analysis was conducted over the totality of the interview transcripts and session summaries. Later the focus was put on selected fragments where the participants talked about their experience of being involved in the music making in both groups where a more in depth form of analysis using IPA was conducted.

The bullet points below provide a synthesis of the findings:

- Both groups reported changes in similar areas with a similar distribution.
- The participants in the GVI group provided slightly more lifestyle changes related to bodily experiences.
- Both groups showed similar views of their experiences in shared features of the groups such as the social and research aspects.
- The IPA of the GVI group provided a stronger focus at a 'core self' or bodily level of consciousness whereas the GMT showed a stronger emphasis on the 'autobiographical self' or narrative level of reflection.
- Whilst the GVI group put more emphasis on the intersubjective experience of harmonising with others the GMT participants reflected on the impact of dissonance and consonance in the group.
- Whilst the GVI participants reflected more on the discovery of new experiences in the group, the GMT group put more emphasis on identifying musical and interpersonal traits.

Having seen that both groups provided rich accounts of meaningful interpersonal experiences of making music with others, it is possible to conclude that whilst the overall

impact of changes for both groups and the experience of the format were relatively similar, the way in which participants talked about what it was like to engage in the music making showed some interesting nuances in subjective experience when comparing the two groups. This suggests that some of the change mechanisms afforded by each of the modalities of GVI and GMT may differ in subtle ways.

The synthesis of findings presented in this first section of the discussion has been incorporated into the proposed model of therapeutic processes in Figure 6.1 to show how the data from the present study influenced the initial views as well as the insights from the literature review.

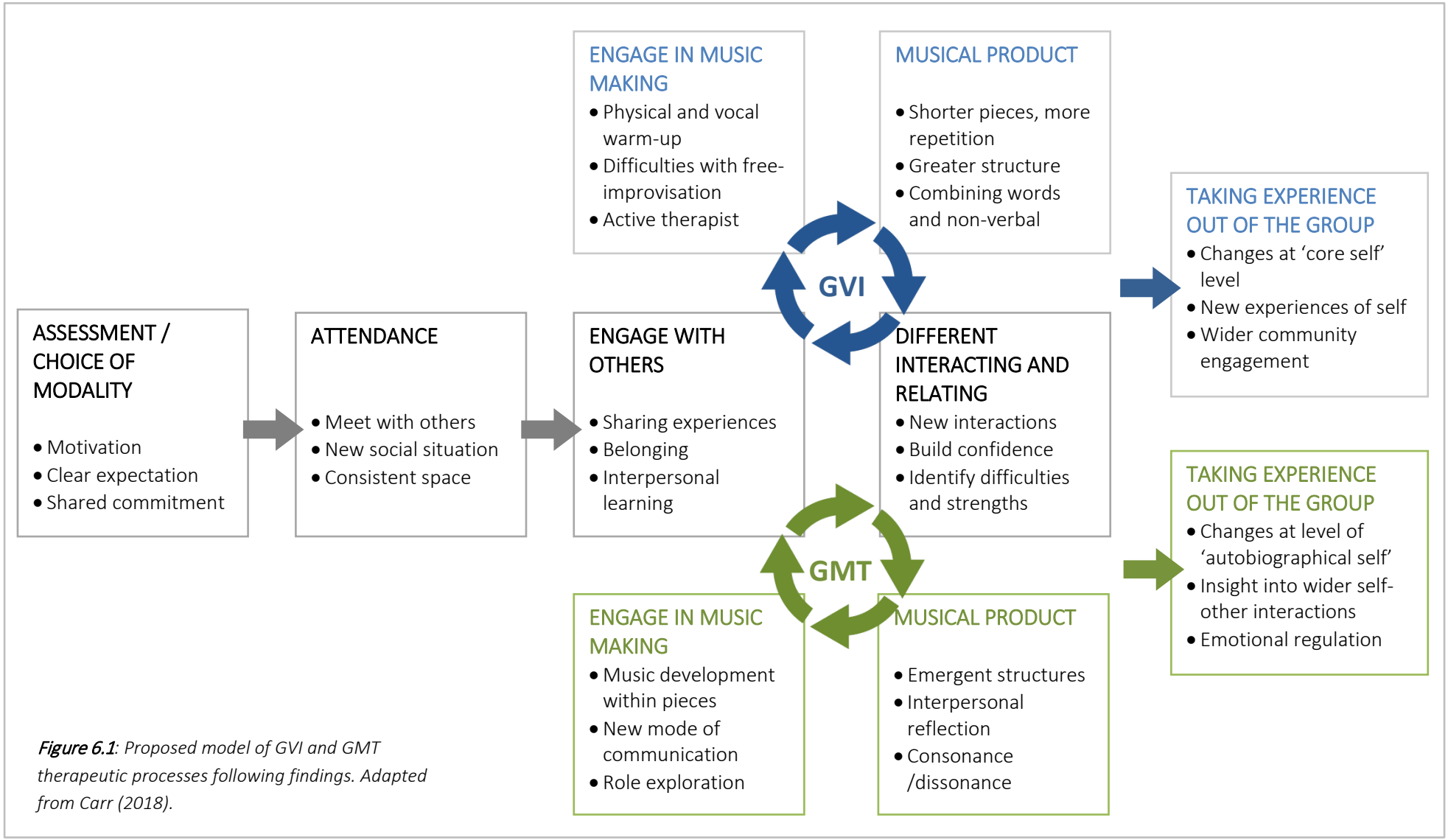


Figure 6.1: Proposed model of GVI and GMT therapeutic processes following findings. Adapted from Carr (2018).

6.2 Main features of practice

This part brings together the reflections from previous sections to make sense of the GVI practice in contrast to the GMT. The ideas explored here will have resonances with issues that have been covered in previous sections of the analysis but from a more general perspective. The various ideas presented are structured around three main themes which are ordered mirroring the narrative that emerged in the IPA, starting with the most 'inner' and basic affective and bodily experiences, zooming out to more conscious elements around the use of the music in order to navigate notions 'self' and 'other', and finally arriving at a higher level of abstraction, looking at more social and narrative aspects of the practice.

With this structuring arch in mind the discussion starts by considering the relevance of bodily involvement in GVI and GMT and how the different experience of embodiment can affect the engagement in the therapy. It will then move to how the musical affordances of each of the two modalities contributed to different ways of organising the group and individual experience in the session. Finally, it will address at a more abstract level the implications for the therapeutic frame and aims resulting from the subtle nuances and differences that are a consequence of the previous two themes.

The organisation of the main findings in these three main themes also mirrors the structure of the study's three research questions – which also go from more concrete to more abstract –, although at this stage the aim is not to attribute one theme per question but rather to bring insights from the three questions in each of the themes.

6.2.1 Involvement of the body

The greater involvement of the body in the use of voice was an aspect which was considered when proposing the GVI technique. However, it was difficult to predict how or whether this dimension would have any implicit and/or explicit impact on the experience of the participants and whether this could be captured in the data. The findings from this study seem to suggest that a difference was present and this was reflected in various ways in the data.

In fact, the physical aspect of the vocal work has emerged as one of the main distinctive features of the GVI group when compared to the GMT group in the way that impacted

various aspects of the work. On one side were the more concrete findings of greater changes linked with lifestyle changes related to the body such as exercising more to 'expand the lungs', as reported by P4 or feeling able to resist cravings for food (P1) and for smoking (P2), which seem to suggest a certain effect on the capacity to self-regulate bodily impulses.

At a more subjective level, the study also shows how the IPA revealed narratives linked to the bodily experience of singing. The notion of feeling something rather vibrant and alive inside, such as the joyful feeling in the chest from P2 or the sensations of euphoria and invigoration from P4, linked with the narratives from P4 and P5 of the voice as bringing something from the inside out. Here it appears important to highlight the obvious, which is that the vocal sound is produced inside the body. The vibratory motion that is necessary to produce the vocal sound originates in the body through an increased engagement of the muscles involved in breathing, which allow a sound to be sustained. This means two things: (1) that the physical inner sensation of singing is slightly different to that of speaking although the sound production mechanism is the same, since the sounds do not require to be sustained in speaking, and that (2) the vibration of the vocal sound can be heard but also felt in the body, since the singing resonates inside the body.

These considerations of experience, which were discussed and categorised as relating to a lower level of awareness, such as Damasio's 'core self' appear particularly relevant in terms of the psychological implications of relating to and being aware of one's own body.

Theories of early psychological development such as attachment theory (Bowlby, 1969), and other constructs such as containment (Bion, 1967), object relations (Klein, 1984), holding (Winnicott, 1971) and affect attunement (Stern, 2010) emphasise the importance of the body in mediating early emotional experiences of a baby. Despite the differences in conceptualisation in the role of the mother and the baby's body, all the mentioned influential theories place bodily experience as an important platform for navigating one's relationship with others as well as for building a sense of self, or as Bard-Schwarz (2018) describes it, "I understand the body as multivalent edges of flesh at the Imaginary, Symbolic and Real. The body is the literal and figurative support we achieve in the mirror stage for the incorporation of our fragmented body parts into a coherent ego" (p. 39). This section will discuss the theoretical framework and clinical implications of this later, but it seems important to consider the potential of a technique that specifically addresses

the bodily experience in accessing and working with important aspects of the psyche of patients suffering from mental health disorders.

Apart from the more explicit aspects of the involvement of the body, as seen in the thematic and IPA analyses from the interviews, the physicality of the voice also seemed to impact more implicitly on other aspects of the GVI practice such as: structure of the sessions, presence of body work, timing of the musical activities, level of reflective distance, narratives of identity and self and aims of the therapy.

One of the most obvious impacts was on the structure of the sessions, where the need to 'prepare' the body to sing implied an opening musical ritual of warming-up before starting to sing. This became a routine way of getting into the music making and the therapeutic significance of this added framing routine will be explored later.

Another specific aspect where the physicality of singing seemed to have a direct aspect was in the elements of bodywork, not only in the warm-up but also in the musical activities involving movement, such as the sound and gesture activity described in the micro analysis of the audio recordings. It is not surprising that given the voice's embodied nature 'voicework is interwoven with work on the body' as Newham describes (1998, p.441) following an explanation of the anatomic mechanisms of voice production. It is also apparent in the various models of working with the voice presented by Baker and Uhlig (2011) that most include some aspects of body work as well.

Turning to look now at the timing, as seen in the macro analysis of the audio recordings, the musical activities in the GVI group appeared considerably shorter and it was speculated that the embodied intensity of the singing might have contributed to this difference in the duration of the musical activities between the two groups. This is closely linked with the level of reflective distance, which refers to the concept of direct involvement of the body in the action of singing and how this seemed to impact on the level of autonomy of the participants in distancing themselves from the music being played or sung. The participants in the GMT appeared more able to observe the music as well as produce it, to look at it with some perspective, which seemed to enable them to make decisions on their use of the music with greater detachment than in the GVI group, where instead the distance between the musician and the music produced was so small that it did not seem to leave much space for reflection.

As Austin describes (2008), “when we sing […] we are intimately connected to the source of the sound and the vibrations. We make the music, we are immersed in the music and we are the music” (p.20). This description renders vividly the unified and merged experience of being the performer and the instrument when singing. Loewy (2011) has a more technical description of three levels of accessibility of sound and how it surrounds the body. The three levels consist of instruments that are ‘twice removed’, such as the piano, instruments that are ‘once removed’, such as wind and string instruments, and the voice, which is “not removed; it is within the body”. This distinction responds to the process of sound production, which for the piano she describes as a two-step process: “the first contact is the finger touching the key, which then influences the hammer to the string”. Loewy adds in the piano “one does not see the point of contact” and that “there is no sensitive approximation of ‘toning’ in the sense that the notes are fixed”. Instead, she argues that in order to produce sound with wind and string instruments “the body must breathe purposefully or the hands must move across a string or strings” which gives access to the “musical phrasing in a more directly accessible way” (p. 256-7).

This question of the more direct experience in the use of the voice and the greater reflective distance in the use of instruments seems to resonate with the tendency towards considerations of a more narrative nature – or at an autobiographical self level – in the GMT group such as the attribution of personal traits in the music making for example. Whilst the GMT narratives revolved around the interpersonal interactions with others in the group, such as P8 wanting to be the solid beat with the bass tone bars or P10 wanting to be heard but invisible with the bongo drum, in the GVI group narratives emerged more in relation to the participant’s own relationship with their individual voice. For example, questions of self and identity emerged such as P1, P4 and P5’s identification of with an ‘old self’, considerations around one’s talent in the case of P3 and P5, and questions around appreciation of one’s voice for P2, P3 and P5.

This emphasis of the self and identity links with the final aspect of the impact of the physicality in this case on the aims of the therapy. Despite the voice being on one hand the most well-known instrument by all the participants since they all were greatly skilled at modulating it for speaking, it has been explained in various ways how singing was in fact quite an unknown territory for most of the participants. For this reason, and due to the great vulnerability attached to the singing voice (as separate from the speaking voice), activities were designed in order to support accessibility. This meant that as well as the therapy aims that were shared with the GMT group, such as providing

opportunities for self-expression, social interaction and reflection on one's relational patterns with others, in the GVI group there was an implicit added aim which was to support participants in relating better and gaining a greater awareness of and confidence in their own voice. Subsequent sections will discuss this further, but it is interesting to note how the physicality of the voice also had an influence at this level.

This was particularly important because of the invisibility of sound production in singing, which makes it more difficult to see the sound possibilities, as we discussed previously. The fact that the instruments visibly show, at least at an amateur level, where the different sounds are mean not only that the possibilities of how to play are more obvious but also that a lot more motor mirroring can take place in a group situation. If one sees someone play a drum in a certain way it is possible to copy the action on another drum or on a xylophone, whereas with singing sound mirroring is possible but participants cannot see how another member is producing a certain sound. Although this might appear as rather insignificant to a musician or music therapist, who (regardless of their vocal confidence) would have an understanding and the ability to copy a vocalisation just based on the heard sound profile, this can prove more difficult for people who are not used to sing. For example, it has been discussed how P3 struggled to find his 'range'. What he meant was that he did not know how to reproduce a sound at a different octave and felt almost paralysed when hearing a sound made by the therapist and tried it to imitate it himself as he could not reach the therapist's octave.

Similarly, as has been explained, participants in the vocal group, who did not have experience of singing in choirs in school (P3, P4 and P5), found it difficult to sing in a different pitch from what someone else was singing. The invisibility of the instrument seems to be relevant here too, since having a visual indication of the different available notes makes it easier to change pitch or sound than if one needs to imagine the note first in order to sing it. For this reason, the cognitive effort appears greater in the singing as it requires the individual to have a more or less formed idea of what to sing before even attending to produce a sound, whereas when playing instruments, one only needs to decide on a simple action that will produce a complex sound, which does not need to be necessarily intended.

This final consideration seems relevant when thinking about the intensity of the involvement in the singing, which might also have contributed to the shorter vocal musical activities due to finding it difficult to sustain such complex level of cognition, if

one is not used to it. This also provides another factor to consider when thinking about the reflective distance in the GVI, since it is possible to see how not only the bodily embodiment is greater leaving less space for thinking about what sound one is producing in relation to others, as has been explored, but also the cognitive aspect is also more complex, leaving even less creative energy to the more reflective position.

Before moving on to discuss the second main feature of the GVI practice, it is important to highlight that the use of instruments also involves a certain physicality and involvement of the body and that this is an important aspect of music therapy when using instruments too (Maratos *et. al.*, 2011). However, as pointed out in this section, the particularities of the embodied nature of singing appear significant and distinct enough from the bodily involvement required for playing instruments in order to justify the arguments presented. The data gathered in the study also supports this difference in bodily experience between the GVI and the GMT group.

6.2.2 Musical and therapeutic affordances

Here the various musical 'affordances' (De Nora, 2003) that have been explored throughout the data analysis are reviewed and a reflection on how these translate into therapeutic affordances is presented. Using the concept of affordances seems particularly appropriate here since the discussion will explore musical aspects that are naturally or organically more easily enabled with one modality or the other rather than thinking about categorical differences.

When thinking about different ways of presenting these it seemed that for each aspect that was easier in one modality there was a more or less equivalent counterpart in the other. For this reason, different musical affordances have been put in parallel in a table (Table 6.1) where one modality complements the other. It is important to stress that the characteristic features of each modality shown here correspond to the findings of the study derived from the musical activities that were conducted. Both modalities could have included other different activities which might have provided different insights and different musical affordances. The clinical implications of these features will be further discussed in the following section (6.3)

Table 6.1: Musical affordances of GMT and GVI practices	
GMT	GVI
Extreme sounds (loud, grinding) easier	More personal (intended) sounds
Easier to explore dissonance and consonance	Easier to copy motifs and to experience harmony and unison
Easier to express individuality	Easier to blend with the group
Equipment limits and offers range	More agency in deciding, needs structure
Possibility to choose instruments with different expressive affordances	Possibility of using words
Easier to negotiate visibility and roles	More opportunities to be seen
Intermediate objects available	Reproduction possible: various functions
Therapist can have different roles	Narrative across sessions and within a session
Longer music activities	Repetition easier

Extreme sounds / Personal sounds

As seen in the analysis of the audio recordings, the use of the instruments allowed participants to experiment with 'weird' and 'extreme' sounds such as playing grinding sounds on the cello or playing loudly on the drums. There is a sense of playfulness in exploring the limits and resistance of different instruments and experimenting with the different materials that can stimulate creativity. For some clients, this might be quite appealing and a way to explore different unexpected ways of expressing oneself.

On the vocal side however, the use of voice allows to produce truly personal sounds, as could be seen in the gesture and sound extract, where P5 offered a very specific sound, which was then mirrored by the other participants. In this sense, for clients who do not have particularly technical abilities in playing instruments, the use of voice is possibly the most malleable tool for conveying intended sounds, melodic motifs and particular phrasings.

Dissonance and consonance / Harmony and unison

We have seen how various participants from the GMT group (P6, P8, P10) commented on their experiences of consonance and dissonance and how they appreciated being able to move between the two. This is a frequent experience in instrumental music therapy

groups, where at points different group members seem to play 'against' each other and at other points they come together. Navigating these different ways of being with others is often a rich experience and often leads to interesting and meaningful discussions about how different members felt in that process. Instead, in the use of voice it seems more difficult to deliberately sing 'against' someone else and purposefully create dissonance. In the experience of the therapist, this tends to be difficult even in workshops with musicians, where people tend to look for consonance as the dissonance is felt as more difficult to sustain.

However, what the singing offers is an easier access to harmonising with others, which some of the participants from the GVI group (P4 and P5) described as a powerful experience. As has been explained, getting to a point where people could harmonise (i.e. sing a different note from the person sitting next to them) was not an easy task, but when they managed to do it in different activities it proved to be a satisfying experience. Something that was a lot easier to experiment in the group was unison, for example when singing pre-composed songs or doing call and response activities. This seemed to be another stimulating experience for the participants, especially those who had not sung in a choir before, as they expressed in the interviews for example in regards to singing carols. The experiences of melodic unison or harmony would be a lot more difficult to achieve in the use of instruments unless the participants were highly musically skilled. Harmony was obviously produced when there was more than one melodic or a harmonic instrument being used, but it tended to be less intentional. Instead, as shown in the 'syllables in harmony' extract, the participants in the GVI managed to harmonise intentionally within the harmonic frame provided by the therapist.

Individuality / Group blend

As a consequence of the previous two features, it seemed easier to express one's individuality in the GMT group in the sense that it was easier to play differently to the rest of the group if the participants' wished to. For example, if the whole group was playing unpitched percussion instruments and one participant started to introduce some melody this would clearly influence the group's music and give it a particular character. Similarly, if the music seemed chaotic and someone started a strong beat this would again be a significant individual contribution. Although this could be possible in the use of voice, it felt a lot more difficult for such individual expressions to take place. The two mini examples provided also denote a sense of some patterns that evolved overtime in the

group's music. Since the activities were shorter in the vocal group, these possibilities also became more remote.

However, what the GVI group offered were many opportunities to 'blend in' with the rest of the group in timbre and pitch, which provided a sense of connection, fitting in and belonging into the group. Whilst there were moments of coming together in the GMT group too, there were often instances where participants commented on finding it difficult to match the group's music or fit in with the instrument that they had, particularly if it had a particularly different timbre to the other instruments.

Range with limits / Agency with structure

In line with the previous section, the more 'individual' sounds from the GMT group were provided by the selection of instruments that was available in the sessions. The selection made by the therapist both offered a range of possibilities and limited it. As discussed when commenting on the audio extracts, the overall aesthetic and stylistic variety amongst pieces was more limited in the GMT group, which was dictated by the available instruments. It was also shown in the thematic analysis how P8 commented on how he would have liked to have more instruments available as he felt limited. Despite this limitation, what the range of instruments provided was a ready-made selection of sounds that the participants could choose from. Crucially, not only were the choices pre-selected but they were also clearly separate from each other (i.e. each instrument would at least produce one sound that was distinctive from the other sounds from the other instruments). As mentioned in the section on the involvement of the body, this allowed participants to change the sound they made by trying a different instrument or by playing the same instrument in a different way. They could try different 'actions' and would obtain different sounds. The sound possibilities were determined (and limited by) the instruments available.

Meanwhile, in the GVI group the changes in sound depended on the active agency of the participants, which was supported by the structure of the improvisations. Once more with the vocal sounds, one would need to create an idea of a sound before being able to produce it. In this sense, the structure in the GVI improvisations acted as a counterpart to the missing sound limitation provided by the instruments in the GMT group. This was important as the instrument's limited sound possibilities were seen as an enabling feature which helped participants to focus their playing in only a restricted number of dimensions (i.e. in a drum they could mainly experiment with rhythms and dynamics, but

not with melody or harmony. Other instruments such as bells or shakers had an even more limited range as the rhythmic creativity is less precise and the dynamic range is narrower) and be creative within those. In order to similarly limit the possibilities in the GVI group, structure and instructions were introduced at points such as using specific consonants which would not allow to play with pitch such as 's', 'f' or 'sh', or particular rhythms (i.e. short and long notes in the syllables in harmony activity). This was designed, as explained, in order to support participants' sense of autonomy and agency in their interventions and to enable them to 'play' and experiment.

Expressivity of the different instruments / Expressivity of words

Following the thread from the previous section, the choice of different instruments provided different kinds of sounds that could represent or symbolise different qualities for the participants. As discussed, participants in the GMT group engaged in comparing and commenting on the correspondence between some personality traits and the characteristic sounds of the instruments. For example, P8 liked the 'solid' sound of the bass tone bars, P6 enjoyed the 'cacophonous' sounds that he produced with the cello and P10 liked the 'soft' sound when playing on the edge of the bongo drums. These were all qualities that they used to describe themselves and they were able to comment on how they identified with these traits. In this sense, if someone was feeling in a particular mood they could choose an instrument that would help them reflect that. In this sense they could find pre-selected sounds that captured something about their mood that they identified with.

It has already been explored how these distinctively different sounds would be more difficult to generate with one's voice. However, what the singing offers is the possibility of using words within the musical medium instead, which is not possible with the instruments. The use of words in songs are more direct symbolic devices to encapsulate particular experiences where own feelings can be transferred (Mössler, 2012), especially "when the creation of own (musical) ideas, wishes or needs are not accessible or perceivable, and therefore cannot yet be expressed" (Mössler, 2012, p. 338). When using improvised lyrics participants were able to access cultural symbolic associations creatively and when singing pre-composed songs they were able to relate to expressions of emotion and resonate with those.

The use of words seemed important for another reason. Particularly when engaging in song writing activities, the periods of working on coming up with and arranging the lyrics

offered dedicated opportunities for reflection. For example, towards the end of the group, in sessions 20 and 21 the group engaged in writing a song about the participants' experiences of being in the group. This was suggested in order to make up for the lesser reflective distance possibly engendered by the modality. The possibility of not only having a discussion but also providing creative writing to express one's views and then having the opportunity to sing this with the rest of the group appeared like a significant activity. Participants engaged actively in finding ways to capture their individual and group experiences and finding ways of singing that together.

Negotiating visibility / Being seen

Another relevant aspect of the expressive choices offered by the different instruments is the different roles that they allowed participants to adopt. For example, P10 often commented on feeling comfortable when playing instruments that allowed him to remain in the background, enabling him to be 'invisible but heard'. P6 liked to experiment with different roles, from being completely in the background to playing lyrical lines on the cello in a soloistic manner. This is one crucial aspect of working with instruments in music therapy. For some patients, playing almost inaudible sounds to start with is a very reassuring experience and a necessary one before feeling able to be more visible in a group. Being able to join in but not feel exposed is a powerful way of navigating anxiety provoking interpersonal situations.

This was clearly more difficult in the GVI group although some participants also sometimes only hummed in the background in some activities. However, it is clear that the useful experience of 'hiding' behind an instrument before feeling able to be heard is more difficult to replicate in a vocal group. However, precisely because of this, the GVI group offered more opportunities for being heard and in a way that was quite direct given the strong association between one's voice and their identity. For a lot of people – in the Western culture – singing in front of others is a rather exposing experience and therefore a significant one. Being able to practise this, by people who were ready to do so (this was assessed in the individual assessment sessions) in a safe space, offered various opportunities to see and be seen by other group members in a sensible way. As already explored, this stimulated some reflection and narratives around the participants' sense of self. The case of P5, who as explained started to wonder whether what was hiding in her and kicking her from the inside might actually be a positive aspect of herself that wanted to be seen by others rather than an evil entity that wanted to punish her was a touching example of this.

Intermediate objects / Reproduction techniques

The musical instruments can also be very useful as intermediate objects towards which projections can be directed (Pavlicevic, 1997; Tyler, 2002; Bunt & Stige, 2014). They can also be useful in mediating interpersonal relationships in the way that people share them. In this sense, the possibility of using reproduction techniques (using pre-composed materials) in the GVI group at times was a useful substitute for the physical objects. For example, when participants decided on a song they wanted to sing they were sharing cultural references. In this sense, the song was acting as an intermediary object of exchange between the participants.

This way of thinking about songs in terms of objects available for different uses or functions is beautifully captured by Bruscia: "Songs are ways that human beings explore emotions. They express who we are and how we feel, they bring us company when we are alone. They articulate our beliefs and values. As the years pass, songs bear witness to our lives" (Bruscia, 1998, p.9).

The introduction of microphones in the GVI group was initially designed to act as another possible substitute for the object to hide behind. Although the microphone amplifies one's voice, it is also a tool to create effects and share a more performative image of the voice, one that is slightly more 'removed' from the sound production source, to use Loewy's terminology. It was thought that it would also be a way of allowing participants to play with the dynamics and choose how much they wanted to be seen.

In the end the microphones were not used very often, partially as described due to P3's sensory difficulties, but also because they sometimes were too much of an intermediary, in the sense that they sometimes got in the way of the spontaneity. Although the microphones were set up and calibrated with the mixing deck and the amplifiers before the start of the sessions, when turning them on they needed some further adjustments to the individual voices. Furthermore, if the therapist was playing the piano or the guitar the microphone needed to be fixed in the right position with a stand which also took some time. This process sometimes felt a little intrusive on the flow of the session and therefore they progressively were used less as the sessions progressed.

Therapist's roles / Narrative

Given the greater structure that was needed in the vocal improvisations, the therapist's role was at times more limited to an accompanist role, whereas in the GMT the therapist could adopt less leading roles when appropriate as shown in the audio extracts. In the

GVI group, the therapist often needed to continuously provide a leading, constant and predictable harmonic support on the piano or the guitar in order to encourage participants to sustain their engagement in the musical activities, although there were exceptions to this as shown in the audio analysis.

However, alongside this limitation in the musical roles that the therapist was able to adopt in the GVI group the greater variety of activities allowed the therapist to provide shape and focus in the group through the choice of the activities instead. This was both true within and across sessions. It has been described in the previous section how the use of reproduction techniques allowed revisiting material from previous sessions. In this sense it was easier to generate a sense of narrative, for example when the participants wanted to go back to the song that we did in the previous session or when they suggested going back to an earlier version of an activity that we had done at the start of a session before finishing. It was therefore easier to establish narrative links between different activities and between different sessions. The song writing in sessions 20 and 21 where we reviewed participants' experience in the sessions was another example of how this activity helped to shape the ending of the group.

Longer music / More repetition

Finally, the fact that the improvisations were sustained for longer periods of time in the GMT group has already been mentioned at various points. This afforded different transitions to take place within the pieces, which was useful in providing opportunities for things to emerge, for changes to be introduced and for the pieces to evolve and develop. This more longitudinal aspect of the instrumental improvisations was a useful aspect to reflect on in the discussions. In the GVI the opportunities for such processes to take place were more limited as it was seen in the macro analysis of the audio recordings, although there still were some occasions where this happened, such as in the soundscape extract.

However, it is interesting to reflect on how the repetitions of the short activities afforded a similar process of growth in some occasions. For example, when practising a pre-composed piece the therapist, and in some cases a group member, would introduce some change in each repetition. Similarly, the 'syllables in harmony' activity developed through progressively adding new variations in each repetition. It is therefore possible to see how the possibility of repeating an activity, which was more difficult to achieve in the instrumental improvisations, served to contribute to the development and evolution of the activities, although in a less organic and spontaneous way than in the GMT group.

As a conclusion from this section, a reflection on the challenges of using voice in group improvisation points out at a confirmation of the strong link with intimacy and sense of self which can generate feelings of exposure, as described in the introduction. It also confirms the weight of cultural norms and notions of talent and having a good voice and the shame associated with not identifying as a skilful singer. These feelings can inhibit people's capacity to be playful and spontaneous in how they use their voice, but also – importantly – some of the limitations experienced by some of the participants related as well to a lack of familiarity of the experience of singing with and alongside others, harmonising and singing different lines.

In this sense, working with these limitations and providing creative and responsive ways of overcoming them also means that GVI has the potential to support participants in exploring what can be powerful new experiences of themselves and of themselves with others. These new experiences then in turn have the potential to open new doors for therapeutic change. Most participants reported an increased confidence in their singing, at least within the group context and this appears to support this idea that the obstacles also offered new possibilities and an experience of change. Section 6.5 will provide a more detailed discussion of how to work with these challenges.

6.2.3 A more active therapeutic stance

The directiveness of the therapist has been presented as an important issue at various points throughout this thesis. This section explores in more detail how the involvement of the body and the musical affordances of GVI (previous two main features already explored) inform this stance and crucially how this shapes the approach of the technique.

We have seen how the greater structure was introduced in the improvisations in order to reduce the musical dimensions available in a similar way that the instruments offer such restrictions. Similarly, a greater direction from the therapist in providing instructions was provided at times in order to meet the greater needs and anxieties present in using the voice. It has already been addressed how singing can feel more 'personal and private' than playing instruments (Baker and Uhlig, 2011, p. 25). Here the discussion reflects on the potential dynamics and sense of vulnerability associated with the experience of singing by examining an extract from a text on individual vocal work by Austin (1998, p.316):

> *"Singing is a powerful experience but can also be threatening to many people. Fear of judgement about the way one sounds can inhibit any attempt to sing even when there is a strong desire to do so. For the untrained singer, the singing voice often carries the projection of the vulnerable, undeveloped young part of the self. Singing might then be as exposing and anxiety producing. For the abused client, the very act of opening his mouth can be extremely stressful. […] The client is often fearful of what might emerge if he produces vocal sounds."*

Although this is a reflection on individual work, it is easy to argue that this would also be the case – possibly even more so – in a group format. P4's strong association between the 'baby sounds' and sounding stupid could be understood as a particularly concrete example of the phenomenon described by Austin in regards to the sense of showing something 'undeveloped' about oneself.

Another layer of vulnerability that might leave an individual feeling almost naked when singing is that the sound produced when vocalising will reflect aspects of the physical and visceral inner anatomy of the singer, one can hear the tongue, the glottis, the teeth, the mucous membranes and the nose as Barthes describes in his notion of the 'grain' of the voice (1977). Revealing such private aspects of the body can add to the experience of exposure when singing.

Given the level of potential anxiety linked with sharing one's voice in a small group where individual voices are going to be heard, providing a greater level of direction seems a natural and organic therapeutic response, particularly if the aim is not only to support participants in using their voice but to use it creatively in improvisation. Finding a 'potential space' where a client is enabled to 'play' (Winnicott, 1971) remains at the core of the therapeutic use of improvisation. This need to match the level of need and anxiety with reassurance and support is one of the basic premises of the use of improvisation in music therapy in general, but the use of instruments often requires a lesser level of support in this regard.

Pavlicevic (2003) points out the general correlation between structure and safety by stating that "generally speaking, the more structured your sessions, the more 'task oriented', the 'safer' your group members will feel (and that includes you as a leader)" (p. 213). The therapist's safety will be addressed later on. Ridder addresses this specific issue in terms of therapeutic priorities: "with the need for safety as the basis for therapy, the therapist must be able to assess the client's adaptive responses to threats to that safety.

For example, if the client is in a state of mobilization showing behaviours indicative of stress, the therapist has to address these first" (Ridder, 2011, p.134). Similarly, Austin provides an example of creating a safe environment through harmonic changes when supporting vocal improvisation: "The chord changes are chosen from my knowledge of the clients I work with […]. My intention is to create a safe environment that facilitates the emergence of the client's spontaneous self" (Austin, 2008, p.136). Austin here refers to the aim of supporting the emergence of spontaneity that is necessary for 'play'.

Bruscia also refers to the therapist's responsibility in helping clients explore alternative ways of being in the music by stating that "if therapy is about finding preferred alternatives that clients have not been able to discover on their own, then it seems self-evident that therapists have to the personal experts at exploring alternatives, their own as well as their clients". (Bruscia in foreword to Wigram, 2004, p.18). Malloch and Trevarthen (2009) highlight that within those alternative explorations an alternation between predictability and novelty are important in providing a safe environment: "music and dance, with their progressions from regularity and predictability to novelty and surprise and back again, can provide a safe, supportive environment" (p. 6). Within this frame, once again the direction and structure introduced in the GVI group can be understood as facilitating the 'regularity' and 'predictability', which in the GMT was provided partially by the characteristics of the instruments, as well as the therapist's interventions. De Backer & Sutton (2014) also add the need for the client to feel not only safe but also free and autonomous in the intersubjective dialogue with the therapist "in which both experience themselves as equal to the other, feeling free and autonomous to play, exist and develop their own images and thoughts" (p. 55).

Having explored the therapist's role in providing a safe space where play can take place and how this needs to match the clients' levels of anxiety, now an example where songs are used as a particular kind of structure to facilitate such environment is presented. The usefulness of songs as musical objects has been shown earlier. Here the discussion presents a clinical reflection from Leite, who uses Thompson's (2009) conceptualisation of songs 'as a way to explore metaphors in the course of treatment, to amplify understanding and meaning within the music therapy experience' in order to think about one of her clients: "choosing a song provided Sarah with an alternative to her intense improvisation / imagery experiences. Also, the song translated into words the emerging dynamics of this case" (Leite, 2014, p.224). Here the use of the song seems to provide a

safer alternative to mediate the intensity of the client's use of improvisation and to provide a way of bringing meaning into the experience.

Similar experiences of such 'amplification' of meaning and understanding of the group experiences were present in the GVI when using or creating songs in the sessions, as has been discussed. Further considerations around the role of structure in therapy will be explored in the following sections which reflect on the therapeutic framework for GVI.

Having discussed the responsibilities of the therapist in providing a safe and enabling creative space, a good summative way to describe the stance required from the music therapist in working with improvisation and voice in a group format could be that it is a more 'active' stance. This includes both some more direction but also generally being proactive in designing different activities with different structures to support clients in being able to express themselves creatively through singing and vocalising, given the lack of visible and discrete possibilities offered otherwise by instruments.

6.3 Clinical implications

Having reviewed the main findings from the study and discussed the main features of the use of GVI in music therapy, it is now the time to consider a number of clinical implications derived from the presented results.

However, it is worth highlighting that although here the focus is put on the particular specific affordances of GVI, overall many aspects of the therapeutic work and its clinical implications show a clear overlap in terms of the findings from the GIV and GMT groups studied in the present research – as was presented in section 5.3.1. In this sense, if we think about Yalom's (2005) therapeutic factors of forms of group psychotherapy, for example, it would be difficult to pinpoint clear differences between the GVI and GMT groups.

6.3.1 The voice at the intersection of body-mind interactions

Starting again with the physicality and embodiment of singing, the notions of perceived inner aliveness and other positive bodily sensations seem particularly relevant in affective disorders, which were the majority of the diagnoses present in the groups (mainly depression and bipolar affective disorder, as well as anxiety). For depression in particular,

psychomotor changes are an established component of the diagnosis (Buyukdura, McClintock & Croarkin, 2011). Questions around affect regulation are important in affective disorders (Pavuluri, Herbener & Sweeney, 2005) and therefore accounts of participants noticing affective states in their body appear like a promising thread for further research.

Here the concept of interoception becomes highly relevant in relationship to the use of voice in music therapy. Interoception is defined as the ability of the organism to monitor and experience itself. Contrarily to exteroception, which concerns the perception of external stimuli, Interoception relates to the perception of stimuli from within the body. It involves the perception, processing and representation of bodily signals by the brain.

Increasing recent interests in the study of interoception (Kemp, 2018) and its links with music, body work, mental health and emotional self-regulation appear to highlight the interconnectedness of these various areas. Since the voice is the only form of generating music within the body, singing or vocalising seems to be placed at a crucial intersection of various processes that are crucial in the understanding of affective and emotional regulation as well as awareness and sense of self. Future research in the links between voice work and interoception would be able to provide further insights as to the extent of their mutual impact.

Another interesting field of research where the physical location of the voice is of particular relevance is in the study of the interaction between vocal sound production and the vagal nerve. Insights from Polyvagal Theory by Porges (2001), which addresses the social engagement role in psychological change seem to indicate that "working with vocalizing, breathing, and regulators such as music in the context of safe environment is particularly effective in therapeutic work" as mentioned by Ridder (2011, p. 134).

In light of these emergent fields of research (interoception and vagal nerve interactions), the psychological experience of accessing something from the 'inner self' and bringing it out from within through the use of voice, as reported in the sessions and interviews in this study, seem of particular interest. The dimension of body work linked to voice work becomes therefore a useful affordance of GVI and one that highlights the experiential component of music therapy within the context of an increasing research interest and greater scientific understanding of the body – mind interaction and mutual influence and its implications for mental health.

6.3.2 Shaping and narrative in the use of voice

The greater use of structure and direction from the therapist, which has been discussed, affords a greater emphasis on the musical product or object, as well as the process, which tends to be less relevant in the use of instruments. The discussion has indicated how songs, for example, could be used in some ways as objects in the group. Another derived consequence of this is that songs can be shared, kept, stored and reproduced, which in instrumental improvisation is more difficult. This aspect of the vocal activities being 'repeatable forms' alludes to Kenny's (2002) 'field of play' and the considerations around the safe space provided by ritual.

This aspect of being able to take a musical object from a session is only possible in instrumental improvisation if clients are provided with an audio recording, which in turn can be problematic in terms of confidentiality in a group format. Even then the client could listen to the improvisation but might not be able to reproduce their part in it. Instead in the use of structured activities (even if containing improvisation) these can be captured, remembered and reproduced.

This study suggests that this was useful in being able to shape sessions and create narratives across sessions. It also considered how in order to facilitate experiencing more dissonant sounds or a greater emphasis on reflection, specific activities would need to be designed and introduced by the therapist and how this suggested a more active stance. In this sense, some clinical implications could be derived further in the light of neighbouring disciplines such as drama therapy, where there too the activities often require an initial direction or instruction from the therapist. The links with drama therapy are also apparent in the vocality and movement which are important elements of this discipline (Bruun, 2015).

It is important to highlight that the fact that there is a greater possibility to work with the musical product in GVI, this does not exclude or eliminate the all-important process dimension of the vocal activities (Wigram and Baker, 2005).

6.3.3 Frame Flexibility

The involvement of body work as well as the more active stance from the therapist have often placed models of voicework as separate from music therapy, as discussed at the beginning of this document. Here it is acknowledged that one of the clinical implications of the use of GVI is for the music therapist to reflect on how flexibly they want to

approach their work and up to what extent they understand a difference in format, stance or emphasis of the work as changing the nature of the work or not. Some music therapists might feel comfortable in navigating different frames or stances within their work whereas others will prioritise a more clearly delimitated approach. The therapist's confidence and safety is also an important contributing factor in the therapeutic relationship.

The professional identity of the therapist will also become important, not only within the sessions, but outside, when liaising with other professionals. As has been presented in the design chapter, talking about singing can bring up important associations – such as it being a light, superficial or recreational activity – which have the potential to play an important role in the perception of the therapeutic frame.

Another implication for dynamic administration around the use of GVI is that a potential discharge pathway to discuss with participants might be for them to join a community choir. A parallel process happens more rarely in GMT given the more limited offer of community groups that engage in music making with instruments and the limited instrumental technique of most clients. Here again, the therapist will have to decide whether to incorporate and engage with this aspect of potential link with other singing activities in the community. In the present study, two of the participants from the GVI joined a community choir following their involvement in the study (P1 and P2) and a third one (P5) indicated that she would like to try it as well.

At this point, the insights gained from discussing GVI's main features of practice and clinical implications are summarised in figure 6.2 providing a final proposed model of processes. This model is accompanied by a table (table 6.2) describing each of the items in more detail to mirror the description from chapter 1.

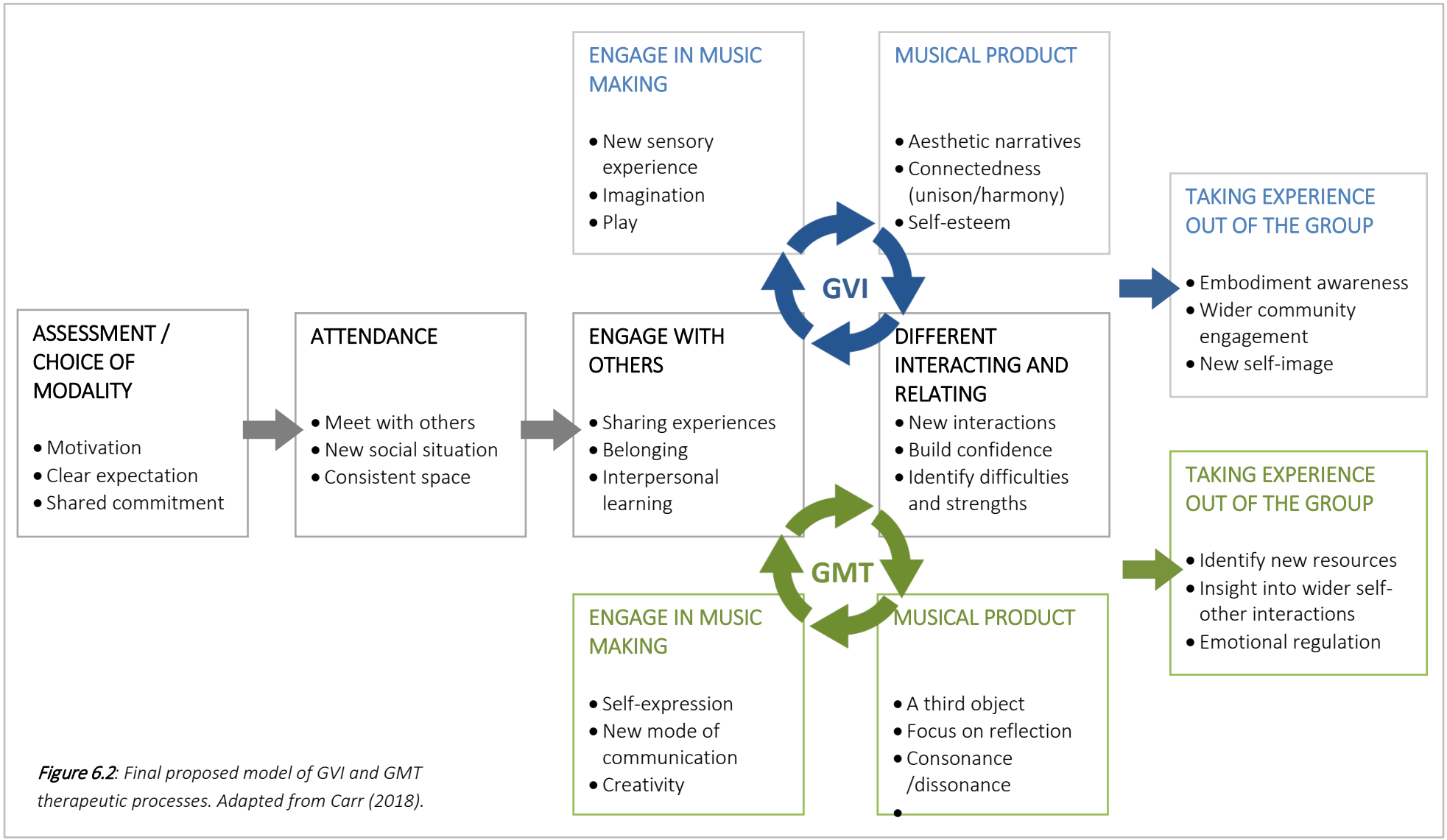


Figure 6.2: Final proposed model of GVI and GMT therapeutic processes. Adapted from Carr (2018).

Table 6.2: Description from final GVI/GMT model or therapeutic processes

GVI		GMT	
ENGAGEMENT IN MUSIC MAKING			
New sensory experiences	Link with embodiment involved in use of singing voice.	**Self-expression**	Greater range of available sounds.
Imagination	In order to produce vocal sound one needs to have imagined that sound first.	**New mode of communication**	Exploration of non-verbal ways of relating with others.
Play	The more intentional sounds afford more intentional playful exchanges.	**Creativity**	Process of trying different combinations of sounds.
MUSICAL PRODUCT			
Aesthetic narratives	Use of words within the music providing a platform for aesthetic narratives.	**A third object**	More separate experience of the musical object.
Connectedness	Experience of connectedness through musical unison and harmony.	**Synchrony**	Experience of synchrony through joint rhythmic structures.
Self-esteem	Ability to reproduce known music, sense of achievement.	**Focus on reflection**	Reflection on patterns and quality of music.
TAKING EXPERIENCE OUT OF THE GROUP			
Embodiment awareness	Awareness of own bodily states and body-mind links.	**Emotional regulation**	Awareness of emotional regulation factors.
New self-image	Capacity to see and experience self in new light.	**Identify new resources**	Opening possibilities of new skills and experiences.
Wider community engagement	Possibility of joining a community choir as a step down.	**Insight into wider self-other interactions**	Better understanding of self-other interactions in other contexts.

6.4 Therapeutic framework for GVI

At this point it seems important to briefly address the therapeutic orientation and theoretical framework implications, particularly given the notion of the 'consensus' model of music psychotherapy that was used for the GMT group.

6.4.1 Improvisatory approach with structure

The study has discussed from a variety of angles the role and function of structure in the musical activities from the GVI group and how this differed from the use of freer improvisation in the GMT group. Given the primacy of improvisation in the 'consensus' model of group music psychotherapy, particularly when approached from a psychodynamic perspective, it would be possible to wonder how the more structured approach can fit in with this therapeutic orientation.

Statements like "improvisation is the very essence of therapy" by Bruscia (in Wigram, 2004, p.18) as well as the emphasis of improvisation in professional guidelines as described by Procter (2016), seem to have contributed to a professional sense of improvisation being the ideal format of music therapy. This becomes even more relevant with the associations often made between improvisation and free association as a tool for psychodynamic psychotherapy. Although there are criticisms of this association as noted by Procter (2016), mainly in regards to the therapist's important contribution in the shared improvisations – which is a very different role from the more neutral stance assumed of the therapist in free association (Bunt & Stige, 2014, p.42) – it would be fair to say that a client's response to the joint music making can communicate something about their unconscious.

However, it is important to note that improvisation is not the same as free improvisation and that an improvisatory approach can also be relevant when using structure, direction and instruction at various levels, from providing a certain tonal centre to singing a well-known song. In fact, one could argue that the choice of instruments by the therapist already conditions the structure of the 'free' instrumental improvisation. It would equally be possible to argue that other activities that have a less improvisatory focus such as songwriting or receptive techniques are also ways of "making contact with unconscious thought processes" (Baker & Wigram, 2005, p. 11).

Nevertheless, some music therapists tend to describe the use of free improvisation as being mutually exclusive with the use of structure, placing the latter outside the

psychodynamic approach. For example, in describing her work with a group for adults with eating disorders Loth (2002) describes how other music therapists have found ways of working with this client group. In the following extract, Loth compares her approach to that of Frank-Schwebel (2001) by stating that "she uses a variety of musical mediums, including bringing favourite pieces, listening to classical and popular music, lying on mattresses, dance and live improvisations. Whilst, I too have searched for ways to work with these clients as a group, I have tried to retain the basic model of music therapy that I use. This is a broadly based psychodynamic approach using improvisation and discussion" (p. 94). This could be read to imply that using activities other than improvisation and discussion deviates from a psychodynamic approach.

In fact, a broader 'improvisatory approach' which can include use of pre-composed material has indeed been recently been referred to within the field of community music therapy, which again tries to propose an alternative to the psychodynamic model. However, it is interesting to note that "none of the early pioneers of improvisatory practice exclusively improvised" (Procter, 2016, p.54) and that in fact there might be reasons other than a psychodynamic approach that have resulted in the 'free' improvisation as being particularly present in the literature. Procter (2016) mentions several aspects contributing to this, amongst which the fact of using it as a marker of professional distinction seems particularly relevant. This fragment from Annesley (2015, p.126) shows some of these narratives when discussing the possibility of adopting a more active role in running a music therapy group: "I think Foulkes' conductor role is what I aspired to. Perhaps this was a result of my training, including my own experience of being a member of an experiential training group. It may also be because I had experience running groups in a teaching role and I wanted to make a clear distinction in my own mind and my own practice between this and my new identity as a 'music therapist' […] I have come to believe that this particular group needs more holding, more encouragement towards interaction". Here, the emphasis on professional distinction between the education and the therapy worlds is clear.

It is also probably fair to say that therapists might be using more structure in their practice than the literature shows. In most case studies authors tend to talk about an improvisation that 'took place' but how this came about, who suggested it or whether any instruction was given is not addressed. An important exception to this is the clinical vignette provided by Sloboda & Carr (2015, p.129) where they describe various structured activities which were "led by the therapists, designed to reduce anxiety levels

and to provide a gradual, staged introduction to the experiences of free improvisation in a group".

We now discuss some other examples where structure has been referred to as a technique belonging to a psychodynamic approach. We return to Bruscia – who, as shown earlier, emphasised the role of improvisation – and to his book on the dynamics of music psychotherapy (1998), which looks at the 'psychodynamic orientation to music therapy' (p.1). Here he presents three types of music experiences, namely improvisation, songs and music imagery. The fact that 'songs' are included here indicates that despite the importance given to improvisation, pre-composed materials also have a role in music psychotherapy: "songs provide easy access to a person's emotional world […] Given the aims of psychotherapy, songs can greatly facilitate the process and provide a very effective vehicle for emotional change" (p.10).

Looking in the book by De Backer and Sutton (2014), which specifically addresses 'psychodynamic music therapy in Europe', it is possible to find quite clear instructions for vocal improvisation activities (in an individual context) in the chapter by Leite (p. 228-230). In this same book, the chapter on the ontology of music therapy by Darnley-Smith (in De Backer and Sutton, 2014) provides an interesting consideration of the ontological discontinuity of musical improvisation in psychodynamic music therapy given its site-specific meaning. Although these considerations consistently refer to the use of 'free improvisation' in this chapter, it is interesting to see how the same author when describing a group case study (Darnley-Smith, 2002) describes her use of pre-composed music. In this case, the author provides a rich reflection in psychodynamic terms about a sense that seemed to convey a notion of being trapped in the 'implicit dichotomy' which was addressed in the literature review going from pre-composed songs to instrumental improvisation. It is refreshing to see towards the end of the chapter that after many months of struggling to manage the group dynamics where a particular participant kept wanting to sing songs, the author "suddenly found a new way to respond to his regular medley of songs […] Instead of simply trying to sing with him, I now improvised around the melodies […] This was a move that he accepted readily and joined in actively and which also had the effect of involving other group members at the same time" (p. 86). This final solution through group vocal improvisation allowed the therapist to combine pre-composed music and improvisation in a way that seemed highly effective.

It is possible to see therefore how the use of voice does tend to invite more structure, even within a psychodynamic framework. If we add the consideration from within group analysis that a shorter duration of therapy (such as 6 months) and a smaller group will bring a more focused and active approach from the therapist (Davies, Richards & Barwick, 2015, p.30), this seems to provide a strong argument for the use of such structure and direction in GVI. Similarly, psychotherapy research points at the need for greater directiveness and structure in time-limited psychodynamic forms of therapy (Piper et. al., 1984).

It is also worth pointing out here that other distinct approaches to music therapy such as Guided Imagery and Music GIM, active listening, Orff, or the playsong structures of Nordoff Robbins, also create contexts that challenge a simple reductive view of improvisation and directiveness. The music therapy landscape is actually really diverse on this topic. Similarly, the notion of co-creativity and intersubjectivity would suggest that choices and actions in music therapy can rarely actually be owned by one person, or attributed to one person (Wood, 2016).

In conclusion, in the case of the present research, the use of structure and direction is conceptualised as part of an improvisatory approach that can be thought about in psychodynamic terms. Arguments have been presented to claim the affordance of identifying the clinical work as having a psychodynamic approach via an understanding that "improvisation need not be seen as antithetical to pre-composed music or to structure" (Procter, 2016, p.62).

6.4.2 Meeting an experience, offering an experience

Another theoretical implication of the use of structure in music therapy, which relates to the therapeutic aims based on the understanding of therapeutic change, concerns the emphasis put on the experiential aspect of the music making.

Whilst, as has just been argued, in this study the approach for both groups was considered psychodynamic despite the differences in the use of structure for the musical activities, an aspect that did feel different as a result of this different was the therapist's

role in 'meeting' the group's experience in the GMT group and 'offering' an experience to the group in the GVI group. Although this offering was based on responding to the group's needs rather than in a pre-conceived manner, this distinction still seems relevant. As seen in the analysis of the interviews, there was a greater sense of discovery of new experiences in the GVI group which seems to resonate with this.

Another way of describing this difference, as experienced by the therapist, would be to refer to a sense of the therapist working with the music that the group spontaneously brings through the improvisations in the GMT group and reflecting on what this means for the group, which contrasts with the GVI where there was a sense of creating a certain musical environment for the group to find new ways of being together and later reflecting on what it was like to experience this.

This subtle and complex nuance in the understanding of the role of the therapist seems to resonate with other distinctions, which do not address the exact notion but seem in some way analogous. If we come back to two of the authors quoted in the previous section, we find that Bruscia (1998) makes a distinction between 'transformative' and 'insight' forms of music psychotherapy. He describes transformative music psychotherapy as aiming at 'experiential change', whereas in insight music psychotherapy 'the aim is always verbally mediated insight' (p.3-4). Darnley-Smith, proposes a different distinction that juxtaposes an 'aesthetic' purpose that characterises a 'music-centred' approach to a 'clinical' purpose that distinguishes the 'psychodynamic approach' (Darnley-Smith, 2014, p. 58-59). She then develops this distinction by providing an analysis of comparative ontology which attributes an 'ontological 'continuity' between the music-making of both the clinical context and the non-clinical context' (p.67) in the case of music-centred music therapy which contrasts with the 'ontological discontinuity' of those two areas of music making in a psychodynamic approach to music therapy.

Although these distinctions proposed by the two authors do not completely overlap in content or purpose they both seem to address a sense of experiential focus and aesthetic aim that relates to the 'offering' of an experience and a sense of verbal insight and clinical orientation that could be more linked to the 'meeting' of an experience. Rather than engage with these nuances which have stimulated long debates in the profession of music therapy, this discussion draws attention into the fact that for Bruscia, both orientations belong under the umbrella of psychodynamic music therapy, whereas for

Darnley-Smith the ontological difference implies that the aesthetic purpose contrasts with the psychodynamic approach.

In this sense, the present research aligns more comfortably with Bruscia's broader notion of psychodynamic music therapy, where the more experiential aspect focus can be understood as important from a psychodynamic perspective. This conceptualisation allows a more fluid continuity between a focus on the insight and on the experiential aspects of the work, which as Bruscia notes, can fluctuate within a single session (1998, p.2).

After all, in music therapy most often there is an implicit and natural fluctuation between the use of music, where the focus is necessarily a more experiential one, and the use of words, there the work can be more involved in developing insight. In this sense, it is important to remember that the psychodynamic approach is not only determined by the musical activities and the level of structure within them but also, crucially, by the therapist's stance and approach in the verbal reflections around the musical experience – improvisatory or otherwise. In other words, it is not only the 'doing' that characterises a therapeutic approach but also the 'reflecting' on the 'doing' and how this is framed.

Finally, it is work pointing out that offering an experience should not be a resource for avoiding difficult emotions associated with meeting the experience of the client or exploring challenging aspects of the therapeutic relationship. Avoidance and resistance are important phenomena in therapy and can be addressed and explored in a variety of ways depending on the context and format of therapy. These are complex processes that could be explored further in relation to the use of voice in music therapy in future research, especially given the associated notions of cultural appropriateness mentioned before. However, the present study has not aimed to focus on these particular aspects of the clinical work in depth.

From a resource-oriented and recovery oriented perspective, some of the clinical implications of GVI highlighted here resonate well with ideas of developing clients' strengths and resources, a focus on positive experiences (Rolvsjord, 2010), building and sustaining relationships to others, and developing interest and motivation (Gold *et. al.*, 2005) as well as finding a new and valued sense of sense of self and of connectedness

(McCaffrey *et. al.*, 2018). Whilst many of the features of GMT as presented in this study also fit in well with such approaches, some of the features from GVI as studied here, such as the use of familiar songs as a form of cultural exchange, discovery of vocal resources and how this empowered participants to take part in community choirs, emphasise a clear resonance with these models of addressing mental health.

6.5 Recommendations for working with GVI

The aim of the present research was never that of manualising a different type of music therapy. However, it seems important having studied the use of GVI from different perspectives to provide a synthesis of helpful recommendations.

As described in this study, GVI is seen as a technique amongst others in the music therapist's repertoire. In this sense, most considerations, intuitions and skills of the profession learned in training and through clinical work apply to it. In fact, although GVI is not a distinctive established technique in the literature, the literature review showed that instances of GVI can take place spontaneously in groups easily as a development or bi-product of an instrumental improvisation or of the use of singing pre-composed songs. Therefore, it could be assumed that music therapists already have the foundational approach and core strategies to incorporate and generate GVI as part of their generic music therapy practice.

However, it is also true that not many case studies portray instances of GVI as part of the 'normal' or 'daily' practice of group music therapy, and therefore there might be music therapists who do not feel particularly equipped for facilitating GVI in their sessions. Instead, often clinical cases using the voice in groups or vocal improvisation in individual contexts have been presented as separate models or methods of music therapy rather than music therapy techniques, such as in the case of Austin's model of 'Vocal Psychotherapy', Loewy's Tonal Intervallic Synthesis or Summer's Hello Space Model.

Another factor that might influence how much music therapists feel confident in engaging in voicework is their confidence in their own singing. Although none of the techniques described here require particularly specialised vocal skills – other than being able to provide a harmonic accompaniment alongside vocal improvisation – being confident in singing and vocalising in different ways is certainly helpful.

Although generic principles of music therapy apply to GVI, it has also been shown throughout this document how the use of the voice has some particularities that are clinically relevant, which were summarised in terms of a greater involvement of the body, certain musical affordances (such as the possibility of using reproduction techniques) and a greater need for structure. This section is divided into two separate questions which will try to provide some answers for: when to use GVI? And how to do GVI?

6.5.1 When to use GVI?

Although this is a relevant question to ask, this study has not looked particularly at it and it feels difficult to answer with precision from the data. On one hand, because here GVI has only been isolated in order to study it specifically, not because it is the only format envisaged for it. As any other technique of music therapy GVI could be part of a wider set of techniques used with a particular group or the main focus as it was the case for the GVI group in this study. Therefore, if GVI was not approached in isolation there might be many clinical contexts, where it might be appropriate to use it, including clients' preferences and spontaneous singing initiated by either the therapist or a group member. Other reasons might include feeling a need to work in a more embodied way, wanting to make use of text or aiming at challenging a group that uses the instrumental music making in an avoidant way, for example.

On the other hand, if the question is around when to use GVI as a main technique, again there might be a range of potential appropriate contexts. This reflection also begs the question of the meaning of choosing a format at all and what factors should determine that (Wood, 2016; Bunt & Stige, 2014). Here several brief considerations are mentioned in order to provide some ideas and pointers for the reader.

On a pragmatic level, since GVI is a more 'portable' format of group music therapy as it does not require much equipment, it might be useful in circumstances where introducing or transporting instruments might be problematic. This might be the case in highly secure forensic, mental health or behavioural institutions, where bringing in instruments might be dangerous. Another pragmatic reason might be in the case of settings where the budget does not allow to have a lot of instruments, or even to introduce a pilot group in a setting where there are no music instruments available. GVI might also be a useful resource in cases where for whatever reason instruments that are normally available cannot be accessed, such as having to move to a different room than usual or if electronic instruments are not working. More clinical reasons for choosing to work solely

on the use of voice might relate to cultural considerations (Bradt et al, 2016), particular clinical aims such as being able to engage in social and community activities such as a choir or in groups with low motivation (Windle et al, 2019).

In client groups where the psychological relationship with one's body is directly linked with the pathology, such as PTSD originating from physical or sexual abuse or eating disorders, a more careful process of decision making should be undertaken and more research is needed in order to ascertain appropriateness of the intervention. On the one hand, it might be that a certain way of approaching GVI might be particularly useful in addressing the issues related to embodiment, however in those cases it might also be the case that using GVI is too intense or threatening and that therefore it is either not indicated or it requires a solid preparation and introductions through other techniques first.

Another area where GVI techniques might be useful are workshops for other professionals (Uhligh, 2006; Loewy in Baker and Uhlig, 2011, Sokolov in Bruscia 1987). The therapist has used these techniques in a number of workshops with arts therapists, music therapy students and psychologists successfully.

Finally, there are some other fields with different aims and approaches where the techniques and processes discussed in this study might be highly relevant, although the GVI technique as presented here is not purposefully intended for those. Some examples of this might be programmes related to singing for breathing or lung health, melodic intonation therapy, other forms of speech and language therapy, music assisted physiotherapy or neurologic rehabilitation music therapy. Similarly, other more structured approaches from brief therapy and behavioural therapy models might also fit in this category.

6.5.2 How to use GVI?

We can now bring together different suggestions based on the therapist and participants' experience from this study:

- Warm-up: although having a warm-up is not a requirement for GVI, especially if it is introduced in a spontaneous or gradual way from other activities, in a GVI specific group such as this one the warm-up was a useful ritual for introducing the singing, both physically and psychologically. Participants in the group quickly appropriated this practice and associated it with getting ready to sing. As well as

generally helping people to feel more grounded in the session, the warm-ups were useful for the singing in the sense that they started to activate the body and helped participants in starting to be aware of it in a different way that invited a greater engagement of their breath and a state of greater readiness to generate singing.

- Gradually: unless singing emerges spontaneously in a group, it is advisable to introduce GVI gradually in order to mitigate the possible anxiety that the idea of singing might trigger for patients. Introducing different aspects one by one might feel more accessible than expecting clients to engage in free vocal improvisation without any preparation.

- Different ways of introducing improvised singing: there are many different ways to gradually introduce GVI. Here are some that were used for the GVI group:

  - Starting from breath, introducing consonants, humming and progressively vowels.

  - Singing pre-composed songs and either using the lyrics to improvise new melodies or keeping the melody and improvising new lyrics.

  - Adding sounds to movements and gestures

  - Game-like activities, such as the syllables in harmony activity where new possibilities are introduced in each round

  - Sound effects on microphones

  - Song writing

- Predictable harmony: support the vocal improvisations with predictable chord changes with a harmonic instrument (or potentially with a robust rhythmic drumming)

- Model sounds: giving examples of potential sounds or vocalisations is particularly useful given the invisibility of the singing, which might leave participants not knowing or understanding what kind of contribution is expected of them

6.6 Reflection on methods

Having reached the end of the presentation and discussion of findings, it is time for a brief reflection on the methods for data collection and data analysis used in the study.

Overall, this study maintained a qualitative mixed methods stance, in which a range of qualitative lenses was used to explore different aspects of the topic, supported by an embedded mixed methods component. It applied methods specifically suited to each question and aspect of practice, seeking to converge and integrate data on those areas, rather than to triangulate separate methods of observation on the same data area of practice. This study draws on approaches that centre qualitative approaches to mixed methods practice, supported by methods drawn from the quantitative paradigm where they can be illuminative to the overall exploration (Hesse-Biber, 2010). This approach seeks to foreground individuals' experiences with the goal of understanding how they make meaning within their social world. Through an extensive case study this study harnesses the synergy of several methods in the service of understanding a topic of common interest in the music therapy profession.

Criteria for assessing the value of qualitative research in music therapy vary in terminology but not in general approach. Bruscia (2005) sets out sixteen criteria for considering the value of qualitative research in music therapy. They range from methodological considerations such as dependability and credibility, to how the research can be applied, in terms of authenticity or usefulness. Intrinsic elements such as ethics, artistry and expressivity are also deemed to be important. Abrams (2005) articulates the standards of validity for qualitative research in music therapy with different terms, but from a similar stance.

Stige, Malterud & Midtgarden (2009) propose an evaluation agenda defined by the acronym, 'EPICURE'. The first part of the word, 'EPIC', refers to the requirement of rich substantive accounts drawn from engagement, processing, interpretation, and self-critique. The second, 'CURE', refers to how the researcher respects the preconditions and consequences of the research, with a focus on social critique, usefulness, relevance, and ethics. Ansdell & Pavlicevic (2001) propose that the value of qualitative research is marked by its trustworthiness, which can be summarised using four criteria: credibility, transferability, dependability, and confirmability.

Across the field of qualitative research in music therapy, authors value a fidelity to subject matter, a respect for participants, integrity in methodology, and coherence in construction. To summarise, the standards of evaluation of qualitative research within music therapy fit broadly within the criteria set out in the wider qualitative tradition.

This research was designed and carried out in the light of these values. It was grounded directly in one naturalistic professional setting, and whilst generalization is not the primary aim of this study, the project has touched upon aspects of significance for other arts therapies and potentially for arts in health practices that interlink with clinical music therapy in this social context. It maintained a respect for the ongoing clinical practices of the services in which it was situated as well as the unique social conditions involved, and was carried out with the purpose of being useful and complementary to a particular professional service. This study illuminates aspects of clinical practice in community psychiatry that may resonate with many others practicing in that sector. It addresses issues of leadership, professional accountability, artistic choice and service user ownership of therapeutic decisions through a design that is transparent and rigorous.

6.6.1 Research Question 1

Using audio recordings as data sources appeared to provide enough, rich and relevant data for the interaction analysis. The methods for the three types of interaction analysis used consisting of timing and coding musical activities (for the macro level), timing and coding verbal interactions (for the meso level) and transcribing extracts of the recordings were useful ways of engaging with the data in different forms of enquiry.

Whilst transcription of music is a common way of analysing interactions in music therapy (De Backer & Wigram (2007), the other two methods of organising, analysing and visualising the data for the macro and meso levels were specifically designed for this project in order to answer the research question in a relevant and strategic way. Due to working with the large amount of data gathered by the recordings of the 46 sessions, finding manageable ways to look both at the general traits of the data as well as the more detailed aspects was important. The coding of the music activities and of the verbal interventions to negotiate group tasks was an effective way of targeting and focusing the data analysis.

The use of Gantt charts for the analysis of the timing and distribution of the musical activities was a useful of visualising this aspect of the sessions and provided a rich and clear differentiation between the two groups. Despite the approximations of up to 15 seconds, which affected the calculations, this method still appeared useful since it was looking at the data from a mainly qualitative perspective and therefore quantitative precision was not the priority.

The use of the scatter chart for the analysis of the verbal negotiation of the group's tasks in the sessions was instead more precise with the timings as this kind of chart allows to enter data in a 'timing' format. This method of analysis provided a much more similar picture for both groups, which was useful in reflecting on how despite the differences in the musical content the verbal overall stance appeared similar in both modalities.

6.6.2 Research Question 2

This study is the first, as far as we know, to use the GSRS questionnaire in a music therapy group. This validated measure was chosen for its brevity and because the wording of the different parameters was felt to be generic enough to be applicable to sessions that involved not only talking but making music as well. This seemed to be the case with participant finding it easy to relate to and answer the questions.

The findings section described how the individual scores were able to capture important elements of the participants' experience, particularly when analysed in relative terms based on the individual participant's style of scoring. When the scores were analysed at a group level this also seemed to provide some generic insights but it was felt that given the differences in individual scoring the summative or average scorings were perhaps less reflective of group's overall processes. Therefore, this method appeared more useful in looking at individuals' processes than group processes in this study. In this sense, having categorical answers, such as a Likert scale, rather than a continuum might have been useful in homogenising the meaning of the scores. The 'ceiling effect' (Austin, 2002) reflected in the scoring of the GSRS also minimised the usefulness of the scores.

Having to complete the questionnaires at the end of each session appeared acceptable and easy to most participants, although some also expressed a sense that they were not very meaningful, particularly for those participants who tended to provide very consistent scores across sessions. In retrospect, in future research this could be addressed perhaps

by encouraging participants to use a broader range of scores and to reflect with them on what the scores meant for them in more depth.

6.6.3 Research Question 3

Using audio recordings and transcriptions for semi-structured interviews is a very common research method in qualitative psychology and psychotherapy research. The adapted Change Interview by Elliott, Slatick & Urman (2001) as a topic guide was a useful and effective way of structuring the interviews, generating interesting reflections and covering relevant areas for discussion.

Using thematic analysis and IPA to analyse the nine transcripts was a useful combination for approaching the large amount of data. The use of IPA for the more specific accounts from the participants' experiences of the music making in each of the groups was a fruitful iterative method for providing a rich analysis of nuanced and personal accounts and narratives. Having completed weekly session summaries in a structured form was also a useful way of capturing the therapist's experience to provide some further reflection.

6.7 Limitations

6.7.1 Main challenges

The main methodological challenges from this research related to the recruitment process. Despite the efforts in being present and liaising regularly with the referrers, the limited resources of the present project, with only one researcher, meant that the recruitment process was slow, both in receiving referrals and in assessing the referred potential participants. Having conducted a preparatory group before the study groups proved highly useful in this sense to learn about the referrer teams' ways of operating and opening up communication channels.

Working within the existing service setup also brought some challenges in finding times and spaces to run the groups alongside other services.

6.7.2 Strengths

This study has provided extensive and detailed data from clinical music therapy sessions. The study has generated data from participants' and therapist's perspectives as well as observational data, processed via thematic, comparative and descriptive methods. This has allowed a rich process of convergence and integration to be built up in discussing the findings.

This has also been the first study, as far as the author is aware – that has targeted group vocal improvisation (GVI) specifically as a main technique for group music therapy with the adult mental health population. However, a similar intervention focusing on 'vocal music therapy' which includes elements of improvisation was studied for patients with depression in a study published very recently (July, 2019) by Antink, Weymann and Ohls. These results appear in line with the present study but due to the timing of submission of the present thesis, it has not been possible to include the study by Antink et. al. in the literature review. This however, reflects the interest in researching the use of GVI in music therapy.

The present research has also trialled the use of new methods in the research of music therapy. The strengths and weaknesses of using GSRS have already been reported as well as the innovative approaches to interaction analysis of musical and verbal interactions designed specifically for the study.

6.7.3 Limitations

The use of qualitative analysis requires that the researcher's backgrounds and experiences are taken into account. In this case the researcher was also the therapist conducting the sessions and therefore bias towards seeing the positive aspects of the data may exist. In order to balance this, other researchers from the supervisory team checked and provided their perspective on the different stages of the analyses.

The fact that the therapist conducted the interviews may have influenced the participants' responses and introduced bias into the interpretation of results. At the same time the close knowledge of each participant and of the activities that took place in the sessions meant that the therapist was able to explore the participants' accounts in greater detail and to stimulate further reflection.

One of the participants from the study (from the GMT group) dropped out and therefore his views and experiences could not be captured in the data, particularly for research question 3. His experience might have provided new insights into the challenging aspects of the practice.

Although the validated Group Session Rating Scale measure provided important insights for group comparison on the subject of therapeutic alliance, particularly when analysed at an individual level, the variability of ratings was limited by the participants' tendency to provide high scores routinely, which resulted in a 'ceiling effect' (Austin, 2002), especially in the GMT group.

Failing to involve service user groups in the design of the study due to time limitations and difficulties in planning or attendance is another limitation of this study. Involving service users in the design and potentially in the analysis as well would have been helpful in providing a more recovery orientated and collaborative approach to the research.

6.7.4 Ethics and Transferability

The insights that this research can offer the music therapy profession have been produced from a close fidelity to the naturalistic experience of mental health service users in a real world setting. The implications that are drawn from the research findings are derived in the knowledge that other music therapists, and potentially other practitioners, might recognise their own professional challenges, inform their practice,

and satisfy their creative curiosities in this text. Interpretations of the data have remained close to the experience and the text, in a way that others have confirmed through supervision and scrutiny. The findings and emerging theory regarding GVI offer practical steps to other practitioners and researchers.

In its planning stages the research was submitted to scrutiny by the Guildhall School of Music and Drama Research Ethics Committee and the extensive IRAS process. All advisory comments and requirements were adhered to in the formulation of the research designs and in the research project. The dominant ethical question during this research was the dual status of being both practitioner and researcher. This dual status can raise issues of interpretation and reporting, especially when the research focus is on a topic of pre-existing personal interest. These risks and issues were aired continually across a broad supervisory team of clinical practice, music therapy-specific research and wider music psychology research. This text seeks to report on the comparison of GVI and GMT in a clear, transparent and non-judgemental way.

7. CONCLUSION

This research enquiry started from a realization of the contrast between the presence of the voice as a music therapy technique in the literature and its absence, in terms of practice and research in regards to group improvisation. A recent increase in research around the health benefits of singing highlighted the need to bring attention to the implications of using the voice in music therapy groups.

Given the relevance of group improvisation within music therapy for the client group of adult mental health, particularly from a psychodynamic point of view, this study has looked at the processes and affordances of Group Vocal Improvisation (GVI) as a music therapy technique from different angles and research methodologies by comparing it to a 'generic music therapy' (GMT) technique which has represented the 'consensus' model of instrumental improvisation.

The research was organised in three main research questions looking at the interactions, therapeutic processes and change mechanisms involved in the GVI and GMT practices. The data for the study were gathered from a longitudinal and naturalistic study with two small closed groups run weekly for 6 months in an outpatient psychiatric setting. In the first question, the analysis of the data provides the therapist's perspective on the differences and similarities in the musical and verbal interactions, whereas in the second question the focus is on the participant's perspectives of the sessions, through their ratings of a validated questionnaire measuring therapeutic alliance. Finally, in the third question, the therapist and the participants engage in one-to-one discussions at the end of the therapy about the participants' experiences of the sessions.

In this way, the various analytical methods used in the study have provided a nuanced and layered picture around the particularities of using GVI in music therapy groups, which has been discussed and put into context in relation to the practices and narratives of the profession.

This study has shown aspects of the two practices (GVI and GMT) that share similarities and areas where the two show distinct features. The discussion of the study's results has engaged in reflecting on the clinical and theoretical implications of such particular characteristics.

This study has contributed exploratory insights into a technique that had not been distinctly addressed in the music therapy literature and research to the author's knowledge. These incipient findings will be able to strengthen the case for further research to bring attention to the use of GVI and its clinical outcomes. The present research has illustrated how the process of examining specific techniques can contribute to the current discourses, dilemmas and debates within the discipline of music therapy.

Recommendations for future research

It is recommended that future research in the field of GVI looks into the clinical outcomes of this technique within community mental health. Another avenue to explore would be to combine GVI and GMT and to explore the implications of this and how to introduce GVI interventions. Research into other client groups, such as children, adolescence, perinatal mental health and substance abuse would also be recommended or any other clinical context where embodiment or the use of reproduction techniques is desirable.

The threads from the discussion suggest different possibilities for studying GVI in other related fields. One of these is neuroscience and relatively recent research areas such as Interoception and the polyvagal theory. Future studies exploring the links between the use of voice in music therapy and the impact on such aspects would provide valuable insights into the potential of techniques such as GVI.

Another area where GVI could provide interesting insights would be more longitudinal programmes combining music therapy and arts in health or community approaches. In this case, the impact of GVI for people to be able to access community activities such as choirs could be studied from a more ethnographic perspective.

Finally, this study has introduced novel methods of data collection and data analysis such as the Group Session Rating Scale (a validated measure that had not been used in music therapy before as far as the author's extensive review indicated) and two purposefully designed coding strategies for interaction analysis of music therapy sessions that could be trialled in other studies in the future.

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9. APPENDICES

APPENDIX A: IRAS ethics application

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
GVI Music Therapy Project (version 0.2)

1. Is your project research?

(•) Yes ( ) No

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
(•) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
( ) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	( ) Yes	(•) No
b) Will you be taking new human tissue samples (or other human biological samples)?	( ) Yes	(•) No
c) Will you be using existing human tissue samples (or other human biological samples)?	( ) Yes	(•) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

[x] England
[ ] Scotland

☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study wide forms, and transfer them to the PIs or local collaborators.

For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

○ Yes ◉ No

5. Will any research sites in this study be NHS organisations?

◉ Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or a Diagnostic Evidence Co-operative in all study sites?

Please see information button for further details.

○ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ◉ No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
I am a PhD student and qualified Music Therapist, and I will be the Chief Investigator of this project. My involvement will consist in conducting group music therapy sessions in a mental health hospital of the NHS.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Integrated Research Application System
Application Form for Research administering questionnaires/interviews for quantitative analysis or mixed methodology study

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
GVI Music Therapy Project (version 0.2)

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

An exploration of the use of Group Vocal Improvisation as a Music Therapy technique with Mental Health service users.

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Ms	Irene	Pujol Torras

Address

Post Code
E-mail
Telephone
Fax

Give details of the educational course or degree for which this research is being undertaken:
Name and level of course/ degree:
PhD Doctoral Research Programme

Name of educational establishment:
Guildhall School of Music and Drama

Name and contact details of academic supervisor(s):

Academic supervisor 1

Title	Forename/Initials	Surname
Dr	Stuart	Wood

Address	Research Department Guildhall School of Music and Drama Silk Street
Post Code	EC2Y 8DT
E-mail	
Telephone	020 7628 2571
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Ms Irene Pujol Torras	☑ Dr Stuart Wood

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- (•) Student
- ( ) Academic supervisor
- ( ) Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Ms	Irene	Pujol Torras

Post	Music Therapist
Qualifications	Degree in Musicology by Université Paris Sorbonne (Paris, France) MA in Music Therapy by Guildhall School of Music and Drama (London, UK)
ORCID ID	
Employer	Guildhall School of Music and Drama
Work Address	Silk Street
Post Code	EC2Y 8DT
Work E-mail	
* Personal E-mail	irene.pujol.torras@gmail.com
Work Telephone	
* Personal Telephone/Mobile	
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Dr	Stuart	Wood
Address	Silk Street		
Post Code	EC2Y 8DT		
E-mail			
Telephone	020 7628 2571		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	N/A
Sponsor's/protocol number:	N/A
Protocol Version:	N/A
Protocol Date:	29/03/2017
Funder's reference number:	N/A
Project website:	N/A

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

There is extensive evidence about the benefits of music therapy in mental health settings, both in individual and group formats. Group work offers benefits from a cost-efficiency perspective and is also a platform to explore interpersonal struggles or difficulties, which are be very relevant for the everyday functioning and wellbeing of people suffering from a mental health illness.

The established use of group music therapy in mental health settings consists mainly in improvising with a range of available instruments. In the last decade there has been an increasing interest to address the voice as an important element in music therapy, especially in community choirs. However, the combination of improvisation and voicework in

a group setting has been overlooked in previous research.

The evidence suggests that voicework is a powerful medium to reinforce social cohesion and therefore this study intends to provide a space of embodied self-expression where the relationship between self and others can be experienced in a creative and safe context. The clear separation in the literature between voicework and instrumental approaches also indicates a strong potential for uncovering innovative modes of unfolding of therapeutic processes and dynamics.

This study will consist of two music therapy groups – one of group vocal improvisation and another one of 'general' (mainly instrumental) music therapy. The groups will take place in the day area of a London NHS psychiatric hospital and will be formed of community service users attending weekly sessions.

Data will be collected via audio recordings of the sessions, questionnaires after sessions and an interview at the end of the treatment. All data will be anonymised. This research is partially funded by the Guildhall School of Music and Drama and partially self-funded.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

The purpose of this study is to look in depth at the way the therapeutic process unfolds in two different music therapy techniques. It also will serve to investigate an area that has been overlooked in the music therapy discipline and will contribute to the growing research into the therapeutic use of voice.
The recruitment of the participants will be conducted via the normal referral paths to the arts therapies service. I will make a presentation to the different referrer teams in order to inform them of the research and what it will involve, so that they are mindful of it before making any referrals.

The inclusion criteria for the study will be:
• Mental Health service users within the local community
• Service users managed by the community teams (2 nearest locality teams)

The exclusion criteria will be:
• Service users that the community team considers unable to commit to weekly attendance
• Service users that do not understand or speak English (since this will be the main language used in the group)
• Service users that have had an admission to a mental health hospital in the last 3 months.
• Service users who don't have capacity.

Following their referral, service users will have an initial consultation with the therapist where the therapist will explain the research purpose, the ways in which data will be gathered and the strategies that will be put in place to protect their interests. Participants will also be informed about their right to withdraw from the study at any stage. All this details will be included in an information sheet given to the service users during the initial consultation.

The capacity of the service users will be assessed by the community teams before referring to the groups. As an extra safeguard, during the consultation as well as through having read clinical notes previous to the consultation, the therapist will be able to assess the service user's capacity to consent. Especial attention will be put in the cases of individuals susceptible to coercion to ensure that they understand the alternatives to taking part in the study.

To ensure that consent is informed, service users will be invited to take the information sheet and the consent form with them and make a decision in their own time.

This study, for its inherent psychotherapeutic focus, has the potential risk raising intense emotional moments for the participants and some participants might struggle with these experiences. The therapist is registered as a music therapy professional and she will be clinically supervised by the principal arts therapist at the hospital. Therefore, risk will be minimized as the therapist will attempt to keep the space physically and emotionally safe at all times. The therapist is also trained to de-escalate potential situations where a participant might present aggressively and she will have a hand alarm at all times to ensure the safety of all participants.

The potential benefits of the study are that the participants might experience an improvement in their quality of life as well as to get a better insight into their condition. The study has potential for the participants to improve their social and

interactional skills as well as to find a way to express their feelings and emotions.

A service user advisory group will be approached to discuss the study as well, in order to refine the project.

Following the Data Protection Act as well as the Caldicott Principles, all the recordings will be edited in order to separate the conversation moments from the music. Only the music fragments will be taken out of the hospital for the analysis of the data. These musical fragments will be stored in a password protected device and only the researcher and the supervisory team will have access to them. All the other elements of data, including the spoken conversation and the answers to the questionnaires and interviews will be transcribed and anonymised.

Regarding confidentiality, the study will adhere to the standard procedures and protocols of the setting. The participants will be told that the content of the sessions is confidential but they will be also made aware that the confidentiality might be broken if participants or others are at serious risk. In such a situation the therapist would immediately inform her managers as well as the community team and the care coordinator of the participant. Following that the therapist would report the situation via a Datix report that would be forwarded to all professionals involved with the participant´s care and would be uploaded on their documents.

There aren't any commercial elements that depend on the result of the study, therefore no conflict of interest is identified for this study. This study is looking at the nature of the psychotherapeutic process rather than any specific outcomes. Therefore the potential risk of being both the researcher and therapist is minimised by the fact that there isn't an original hypothesis that the study is trying to confirm or disconfirm.

At the end of the study the researcher will analyse the collected data and will present the findings in the context of a PhD thesis. These findings might also be presented in conferences or other training contexts.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

How can Group Vocal Improvisation (GVI) be used as a therapeutic technique to support community mental health service users?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

1. What kinds of verbal and musical interactions take place in GVI? (looking at specific types of interactions)

2. What therapeutic processes emerge when using GVI? (looking at therapeutic processes)

3. How do patients and therapist experience GVI? (looking at change mechanisms)

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

This study addresses group music therapy clinical practice, which is a well-established format within the profession. Group work offers benefits from a cost-efficiency perspective and is also a platform to explore interpersonal struggles or difficulties, which are be very relevant for the everyday functioning and wellbeing of people suffering from a mental health illness.

The standard use of group music therapy in mental health settings consists mainly in improvising with a range of available musical instruments. In the last decade there has been an increasing interest to address the voice as an important element in music therapy, especially in community choirs. However, the combination of improvisation and voicework in a group setting does not appear significantly in the literature.

This study attempts to bring together the identified therapeutic properties of group improvisation in group music therapy and those of voicework. The aim is to reinforce social cohesion and to provide a space of embodied self-expression where the relationship between self and others can be experienced in a creative and safe context. The clear separation in the literature between voicework and instrumental approaches also indicates a strong potential for uncovering innovative modes of unfolding of therapeutic processes and dynamics.

The aims of this research are to contribute to service users' wellbeing and quality of life whilst contributing insight and new methods to the growing field of research in the Music Therapy discipline.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Methodology

A mixed methods approach seems appropriate in this case as it allows to look at the phenomenon from different perspectives, both qualitative and quantitative, in order to get a prismatic description. This will also allow the use of complimentary methods in order to obtain data driven findings as well as applying theory driven data collection methods that will provide a more standardised set of results, allowing for the discussion to draw on previous research using the same methods.

The data analysis will consist of a first phase where the 3 main research questions will be answered separately and a second stage where they will be put into perspective through triangulation. This last stage will provide a holistic picture of the studied phenomenon, from different points of view (self-report and observation) and from different agents (therapist, patient).

In order to substantiate the findings a comparative element has been introduced in the research design as a point of reference since the initial purpose was to find out in what ways the use of voice would affect the established use of group improvisation in music therapy groups in mental health settings.

Therefore, the study will be designed as a comparative case study looking at whether clear differences in the process can be identified between GVI and the established practice of group music therapy (GMT). In case of observing different tendencies it would be interesting to identify and locate them in order to discuss what clinical and therapeutic implications this has. This last consideration leads to an implied 4th research question that will be only addressed in the discussion: How is GVI different from GMT; what does GVI add to GMT?

There will be an initial probation phase of the study that will serve as a pilot in order to refine the methods and the structure of the groups if needed. After the pilot group to test the methodology and design the main research group will start.

Design

Community mental health service users will be identified by 2 local community teams. Then the therapist will approach the potential participants via a letter giving a broad idea of the study. In this letter, the potential participants will be invited to an initial consultation with the therapist in which they will be presented with a more detailed outline of the project and of the involvement of their potential participation.

Potential participants will be given an information sheet and a consent form during the initial consultation that they will

be able to take home and sign if they want to accept to participate. If they do they will be invited to attend weekly one hour sessions at the outpatient clinic of the hospital. The participants will attend for a period of 6 months in total, being able to withdraw from the study at any given moment.

In the consent form participants will have consented to having their voices recorded during the sessions. Data will be gathered as a form of observation from the audio recordings of the sessions. There will also be an element of self report in two forms, one during the study and one at the end. During the intervention participants will be asked to fill out short questionnaires after the session. At the end of the study semi-structured interviews will be conducted with the participants. Generic demographics information and medical history will be taken at the beginning of the study.

In order to minimise the potential researcher bias, the researcher will be supervised by 3 senior music therapists and an experimental psychologist both in clinical and academic terms.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- [x] Design of the research
- [ ] Management of the research
- [x] Undertaking the research
- [ ] Analysis of results
- [ ] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
During the design of the study the chief investigator contacted 2 service user advisory groups, one connected to the sponsor institution, SUGAR: Service User Group Advisors on Research (City University London), and one connected to the clinical site of the study, Central and North West London (CNWL) Research Partnership Group. The chief investigator is continuing to work to find a meeting date in order to seek advice on how the participation information in written as well as to discuss suitability of the proposed exit strategy.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular
- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [ ] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents
- [x] Mental Health

- ☐ Metabolic and Endocrine
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Oral and Gastrointestinal
- ☐ Paediatrics
- ☐ Renal and Urogenital
- ☐ Reproductive Health and Childbirth
- ☐ Respiratory
- ☐ Skin
- ☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 65	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

• Mental Health service users within the local community

• Service users managed by the two nearest locality teams

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

• Service users that the community team considers unable to commit to weekly attendance
• Service users that do not understand or speak English (since this will be the main language used in the group)
• Service users that have had an admission to a mental health hospital in the last 3 months
• Service users who do not have capacity.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Weekly group music therapy sessions	30	30	1 hour	The chief investigator will be the therapist. The sessions will take place at the music therapy room at the therapies area of the hospital.
Completion of GSRS brief questionnaire at the end of each session	30	30	2 minutes	The chief investigator will administer the questionnaires which will be filled by the participants. The questionnaires will be filled in the same therapy room.
Individual interview	1	0	1 hour	The chief investigator will be the interviewer.

The interviews will take place at the same therapy room as the sessions.

A21. How long do you expect each participant to be in the study in total?

6 months

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

This study, for its inherent psychotherapeutic focus, has the potential risk of dealing with intense emotional moments for the participants and some participants might struggle with these experiences.

However, taking into account that the therapist is registered as a music therapy professional and that she will be clinically supervised by the principal arts therapist at the hospital this risk will be minimized as the therapist will attempt to keep the space physically and emotionally safe at all times.

The therapist is also trained to de-escalate potential situations where a participant might present aggressively and she will have a hand alarm at all times to ensure the safety of all participants.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

(●) Yes ( ) No

If Yes, please give details of procedures in place to deal with these issues:

During the final interview sensitive areas might be addressed, mainly dealing with emotional experiences. In this context there is potential for unexpected disclosure of information by the participants that requires notification or follow up by the researcher.

Participants will have been informed of the cases in which confidentiality needs to be broken at the beginning of the study, before they chose to consent to participate.

In such a case the researcher would immediately inform her managers and supervisors who would be able to assist in deciding the level of escalation that the disclosure needs. The researcher is trained in completing a Datix report and she would forward it to all relevant professionals that are involved in the care of the service user, especially their care coordinator.

The researcher will also be suported by her academic and clinical supervisors if direct action needs to be taken.

A24. What is the potential for benefit to research participants?

The potential for benefit in this study for the participants is that they will receive a thorough assessment, substantial period of treatment and further referral to other services by a qualified music therapist. During the progress of the sessions, participants will have opportunities to develop self-confidence, creative expression and better insight into issues that they find challenging. The sessions will also provide an opportunity to develop social and interpersonal skills as well as sharing their experience of suffering from mental health difficulties with peers.

A26. What are the potential risks for the researchers themselves? *(if any)*

The researcher will have a hand alarm at all times during the sessions and other members of staff working in the offices next to the therapy room will be aware of the sessions and will be able to assist in case of an emergency.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).*

Potential participants will be identified by the community teams, who will refer them to the researcher in the normal referral paths. The researcher will be attending fortnightly meetings with the teams to reinforce the liaison with them.

As a therapist, the researcher will be able to access potential participant's records before inviting them to the initial consultation as part of a normal assessment procedure. JADE will be the main resource used to access patients' records.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:
As a therapist within the clinical care team, the researcher will have access to identifiable information of patients. No one outside from the clinical care team will have access to that information.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

○ Yes ◉ No

A29. How and by whom will potential participants first be approached?

Participants will be initially approached by the professionals of their community care team such as nurses, doctors and social workers. The researcher will meet with the teams regularly in order to work jointly towards identification of potential participants. These professionals will be sent an information letter about the group as well as a service user leaflet that they can give to potential participants. These materials will be enclosed with this application.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

During the initial consultation potential participants will be given a detailed overview of the project with particular attention to what the participants' involvement will be throughout the study. The language of the explanation will be adapted to each service user's level of understanding to make sure that they have a clear idea of the study.

Potential participants will not be in a dependent relationship with the researcher. Nevertheless some individuals might be more vulnerable and in such cases they will be addressed with special caution not to force their consent. Emphasis will also be put into how their interests will be protected as well as their right to withdraw at any point during the study.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

The potential participants will be invited to communicate their decision within a week. However, in some cases it might be appropriate to allow patients to accept to take part after a longer decision period, taking into account the difficulties in maintaining contact with community mental health service users.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Since one of the exclusion criteria for this study is for service users that can't adequately communicate or understand English, the consent process will be an opportunity to assess their capacity.

The reason for listing this exclusion criterion is that the group will focus both on music and verbal interaction. If one member of the group is unable to communicate or understand others this would disrupt the dynamic of the group, especially for that person, who might become isolated quickly and therefore unable to fully benefit from the intervention.

It wouldn´t be appropriate or practical to have an interpreter in this therapeutic context so any potential participants that are not able to adequately communicate in English will be offered alternative options such as other language specific community groups or a referral for individual arts therapies where the presence of an interpreter might be considered.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

◉ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

☐ Access to medical records by those outside the direct healthcare team

☐ Access to social care records by those outside the direct social care team

☐ Electronic transfer by magnetic or optical media, email or computer networks

- [ ] Sharing of personal data with other organisations
- [ ] Export of personal data outside the EEA
- [x] Use of personal addresses, postcodes, faxes, emails or telephone numbers
- [x] Publication of direct quotations from respondents
- [ ] Publication of data that might allow identification of individuals
- [ ] Use of audio/visual recording devices
- [ ] Storage of personal data on any of the following:
  - [ ] Manual files (includes paper or film)
  - [x] NHS computers
  - [ ] Social Care Service computers
  - [ ] Home or other personal computers
  - [ ] University computers
  - [ ] Private company computers
  - [ ] Laptop computers

Further details:
Personal addresses will be used to communicate with the participants. For example to let them know the time and location where of their initial consultation appointment.

Direct quotes from the final interviews might be quoted and participant will have been informed of this and will have given their consent.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Personal information will only be stored in NHS computers.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

All personal data will be anonymised. Confidentiality will be protected following the NHS Code of Confidentiality.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Participants' personal data will be only accessed by professionals within their care clinical team.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

All the data will be anonymised before being transferred out of the premises of the NHS. Locked space in the research department will be used to store anonymised hard copy data, which will then be double shredded when at the time of destruction of the other data

A42. Who will have control of and act as the custodian for the data generated by the study?

Title	Forename/Initials	Surname
Miss	Irene	Pujol Torras

Post	Therapist and Researcher for this study
Qualifications	Music Therapist, registered with HCPC
Work Address	
Post Code	
Work Email	
Work Telephone	
Fax	

A43. How long will personal data be stored or accessed after the study has ended?

- ○ Less than 3 months
- ○ 3 – 6 months
- ◉ 6 – 12 months
- ○ 12 months – 3 years
- ○ Over 3 years

A44. For how long will you store research data generated by the study?

Years: 7
Months:

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

Research anonymised data will be safely stored and password protected by the Chief Investigator.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ◉ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

◉ Yes ○ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

A49-2. Will you seek permission from the research participants to inform their GP or other health/ care professional?

◉ Yes ○ No

It should be made clear in the participant's information sheet if the GP/health professional will be informed.

PUBLICATION AND DISSEMINATION

A50-1. Will the research be registered on a public database?

◉ Yes ○ No

Please give details, or justify if not registering the research.
The project will be registered in the British Association for Music Therapy log of research projects.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☑ Internal report
- ☑ Conference presentation
- ☑ Publication on website
- ☑ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Anonimity will be ensured by not giving too many details that may lead to individuals being identifiable.

A53. Will you inform participants of the results?

◉ Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
After the completion of the study participants will be sent a letter with the main findings of the study.

5. Scientific and Statistical Review

A54-1. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi−centre research group
- ☐ Review within the Chief Investigator's institution or host organisation
- ☑ Review within the research team
- ☑ Review by educational supervisor
- ☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
This project has followed a process of review in several phases. The initial proposal was accepted by the research committee at the Guildhall School of Music and Drama. Following the researcher's acceptance into the doctoral programme the project has been refined and submitted again to the same research committee in the form of a Revised Proposal.

The development of the design and methodology of the study has been reviewed by the researcher's supervisory team.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A56. How have the statistical aspects of the research been reviewed? *Tick as appropriate:*

- ☐ Review by independent statistician commissioned by funder or sponsor
- ☐ Other review by independent statistician
- ☐ Review by company statistician
- ☐ Review by a statistician within the Chief Investigator's institution
- ☐ Review by a statistician within the research team or multi−centre group
- ☐ Review by educational supervisor
- ☐ Other review by individual with relevant statistical expertise
- ☑ No review necessary as only frequencies and associations will be assessed – details of statistical input not required

In all cases please give details below of the individual responsible for reviewing the statistical aspects. If advice has been provided in confidence, give details of the department and institution concerned.

Title Forename/Initials Surname

Department
Institution
Work Address

Post Code
Telephone

Fax
Mobile
E-mail

Please enclose a copy of any available comments or reports from a statistician.

A57. What is the primary outcome measure for the study?

This is a process oriented research project rather than an outcome based one. The primary means of obtaining data will be audio recordings of sessions, questionnaires and interviews.

The outcome of the study will be the combination and reflection on these different aspects of the therapy.

A58. What are the secondary outcome measures? *(if any)*

N/A

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	10
Total international sample size (including UK):	10
Total in European Economic Area:	10

Further details:
There will be 2 groups of a maximum of 5 participants each.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The limit of 5 participants per group and of 2 groups was reached due to the limitations of time and space of the study as well as following appropriate numbers for music therapy groups in mental health.

A61-1. Will participants be allocated to groups at random?

○ Yes ◉ No

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Interaction analysis will be used to analyse the data collected through the audio recordings of the sessions.

Statistical analysis will be used to analyse the quantitative data gathered through the GSRS questionnaires.

Thematic analysis will be used to analyse the data from the interviews and process notes.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

Title Forename/Initials Surname

Post
Qualifications
Employer
Work Address

Post Code
Telephone
Fax
Mobile
Work Email

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status:

If Other, please specify:

Contact person

Name of organisation	Guildhall School of Music and Drama
Given name	Stuart
Family name	Wood
Address	Silk Street
Town/city	London
Post code	EC2Y 8DT
Country	UNITED KINGDOM
Telephone	02076282571
Fax	
E-mail	

Is the sponsor based outside the UK?

○ Yes ◉ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

- [ ] Funding secured from one or more funders
- [ ] External funding application to one or more funders in progress
- [x] No application for external funding will be made

What type of research project is this?

- ○ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ◉ Project that is part of a fellowship/ personal award/ research training award
- ○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
			Noclor
Organisation			
Address			
Post Code			
Work Email			
Telephone			
Fax			
Mobile			

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 10/01/2018
Planned end date: 10/07/2018
Total duration:
Years: 0 Months: 6 Days: 0

A71-1. Is this study?

- (•) Single centre
- ( ) Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

- [x] England
- [ ] Scotland
- [ ] Wales
- [ ] Northern Ireland
- [ ] Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?
( ) Yes (•) No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

- [x] NHS organisations in England 1
- [ ] NHS organisations in Wales
- [ ] NHS organisations in Scotland
- [ ] HSC organisations in Northern Ireland
- [ ] GP practices in England
- [ ] GP practices in Wales
- [ ] GP practices in Scotland
- [ ] GP practices in Northern Ireland
- [ ] Joint health and social care agencies (eg community mental health teams)
- [ ] Local authorities
- [ ] Phase 1 trial units
- [ ] Prison establishments
- [ ] Probation areas
- [ ] Independent (private or voluntary sector) organisations
- [ ] Educational establishments
- [ ] Independent research units
- [ ] Other (give details)

Total UK sites in study: 1

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ◉ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

The conduct of the research will be audited and monitored by the chief investigator's supervision team, clinical supervisor and line manager. Any accidental deviations will be reported and documented. The chief investagator understands that deviations from the protocol will require immediate action and could potentially be classified as a serious breach. This will be managed in reference to the supervisory team and line manager.

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Guildhall School of Music and Drama

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Guildhall School of Music and Drama

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ○ No ◉ Not sure

PART C: Overview of research sites

Please enclose details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name	
IN1	◉ NHS site ○ Non-NHS site	Forename	Irene
		Middle name	
	Country: England	Family name	Pujol Torras
		Email	
		Qualification (MD...)	Music Therapist
	Organisation name	Country	UNITED KINGDOM
	Address		
	Post Code		

APPENDIX B: Letter of HRA approval

NHS
Health Research Authority

Skipton House
80 London Road
London SE1 6LH

Email: hra.approval@nhs.net

Ms Irene Pujol Torras
Music Therapist
Guildhall School of Music and Drama
Silk Street
EC2Y 8DT

21 November 2017

Dear Ms Pujol Torras

Letter of HRA Approval

Study title:	**An exploration of the use of Group Vocal Improvisation as a Music Therapy technique with Mental Health service users.**
IRAS project ID:	**200717**
REC reference:	**17/WA/0356**
Sponsor	**Guildhall School of Music and Drama**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the HRA website.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

procedure. If you wish to make your views known please use the feedback form available on the HRA website.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the HRA website.

Your IRAS project ID is **200717**. Please quote this on all correspondence.

Yours sincerely

Chris Kitchen
Assessor

Email: hra.approval@nhs.net

Copy to: *Dr Stuart Wood, Guildhall School of Music and Drama (Sponsor Contact)*
Noclor, *(R&D Contact)*

IRAS project ID	200717

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	*Version*	*Date*
Covering letter on headed paper [COVERING LETTER]	0.2	10 November 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [SPONSON LIABILITY]		19 June 2017
GP/consultant information sheets or letters [INFORMATION FOR REFERRERS]	0.1	11 October 2017
HRA Schedule of Events [SoE]	1	20 November 2017
HRA Statement of Activities [SoA]	1	25 October 2017
Interview schedules or topic guides for participants [INTERVIEW TOPIC GUIDE]	0.2	10 November 2017
IRAS Application Form [IRAS_Form_13112017]		13 November 2017
Letter from sponsor [LETTER FROM SPONSOR]		03 May 2017
Other [Service User Leaflet]	0.1	11 October 2017
Other [LETTER TO HEALTH PROFESSIONALS]	0.1	11 October 2017
Participant consent form [CONSENT FORM FOR PARTICIPANTS]	0.2	10 November 2017
Participant information sheet (PIS) [PARTICIPANTS INFORMATION SHEET]	0.2	10 November 2017
Referee's report or other scientific critique report [REFEREE'S REPORT]		02 May 2017
Research protocol or project proposal [RESEARCH PROTOCOL]	0.2	10 November 2017
Response to Request for Further Information		14 November 2017
Summary CV for Chief Investigator (CI) [IRENE PUJOL CV]		
Summary CV for supervisor (student research) [SUMMARY CV FOR SUPERVISOR]		
Summary, synopsis or diagram (flowchart) of protocol in non technical language [STUDY SUMMARY DIAGRAM]	0.1	11 October 2017
Validated questionnaire [VALIDATED QUESTIONNAIRE (GSRS)]	-	

IRAS project ID	200717

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Dr Stuart Wood
Tel: 02073825283
Email: stuart.wood@gsmd.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A Statement of Activities will act as the agreement of the NHS organisation to participate.
4.2	Insurance/indemnity arrangements assessed	Yes	The applicant has confirmed that the sponsor is covered by City of London insurance. Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical

IRAS project ID	200717

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No application for external funding will be made. As per the Statement of Activities, no funding will be provided to the participating organisation.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
This is a non-commercial study with a single NHS site. All research activities will take place at the participating organisation. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents

should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research**.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Principal Investigator is expected at the participating organisation.

The Statement of Activities confirms that Informed Consent in Clinical Research training is expected.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

No access arrangements are expected as all study activity at the participating NHS organisation will be undertaken by NHS staff who have a contractual relationship with the organisation.

Other Information to Aid Study Set-up

IRAS project ID	200717

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

APPENDIX C: Research Protocol

Research Protocol

This protocol has regard for the HRA guidance and order of content

FULL/LONG TITLE OF THE STUDY
An exploration of the use of group vocal improvisation as a music therapy technique in a mental health setting.

SHORT STUDY TITLE / ACRONYM
GVI Music Therapy Project

PROTOCOL VERSION NUMBER AND DATE
Version 0.1
Date: 11/10/2017

RESEARCH REFERENCE NUMBERS

IRAS Number:	200717
SPONSORS Number:	N/A
FUNDERS Number:	N/A

SIGNATURE PAGE

The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publically available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.

For and on behalf of the Study Sponsor:

Date: 11 / 10 / 17

Signature: 

Name (please print): STUART G WOOD

Position: Research Fellow

Chief Investigator:

Date: 11 / 10 / 17

Signature: 

Name: (please print): IRENE PUJOL TORRAS

LIST of CONTENTS

KEY STUDY CONTACTS

Chief Investigator	Irene Pujol Torras
Study Co-ordinator	Dr Stuart Wood 020 7628 2571
Sponsor	Guildhall School of Music and Drama Research Department research@gsmd.ac.uk 020 7628 2571
Joint-sponsor(s)/co-sponsor(s)	N/A
Funder(s)	N/A
Key Protocol Contributors	• Chief Investigator Irene Pujol Torras • Study Co-ordinator Dr Stuart Wood 020 7628 2571
Committees	N/A

STUDY SUMMARY

Study Title	An exploration of the use of group vocal improvisation (GVI) as a music therapy technique in a mental health setting.
Internal ref. no. (or short title)	N/A
Study Design	Mixed methods comparative case study
Study Participants	Community mental health service users
Planned Size of Sample (if applicable)	N = 10
Follow up duration (if applicable)	N/A
Planned Study Period	6 months (possibly autumn 2017 – spring 2018)

Research Question/Aim(s)	Aim: to explore the clinical particularities, challenges and affordances of putting the voice at the centre of group music therapy improvisation. Research question 1: What kinds of verbal and musical interactions take place in GVI? Research question 2: What therapeutic processes emerge when using GVI? Research question 3: How do patients and therapist experience GVI? Research question 4: How is GVI different from standard group music therapy?

FUNDING AND SUPPORT IN KIND

FUNDER(S) (Names and contact details of ALL organisations providing funding and/or support in kind for this study)	**FINANCIAL AND NON FINANCIALSUPPORT GIVEN**
Guildhall School of Music and Drama	Partly university fee waive
Music therapy charity	Grant of £1500
Self-funding	Remaining of fees and maintenance

ROLE OF STUDY SPONSOR AND FUNDER

The responsibilities of the Guildhall School of Music and Drama as the sponsor of this research project are:

- Research supervision
- Guidance on research methods
- Doctoral programme coordination
- Provision of team supervision input

The Guildhall School of Music and Drama does not have control over the study design, conduct, data analysis and interpretation, manuscript writing and dissemination of results.

ROLES AND RESPONSIBILITIES OF STUDY MANAGEMENT COMMITEES/GROUPS & INDIVIDUALS

During the design of the study the chief investigator contacted 2 service user advisory groups, one connected to the sponsor institution, SUGAR: Service User Group Advisors on Research (City University London), and one connected to the clinical site of the study, Central and North West London (CNWL) Research Partnership Group. The chief investigator is continuing to work to find a meeting date in order to seek advice on how the participation information in written as well as to discuss suitability of the proposed exit strategy.

PROTOCOL CONTRIBUTORS

The protocol has been devised by the chief investigator and my supervisory team, constituted by Dr Stuart Wood, Dr Karen Wise and Dr John Sloboda. Their role was advisory, guidance and expert review. The final decision is of the chief investigator although it has been signed of by the team.

Aspects of the protocol have been based on my the chief investigator's clinical experience with service users, staff feedback, multidisciplinary team meetings, referral groups and local Community Mental Health Teams (CMHTs)

KEY WORDS:

Music therapy
Voice
Group work
Improvisation
Mental health

STUDY FLOW CHART

The first table shows an overall flow chart describing the main parts of the study. Below, the second table outlines the methodology and the project design in more detail.

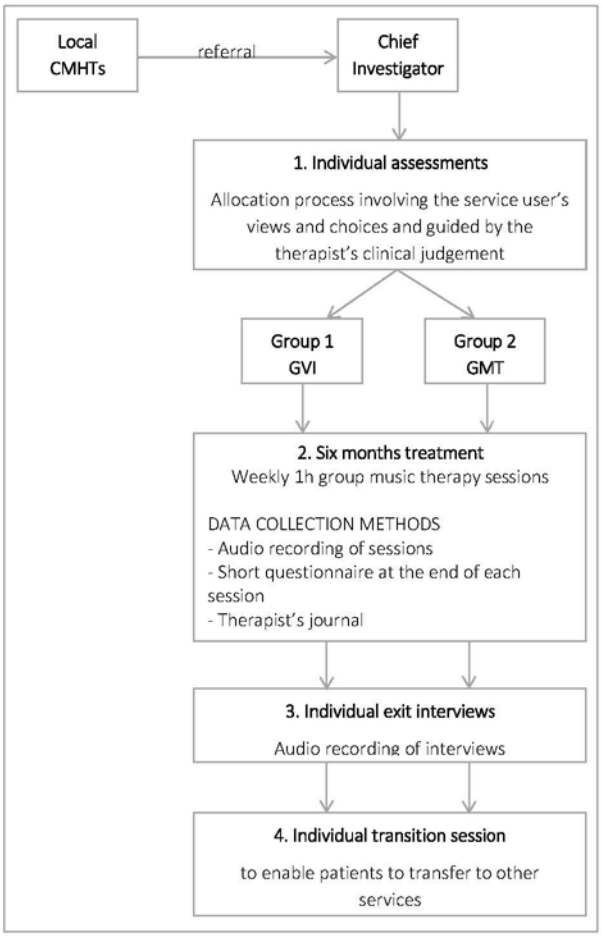

Table 1: Outline of main parts of the study

SUBJECT	GVI as a Music Therapy technique in Mental Health									
RESEARCH QUESTIONS	INTERACTIONS				THERAPEUTIC PROCESS		CHANGE MECHANISMS			
	1) What kinds of verbal and musical interactions take place in GVI?				2) What therapeutic processes emerge when using GVI?		3) How do patients and therapist experience GVI?			
METHODOLOGY	Convergent mixed methods									
	Qualitative				Quantitative		Qualitative			
METHODS	Observation				Self-report		Self-report			
	Measure and categorisation of the interaction dynamics				Therapeutic alliance		Significant experiences			
	Text		Music				Patients		Therapist	
DESIGN	Comparative case study: Naturalistic, longitudinal, purposeful sampling → Group 1 – GVI → Group 2 – GMT									
DATA COLLECTION	G1	G2	G1	G2	G1	G2	G1	G2	G1	G2
	Verbatim transcription		Audio recordings		Questionnaires post session (GSRS)		Interview		Process notes	
DATA ANALYSIS	Interaction analysis				Statistical analysis		Thematic analysis			
	Comparison G1/G2		Comparison G1/G2		Comparison G1/G2		Comparison G1/G2		Comparison G1/G2	
	Discussion of results									
	Research question 4: How is GVI different from GMT?									

Table 2: Outline of design and methodology of the study

STUDY PROTOCOL

An exploration of the use of group vocal improvisation as a music therapy technique in a mental health setting.

1 BACKGROUND

A thorough systematic literature search was conducted in preparation for this study. Through a narrative synthesis method the systematic search yielded 300 potentially relevant studies, out of which 30 met the full inclusion criteria. The databases provided by the Health Database Advanced Search (HDAS) and suggested by the NICE Evidence Platform were used to conduct this review (PstchINFO, EMBASE, MEDLINE, CINAHL, AMED).

The main finding of this review is that GVI is not yet an established differentiated technique that is researched specifically in the literature. It has been shown how different interventions that involve some form or degree of GVI have been given very different names, from very specific to very generic. It has also been shown how these differences can in some cases respond to differentiated national schools and traditions of music therapy.

Another phenomenon that this review has highlighted is the implicit dichotomy within group music therapy in the field of mental health that associates the voice with pre-composed songs and instruments with free improvisation. In the context of this polarisation, GVI could be thought to happen as a by-product or extra-ordinary event derived from one of these two categories.

For example, a community choir might sometimes make use of some improvisatory techniques during their warm up, and whilst this might be an important component of the session it's often not the studied phenomenon. On the other hand, a group music therapy session that is instrumentally based might involve some improvised singing initiated either by the therapist or one of the members, but again this would not be the main activity, not all participants might join and it might not occur frequently.

Some authors have made this non-specificity of GVI explicit when describing the music therapy interventions studied. For example, in the study by Mössler et al. (2012) where the Questionnaire for the Assessment of Music Therapeutic Working Modes was used as one of the data collection methods, the authors point out that "the original scale suggested a separation of vocal improvisation techniques and improvisation techniques in general. This separation was viewed as redundant and we therefore merged the vocal improvisation techniques into the improvisation techniques".

Another example of the presented dichotomy and of the non-specificity of GVI can be found in Magee's investigation (1998) where two conditions are studied, comparing pre-composed song material where "participants chose which instrument the therapist played the songs on and whether the words were sung" versus improvisation, where "mostly improvisations were purely instrumental, however occasionally they involved both instruments and vocalisations".

It becomes clear that the literature reflects a disparate set of working practices. It is possible to say that, despite the useful and promising results, the evidence is fragmented in that every study looks at slightly different aspects of different interventions in different client groups. However, this review has been able to identify some general tendencies that will inform the present project.

For example, there are generally positive responses in areas such as self-efficacy, quality of life and decrease of depressive symptoms. Some studies also point out at benefits that are specific to singing, such as Tamplin et al. (2014) who in their active music therapy group, which was based in vocal techniques, found that the singing was "challenging" at first but in the end provided an increase in motivation for the participants.

This fragmented evidence is complemented and supported by more thoroughly researched four neighbouring areas. The findings from these are in agreement with some other systematic reviews.

For example, in the neighbouring field of community choirs (1), this review included studies showing motivation increase, emotional well-being, positive affect, social connectedness and decrease in anxiety, which is concordant with the systematic mapping and review by Clift et al. (2008).

In terms of the use of vocal improvisation in individual music therapy (2), there is a need for more systematic research since many authors have written about the use of voice in individual music therapy (Austin, 2009: Baker & Uhlig, 2011; Warnock, 2011) but this literature is not based on empirical research studies.

In this area, the study by Bodner & Gilboa (2006) supports an argument for the voice as a distinct instrument in music therapy in terms of its emotional communicability advantage over other instruments.

In yet another neighbouring field, that of vocal improvisation with no therapeutic aims (3), two studies comparing improvisation versus pre-composed music making (with no therapeutic aims) found that the improvisation condition correlated with a higher levels of plasma oxytocin, which is associated with an increase in trust, and with a decrease of conscious volitional control. Both these biological observations point at specific elements of vocal improvisation that might be very influential and positive for mental health patients.

Finally, in the area of group clinical improvisation (mainly instrumental) (4), general positive results similar to those pointed out in the review by Carr, Odell-Miller & Priebe (2013) have been shown by the present literature review. Despite the general benefits, often no significant change was observed between two experimental conditions looking at different music therapy interventions. When facing this phenomenon, it it's important to consider Grocke, Bloch & Castle's (2009) confirmed hypothesis that differences in therapeutic change might not be mediated by difference in symptoms, which are often the targeted outcomes.

An important finding from this section, with potentially great influence on the present study, comes from the article by Mössler et al. on music therapy techniques as predictors of change in mental health care (2012). Mössler concludes that "reproduction techniques might play an important role in predicting outcomes related to relational aspects. In contrast to production and reception techniques, reproduction techniques tend to decrease interpersonal problems and increase social relationships".

This is important in two ways. On one hand, it stresses the relevance of adopting an "improvisatory approach", as has been argued in the introduction of this document, rather than proposing an intervention exclusively based in improvisation only. Moreover, since relational aspects and interpersonal matters are core to the therapeutic work in the context of the present study, it is worth noting that, in theory, it should be easier to introduce reproduction techniques within a vocal medium than with instruments since, whilst all verbal individuals are naturally skilled at modulating their voice,

most people do not possess the musical skills to be able to "reproduce" a pre-composed piece with instruments. Therefore, including some reproduction techniques within GVI might be an easy and useful resource.

Review of methodologies

This literature review has also been useful to assess the methodology of the studies in order to inform the design of the present project.

It was noticeable that an important number of articles introducing a comparison between two types of interventions did not find significant differences in outcome measures between two experimental groups (Silverman, 2011, 2007; Tague, 2012; Mohammadi, 2012) and only one study (Werner, Wosch & Gold, 2016) found a significant difference between the two interventions (group music therapy including group singing versus recreational singing).

The study by Tague (2012), which in design was the most similar to the present research as it compared general music therapy to a particular music therapy technique (group drumming) through a range of observational and self-rated scales, did not show any significant differences in any of the data sets. This study did not include qualitative methods to look at more nuanced differences and all the measures were outcome based rather than process oriented.

Other mixed methods studies reviewed here that did not observe significant differences in the quantitative measures relied mainly in the findings from the qualitative and process oriented methods (Grocke et al. 2014; Silverman, 2011, 2007). However, in some cases the weight that had been given to the qualitative part within the study was not big enough to capture deep reflections and sometimes remained in the surface.

One study with a robust design combining a RCT with qualitative findings (Bradt et al., 2016) specifically found in the qualitative data that "participants were highly critical of the outcome measures related to physical functioning, particularly the Multidimensional Pain Inventory (MPI) General Activities Subscale, and the Hospital Anxiety and Depression Scale (HADS) for emotional functioning scale, as not capturing the treatment benefits they had experienced".

Therefore, the findings form this literature review, in agreement with Braakman (2015), suggest using mixed methods and more thorough qualitative and process oriented tools to study the differences between different music therapy interventions.

Situation of present project within the existing literature

Having reviewed the existing literature on the use of GVI and similar interventions in music therapy for mental health, it is important to situate the present project in relation to the map that has been outlined.

The study will make use of an intervention that is very similar to that described within the label "vocal music therapy" in the investigation by Bradt et al. (2016). It will take place within a clinical setting resembling Grocke, Bloch & Castle's (2009) research: outpatient mental health. The design will also be parallel to this study in that it will include three sources of data collection: self-report, analysis of

musical material (and in the present project also analysis of conversation) and a qualitative analysis of the experience after the clinical intervention. In Grocke, Bloch & Castle's case the method used was focus groups and in the present study this data will be collected by means of individual interviews instead.

Finally, the starting point of the study is very similar to that of Tague (2012) in that it compares general music therapy to a sub type of it. The rationale for these choices will be explained in the following section.

2 RATIONALE

The research questions addressed in this study are important in terms of exploring the gap identified in the literature review. They will shed light into the clinical reasoning behind the use of voice in production and reproduction techniques within music therapy and into its potential therapeutic benefits.

The research questions are also aimed at exploring challenges arising from the process of implementing the new technique and providing guidance for applying it effectively for other practitioners.

As the literature has shown, voicework is increasingly attracting a range of clinical populations who seem to relate easily and positively with the idea of singing. Due to the naturally accessible nature of the voice for a vast majority of people, GVI will be a way in for service users to work therapeutically with their voice and engage easily with the relational dynamics of the music therapy work.

This study is only exploratory since no previous research has focused in GVI as a specific technique in music therapy yet, as the literature review has shown. Further, more specific and nuanced questions regarding the use of GVI might follow from this research that can be looked at in future research.

This study is in line with the above mentioned increasing interest in voice work that the music therapy discipline has seen in the last decade. GVI also offers an advantage in terms of time and resources costs since it is a group intervention and requires minimal equipment. This makes the intervention also more flexible and mobile.

3 THEORETICAL FRAMEWORK

This study proposes a theoretical framework that is very similar to that of standard group music therapy in terms of the clinical rationale for group improvisation and of the musical medium. This adoption of a similar approach responds to an aim to situate GVI as another model within standard group music therapy in terms of aims and rationale rather than presenting it as a separate alternative to instrumental group improvisation.

Clinical group improvisation in music therapy focuses on the exploration of relational dynamics whilst allowing space for creative self-expression within a safe space. The non-verbal nature of the medium affords working with pre-verbal intersubjective communication and modes of making contact with

others. This exploration facilitates the processing of emotions in an experiential way and provides a platform from which to develop a reflective conversation within the group.

Objects theory, attachment theory, vitality affects and mentalisation are central concepts within the established practice of clinical improvisation in group music therapy and this study sits within this framework.

More recent concepts associated with voicework such as embodiment will be added to this framework due to the vocal nature of the studied technique.

4 RESEARCH QUESTION/AIM(S)

To explore the clinical particularities, challenges and affordances of putting the voice at the centre of group music therapy improvisation.

Research question 1: What kinds of verbal and musical interactions take place in GVI?

Research question 2: What therapeutic processes emerge when using GVI?

Research question 3: How do patients and therapist experience GVI?

Research question 4: How is GVI different from standard group music therapy?

4.1 Objectives

To provide data and findings on the clinical use of GVI as a music therapy technique.

To provide a model of process oriented methodology for further music therapy research projects.

To complete an academic doctoral programme.

4.2 Outcome

Outline of differences and similarities in the musical and verbal styles of interactions in the two studied groups.

Outline of differences and similarities in the formation and establishment of therapeutic alliance in the two studied groups.

Outline of differences and similarities in the change mechanisms.

Discussion of the findings in each group and comparison between the two groups.

5 STUDY DESIGN and METHODS of DATA COLLECTION AND DATA ANALYIS

The data collection and analysis will be conducted by the researcher.

METHOD	DATA COLLECTION	DATA ANALYSIS
Observation: audio recording of sessions	A recording device connected to a computer will be used to audio record the sessions, capturing both verbal and musical interactions.	Coding of data Interaction analysis
Self-report: short questionnaires	Completion of Group Session Rating Scale (GSRS) at the end of each group music therapy session.	De-identification of data Descriptive statistical analysis
Self-report: semi structured interviews	Individual interviews at the end of intervention. The researcher will develop a prompt guide in order to support participants to reflect on their experience of the intervention. The interviews will be in person and audio recorded.	Verbatim transcription Thematic analysis

6 STUDY SETTING

This is a single centre study that aims to be naturalistic. Therefore, there are no specific requirements to run the study apart from those standard in music therapy clinical activity.

The study will be based [redacted]The sessions will take place at the music therapy Studio in the basement. The data will all be gathered there and managed in the arts therapies office located also in the basement.

As a well-established outpatient arts therapies service, this has been chosen as an appropriate site for the research study.

7 SAMPLE AND RECRUITMENT

7.1 Eligibility Criteria

This is a study working with mixed diagnosis groups. Participants will be outpatient service users managed by local community mental health teams. Participants will be allocated to each group in an attempt to be homogeneous, based in severity of symptoms and level of progress in recovery.

7.1.1 Inclusion criteria

- Mental Health service users within the local community
- Service users managed by the community teams (South and Central locality teams)

7.1.2 Exclusion criteria

- Service users that the community team considers unable to commit to weekly attendance
- Service users that do not understand or speak English (since this will be the main language used in the group)
- Service users that have had an admission to a mental health hospital in the last 3 months
- Service users who do not have capacity

7.2 Sampling

The sample will be obtained by a standard procedure of referral and assessment based on clinical appropriateness. Potential referrers will be made aware of the research nature of the groups.

7.2.1 Size of sample

The total sample will be of a maximum of 10 participants. A maximum of 5 participants will be allocated to each of the two groups of the study.

This sample size has been chosen in accordance to the naturalistic nature of the study as well as the limitations of space of the clinical setting and timeline of the study.

7.2.2 Sampling technique

The sampling for this study will be purposive. The appropriateness for participation and allocation will be discussed and negotiated collaboratively with service users.

The rational for this sampling strategy is to obtain appropriate and effective participants who will be engages through the process in order to encourage attrition rates in a study that depend on a small sample.

This sampling strategy also reflects the methodological and theoretical framework of the study, which aims at being qualitative, inclusive, non-diagnosis driven and naturalistic.

The sample will be derived from the standard clinical referrals pathway from the CMHTs to the arts therapies service.

7.3 Recruitment

Participants will be identified and recruited via the existing referral pathways from the local community mental health teams to the arts therapies service. Potential referrers will be informed about the project and the commitment for participants.

As guidelines for eligibility, referrers will be given the following broad profile description to aid them in the initial identification of potential participants:

- Doing relatively well in the community (level of independence, severity of symptoms)
- Needing support with self-confidence and self-expression
- Possibly self-isolating
- Could benefit from a creative outlet
- No need to have musical skills

7.3.1 Sample identification

The multidisciplinary team at the CMHTs will identify potential participants, within their normal job functions of assessing service users' needs and referring them to appropriate services. The staff will use the guidance document provided by the researcher to help assist them in identifying potential participants.

7.3.2 Consent

Informed consent will be obtained prior to the participant undergoing any activities that are specifically for the purposes of the study. Potential participants will meet with the researcher individually in an initial consultation after being referred by the CMHTs.

In this meeting the service users will be presented with an information sheet (with a detailed description of what the study involves, its objectives and possible risks associated with their participation) and a consent form. These will be introduced and discussed with the services user, who will be able to ask questions about the project.

The conversation will also serve to assess the service user's capacity, making sure they understand and are able to retain the information presented relating to the purpose, the possible benefits and risks of the study and how their interests will be protected (especially in service users particularly susceptible to coercion). It will also be emphasized that the service users are able to make a free choice and it is important that they understand the alternatives to taking part in the study.

8 ETHICAL AND REGULATORY CONSIDERATIONS

The study fits into the ethical and regulatory framework and is in line with the Trust's ethics policy, complying with the data protection act (1989) and the chief investigator's own HCPC regulated code of conduct.

The potential benefits of this study for the participants is that they will receive a thorough assessment, substantial period of treatment and further referral to other services by a qualified and HCPC registered music therapist. During the progress of the sessions, participants will have opportunities to develop self-confidence, creative expression and better insight into issues that they find challenging. The sessions will also provide an opportunity to develop social and interpersonal skills as well as sharing their experience of suffering from mental health difficulties with peers.

This study, for its inherent psychotherapeutic focus, has the potential risk of raising intense emotions for the participants and some participants might struggle with these experiences. The will be clinically supervised by the principal arts therapist at the hospital in order to prevent these instances as much

as possible. Risk will be minimized as the therapist will attempt to keep the space physically and emotionally safe at all times. The therapist is also trained to de-escalate potential situations where a participant might present aggressively and she will have a hand alarm at all times to ensure the safety of all participants.

In regards to upholding the dignity of the participants a number of measures are in place such as full informed consent, choice where relevant and appropriate, anonymity and ability to withdraw from the study. Within the naturalistic style of the study this will be possible since these measures and data collection methods coincide with normal music therapy process documentation to a large extent.

8.1 Assessment and management of risk

As explained in the section above, there is a potential risk of emotional distress for the participants arising. Apart from the preventive measures around this there is also a risk management plan to deal with potential safeguarding issues and potential disclosure of information.

The management of these kinds of risk is a standard procedure in the music therapy profession and a plan is in place at the site. The process of data collection is naturalistic and therefore doesn't add further risks to the clinical activity. The therapy room is an existing music therapy room subject to existing risk management.

The study has been designed in accordance with the trust's policies on data protection, confidentiality, safeguarding and risk management, as well as the university's policies on research ethics and liability. The main points of the risk assessment will be included in the individual initial assessment and exit interview.

The outline of the risk management plan consists of a chain of professionals to be contacted in raising a concern. The first point of contact should be the chief investigator's clinical supervisor and/or line manager unless this means a delay which would increase the risks. They would be able to assist in deciding the level of escalation that the disclosure of information or safeguarding concern needs.

Depending on this judgement of level of severity of risk other professionals involved in the service user's care team (or the local safeguarding adults referral point) would be contacted as well in order to take further action. The chief investigator is also trained in completing a Datix form to record the facts, as well as updating progress notes on JADE.

8.2 Research Ethics Committee (REC) and other Regulatory review & reports

Before the start of the study, a favourable opinion will be sought from a REC for the study protocol, informed consent forms and other relevant documents e.g. advertisements.

Substantial amendments that require review by NHS REC will not be implemented until that review is in place and other mechanisms are in place to implement at site.

All correspondence with the REC will be retained.

It is the Chief Investigator's responsibility to produce the annual reports as required.

The Chief Investigator will notify the REC of the end of the study.

An annual progress report (APR) will be submitted to the REC within 30 days of the anniversary date on which the favourable opinion was given, and annually until the study is declared ended.

If the study is ended prematurely, the Chief Investigator will notify the REC, including the reasons for the premature termination.

Within one year after the end of the study, the Chief Investigator will submit a final report with the results, including any publications/abstracts, to the REC.

Regulatory Review & Compliance

Before any site can enrol patients into the study, the Chief Investigator/Principal Investigator will ensure that appropriate approvals from participating organisations are in place. Specific arrangements on how to gain approval from participating organisations are in place and comply with the relevant guidance.

For any amendment to the study, the Chief Investigator, in agreement with the sponsor will submit information to the appropriate body in order for them to issue approval for the amendment. The Chief Investigator or designee will work with sites (R&D departments at NHS sites as well as the study delivery team) so they can put the necessary arrangements in place to implement the amendment to confirm their support for the study as amended.

Participating organisation have provided approval to this point. Before activating this project properly the chief investigator will gain final approval from the clinical supervisor and service manager. Specific arrangements on how to gain approval from participating organisations are in place and comply with the relevant guidance.

For any amendment to the study, the Chief Investigator, in agreement with the sponsor will submit information to the appropriate body in order for them to issue approval for the amendment. The Chief Investigator will work with the CNWL R&D department as well as the study supervisory team so they can put the necessary arrangements in place to implement the amendment to confirm their support for the study as amended.

Amendments

If the sponsor wishes to make a substantial amendment to the REC application or the supporting documents, the sponsor will submit a valid notice of amendment to the REC for consideration. The REC will provide a response regarding the amendment within 35 days of receipt of the notice. It is the sponsor's responsibility to decide whether an amendment is substantial or non-substantial for the purposes of submission to the REC.

Amendments will also be notified to the national coordinating function of the UK country where the lead NHS R&D office is based and communicated to the participating organisations (R&D office and local research team) departments of participating sites to assess whether the amendment affects the NHS permission for that site. Note that some amendments that may be considered to be non-substantial for the purposes of REC still need to be notified to NHS R&D.

Any amendments will be discussed with the Chief Investigator's academic supervisory team and clinical supervisor, who will be responsible, along with the Chief Investigator, of determining wether an amendment is substantial or non-substantial. Any amendments will be communicated to the relevant stakeholders by the Chief Investigator.

The amendment history will be tracked to identify the most recent protocol version following the HRA's guidance on the categorisation of amendments.

8.3 Peer review

This study protocol has been reviewed by the chief investigator's supervisory team.

8.4 Patient & Public Involvement

During the design of the study the chief investigator contacted 2 service user advisory groups, one connected to the sponsor institution, SUGAR: Service User Group Advisors on Research (City University London), and one connected to the clinical site of the study, Central and North West London (CNWL) Research Partnership Group. The chief investigator is continuing to work to find a meeting date in order to seek advice on how the participation information in written as well as to discuss suitability of the proposed exit strategy.

8.5 Protocol compliance

Protocol compliance will be monitored by the chief investigator's supervision team, clinical supervisor and line manager. Any accidental deviations will be reported and documented. The chief investagator understands that deviations from the protocol which are found to frequently recur are not acceptable, will require immediate action and could potentially be classified as a serious breach. This will be managed in reference to the supervisory team and line manager.

8.6 Data protection and patient confidentiality

All investigators and study site staff must comply with the requirements of the Data Protection Act 1998 with regards to the collection, storage, processing and disclosure of personal information and will uphold the Act's core principles

Personal identifiable information will not be collected beyond generic demographics for data analysis purposes. Any personal information used for clinical purposes will not be shared with any professionals outside the standard care team and will not leave the NHS premises of the site.

Coded, depersonalised data will be created where the participant's identifying information is replaced by an unrelated sequence of characters.

Data and the linking code will be securely maintained in separate locations using encrypted digital files within password protected folders and storage media

Access will be limited to the minimum number of individuals necessary for quality control, audit, and analysis.

The confidentiality of the data will be preserved when the data are transmitter to sponsors and co-investigators through the edition of audio extracts so that identifiable traits are obscured. This is a standard procedure within the music therapy profession and easy to use audio edition software is available so that this procedure can be done quickly without interfering too much with the research timeline.

The data will be stored for 7 years after its collection and its custodian will be the chief investigator.

8.7 Indemnity

The sponsor's liability insurance will meet the potential legal liability for harm to participants arising from the management and design of the research.

The NHS indemnity scheme will meet the potential legal liability for harm to participants arising from the conduct of the research.

Regarding payment of compensation in the event of harm to the research participants where no legal liability arises, the inherent risks of the study are to do with normal operations of the service, so the sponson remains vigilant but has no additional mechanisms beyond their existing employers liability.

No equipment is to be provided to sites for the purposes of the study.

8.8 Access to the final study dataset

The chief investigator will be the sole individual who will have access to the full dataset. For review purposes parts of the dataset will be made available to the supervisory team.

It is not envisaged that the dataset will be used for secondary analysis.

9 DISSEMINIATION POLICY

9.1 Dissemination policy

The ownership of the data arising from the study resides in the chief investigator. On completion of the study, the data will be analysed and tabulated and a Final Study Report, which will be publicly available at the Guildhall School of Music and Drama's library. Other publications in form of journal articles may arise as well. An outline of this protocol will be included in the methodology chapter of the final report.

There is a deadline for the submission of the final report in accordance with the Guildhall School of Music and Drama's doctoral programme.

There is also a plan to share a summary of the findings of the study with the participants. However, participant will not be able to specifically request results from the chief investigator.

In the Final Report funding from the Guildhall School of Music and Drama as well as from the Music Therapy Charity will be acknowledged but these bodies do not have review or publication rights of the data from the study.

9.2 Authorship eligibility guidelines and any intended use of professional writers

Authorship on the final study report will be granted to the chief investigator.

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11. APPENDICIES

11.1 Appendix 1- Required documentation

The following documentation will be required prior to initiation a participating site and will be enclosed in the IRAS form:

- CVs of the research team,
- Patient Information Sheet (PIS) on headed paper
- Research protocol
- Participant consent form
- Letters of invitation to the participant
- Interview topic guides for interviews
- Validated GSRS questionnaire
- Referee's report
- Diagram of protocol in non-technical language
- Letter from sponsor
- Evidence of Sponsor insurance

11.2 Appendix 2 – Schedule of Procedures (Example)

Procedures	Screening 3 visits	Baseline	Weeks 1 – 24 6 months of weekly visits	Post treatment 2 visits
Informed consent	x			
Demographics		x		
Medical history		x		
Observation of treatment		x	x	
Interview				x

13.3 Appendix 3 – Amendment History

Amendment No.	Protocol version no.	Date issued	Author(s) of changes	Details of changes made

APPENDIX D: Consent form

Version 0.2 (10/11/2017)

Research Participant Consent Form

Title of project: Group Vocal Improvisation as a Music Therapy technique in a Mental Health setting (IRAS ID: 200717)
Study approved by: Health Research Authority (HRA)

Thank you for agreeing to take part in this research. The person organising the research must explain the project to you and you should have read any accompanying information sheet before you complete this form.

- If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to participate. You will be given a copy of this Consent Form to keep and refer to at any time.
- I consent to the audio recording of the group sessions and an interview at the end of the therapy.
- I consent that my health professional is informed that I am taking part in this study.
- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to the point of transcription for use in the final report.
- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be treated in accordance with the terms of the Data Protection Act 1998.
- The outcome of the research study will be published as a report and you will be sent a copy. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications.

Participant's Statement:

I _____
(full name, please print)

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the project. I have read both the notes written above and the Information Sheet about the project, and understand what the research involves.

Signed: **Date:**

_____

Name of person taking consent_____

Signature: **Date:**

_____

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

APPENDIX E: Patient Information Sheet

Version 0.2 10/11/2017

Participant Information Sheet

Study title

An exploration of the use of group vocal improvisation as a music therapy technique in a mental health setting. (IRAS ID: 200717)

Invitation and brief summary

I would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What's involved?

There's evidence that group music therapy is an effective psychological treatment for individual suffering from mental health problems. This research project aims to explore different techniques of group music therapy and it will look at the potential mental health and wellbeing benefits of these techniques, especially looking at improvement in areas such as social skills, self-confidence and creativity.

What would taking part involve?

The participants of this study will take part in weekly group music therapy sessions for 6 months at the Music Therapy Studio in [redacted] in small groups of a màximum of 5 participants. Participants will be community mental health service users managed by the local community teams. Participants may be excluded during the project if they need an admission to acute psychiatric services.

The group music therapy sessions will be recorded and participants will be asked to complete a very short questionnaire (less than 1 minute to complete) at the end of each session. Within two weeks of the end of the

six month therapy period participants will be asked to take part in an individual interview that will last up to 1 hour and a half to discuss your experience of the therapeutic process.

What are the possible benefits of taking part?

The possible benefit of this study for the participants is that they will receive a thorough assessment, substantial period of psychotherapeutic treatment and further referral to other services by a qualified music therapist. During the progress of the sessions, participants will have opportunities to develop self-confidence, creative expression and better insight into issues that they find challenging. The sessions will also provide an opportunity to develop social and interpersonal skills as well as sharing their experience of suffering from mental health difficulties with peers.

What are the possible disadvantages and risks of taking part?

As in any form of psychotherapy, there is the potential for emotional distress during the sessions. The therapist running the sessions will be monitoring this risk and is trained to de-escalate difficult situations.

Anonymity and confidentiality

All data will be anonymised and the sessions will be confidential, although confidentiality might be broken if participants or others are at serious risk. No identifiable information about the participants will be shared outside the standard care team. Generic demographics information and medical history will be taken at the beginning of the study. All anonymised data from the study will be kept securely in password encrypted storage devices and will be stored for 7 years after the study terminates. Anonymised data might be used in academic presentations and publications.

APPENDIX F: GSRS questionnaire

VALIDATED QUESTIONNAIRE: GROUP SESSION RATING SCALE

Group Session Rating Scale (GSRS)

(ages 13 to adult)

Name _____Age (Yrs):____ Session # ____ Date: _____

Please rate today's group by placing a mark on the line nearest to the description that best fits your experience.

	Relationship	
I did not feel understood, respected, and/or accepted by the leader and/or the group.	|----------|	I felt understood, respected, and accepted by the leader and the group.
	Goals and Topics	
We did *not* work on or talk about what I wanted to work on and talk about.	|----------|	We worked on and talked about what I wanted to work on and talk about.
	Approach or Method	
The leader and/or the group's approach is a not a good fit for me.	|----------|	The leader and group's approach is a good fit for me.
	Overall	
There was something missing in group today—I did not feel like a part of the group.	|----------|	Overall, today's group was right for me—I felt like a part of the group.

APPENDIX G: Interview topic guide

Adapted Client Change Interview Protocol (Elliott, 1999)

General Questions	1. How are you doing now in general? 2. What was attending the group like for you? • Tell me about some of the music activities you remember • What was it like being part of the group?
Changes	3. What changes, if any, have you noticed since starting the therapy? • Are you doing, feeling, or thinking differently from the way you did before? • What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? • Have any changes been brought to your attention by other people? 4. Is there anything that has changed for the worse? 5. Is there anything that you wanted to change when you started therapy that hasn't?
Change Ratings	6. For each change, please rate how much your expected it vs were surprised by it: • Very much expected it • Somewhat expected it • Neither expected nor surprised • Somewhat surprised by it • Very much surprised by it 7. For each change, please rate how likely you think it would have been if you hadn't been in therapy? • Very unlikely without therapy (clearly would not have happened) • Somewhat unlikely (probably would not have happened) • Neither likely nor unlikely (no way of telling) • Somewhat likely (probably would have happened) • Very likely (clearly would have happened anyway) 8. How important or significant to you personally do you consider this change to be? • Not at all important • Slightly important • Moderately important • Very important • Extremely important
Attributions	9. In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy) • Music • Reflection on the music • General conversation in the group
Helpful aspects	10. Can you sum up what has been helpful about your therapy? • Please give examples. (For example, general aspects, specific events)
Problematic aspects	11. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? • Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they? • Has anything been missing from your therapy? (What would make/have made your therapy more effective or helpful?)
Research aspects	12. What has it been like to be involved in this research? (Initial screening, research interviews, completing questionnaires etc) • Can you sum up what has been helpful about the research so far? Please give examples. • What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of therapy? Please give examples.
Suggestions	13. Do you have any suggestions for us, regarding the research or the therapy? 14. Do you have anything else that you want to tell me?

APPENDIX H: Information for referrers

Version 0.1 (11/10/2017)

SUPPORTING DOCUMENTATION: INFORMATION FOR REFERRERS

We are doing a **NEW MUSIC THERAPY GROUP** for community patients as part of a **Research Project**.
We need your referrals!

Referral guidelines for the Music Therapy research project
Brief overview of the project:
• 6 months of weekly sessions • Wednesdays • Music Therapy Studio
Who is the group for?
Community patients from South and Central CHMTs who correspond to the following presentations:
• Socially isolated • Lacking in self-confidence • In need for a creative outlet • Who would benefit from being in a group • Able to commit to regular sessions
No experience or musical skills are needed.
Once identified and after an assessment participants will be allocated to either a general music therapy group or to a vocal music therapy group.
If you think that any of your patients would fit in any of the mentioned presentations please get in touch with Irene Pujol at Do not hesitate to get in touch if you have any questions!

APPENDIX I: Leaflet for potential participants

What is music therapy?

Music therapy is a space where you can safely express and explore yourself through music making as a mode of communication.

It is a creative process that can be helpful to anyone who can find it difficult to express or connect with their thoughts and feelings verbally.

How does it help?

The process of making music can help someone to get in touch with difficult emotions and express them in a safer and more manageable way.

The use of sounds and instruments can support you to understand yourself better while containing feelings that otherwise may be overwhelming.

Working in a group can help you to explore change while building relationships and self-confidence.

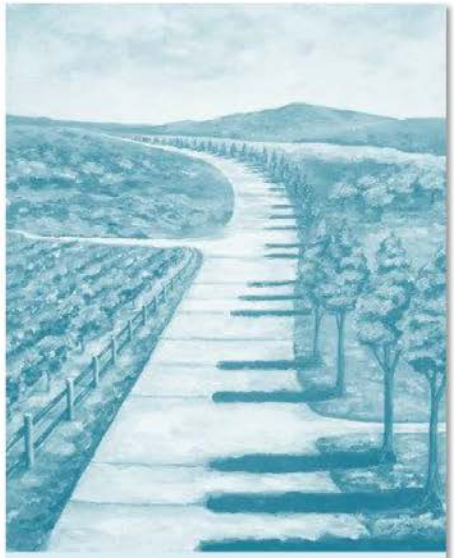
No musical skills required.

You will be supported by the therapist to make use of the sounds in the sessions.

Please contact your care coordinator if you have any further questions.

They will be able to refer you to Music Therapist Irene Pujol

NEW MUSIC THERAPY RESEARCH PROJECT



Two new music therapy groups for community service users will be starting soon at the

What is this project?

These two new music therapy groups will be part of a research project looking at different music therapy techniques.

The groups will have a maximum of 5 participants and will aim at developing meaningful therapeutic relationships.

What does it involve?

Service users will be asked to commit to 6 months of weekly 1h group sessions.

You will be invited by the therapist to take part in group music making with support and guidance and to reflect on your experience with the other members of the group.

How to join the groups?

If you feel you might benefit from this service please ask your care coordinator to refer you.

Once you've been referred you will have an initial consultation with the music therapist who will explain the project in more detail.

You will have the opportunity to ask any questions you have about the group and if you want to participate you will go through an individual assessment with the music therapist.

No musical skills required

You will be supported by the therapist to make use of the sounds in the sessions.

When and where

The sessions will take place on Wednesdays at the Music Therapy Studio of

APPENDIX J: Referrals summary

REFERRALS SUMMARY

	Invited and engaged with the assessment process
	Invited and partially engaged with assessment process
	Invited but didn't engage in the assessment process
	Not invited for assessment

	DIAGNOSIS	GENDER	AGE
R1	Schizoaffective disorder manic type	M	58
R2	Schizoaffective disorder manic type	F	55
R3	Schizophrenia	M	45
R4	Bipolar	M	25
R5	Recurrent depressive disorder	M	57
R6	Mental disorder (depression)	F	50
R7	Diagnose unclear (PD or Psychosis)	F	49
R8	Bipolar affective disorder. Anxiety issues	M	44
R9	Bipolar affective disorder	F	29
R10	Paranoid schizophrenia	M	59
R11	Bipolar affective disorder	F	56
R12	Anxiety and depressive symptoms	M	51
R13	Unspecified mental and behabioural dis. Complex Trauma	M	61
R14	Severe depressive episode with psychotic sypmtoms	M	36
R15	Schizoaffective dis. Manic type	F	52
R16	Emotionally Unstable Personality Disorder	M	37
R17	Residual schizophrenia	M	44
R18	Organic personality disorder	M	59
R19	Schizophrenia	M	52
R20	Bipolar affective disorder	M	67
R21	Depressive episode	M	55
R22	Autism and depression Unspecified personality disorder	M	57
R23	Anxiety and depression	M	63
R24	Paranoid schizophrenia	M	40
R25	Mixed anxiety and depressive disorder	M	56
R26	Bipolar disorder, manic episode with psychotic symptoms Personality disorder unspecified	F	38
R27	Dependant personality disorder	F	48
R28	Severe depressive episode with psychotic symptoms	F	52
	AVERAGE	32% F 68% M	49.8 years old

APPENDIX K : IPA clusters and themes

CLUSTERS AND THEMES FROM IPA ANALYSIS

GVI	P1	P2	P3	P4	P5	GMT	P6	P7	P8	P10
Sensory aspect of singing	**X**	**X**		**X**	**X**	**Music's impact on emotions**	**X**	**X**	**X**	**X**
Chest filled with joyful sensation. Invigorating. Euphoria, exhilarating.		X		X		MT was subtle and abstract, not easily relatable to emotions	X		X	
Physical exercise linked with singing and breathing (expanding lungs)				X		Deep emotional affectation from the music (in a good and safe way)				X
Different breathing. Link between anxiety and breath.		X			X	Particularly powerful mood change. Useful mood regulator at the beginning of the day.	X	X		
Shift of the attention to the body	X					Playing with others more powerful than on your own. Instant connection in the music.				X
						Impact on disasociation: overhwleming when it got loud. It touched something real.				X
						Music as a healthy way to change how you feel and creative outlet for sensitivity			X	
Something from inside out and accessing something very inner				**X**	**X**	**Importance of the expressivity on the instruments**	**X**		**X**	**X**
Old lively side/self that is inside could come out and be expressed in the singing				X	X	Importance of being able to change instruments	X			
Getting something out fluently				X		Being able to play an instrument was important. Actually playing the instruments			X	X
It touched the 'inner self'				X		Feeling able to be expressive	X			
Seeing something of a persons' inside – link with personal mental health narrative					X	Importance of sharing poem (text) as a different way of bonding	X			
						Push to play in a space where you are expected to			X	
						Wanting to stay invisible but be heard				X
Accessing a different mental space through singing	**X**	**X**	**X**	**X**	**X**	**Dissonance and consonance in and out of music**	**X**	**X**	**X**	**X**
Creative stimulation: writing a poem, 'good images in my head'	X	X				Negotiating dissonance and consonance in the group	X			
Turning mind 'off' and being relaxed: no rushing	X					Enjoyable even if non coherent music	X			
Getting lost in the music: it takes me away, like I'm flying					X	Peaks of harmony as well as clashes. Emotional when it 'gels' together.			X	X
Being in the now			X			Importance of grinding sounds			X	
I want to have fun, I deserve a break. Put the anxiety on hold for an hour.			X			Intersubjectivity and how the clashes can be overcome with humour		X	X	
Motivation to 'leave the bubble' and push one's boundaries			X							
Importance of singing when comparing with a previous approach to MT				X	X					
'It's given me a full range of emotions'				X						
Experience of intersubjectivity	**X**	**X**	**X**	**X**	**X**	**Relating personal traits with music traits**	**X**	**X**	**X**	**X**
Therapist meeting and matching vocally					X	Looking at and learning about oneself differently, 'in a way of music'				X
Improvised harmonising as a unique experience		X				Different kind of awareness during music making	X			
Collective result greater than individual sound		X		X	X	Link between the different musical role of instruments and personal narrative			X	
Sense of being part of society					X	One instrument in particular felt enabling to channel emotions related to trauma			X	
Connection with others, in and out of the singing	X	X	X		X	Noticing something in the music and being able to discuss it afterwards			X	
Sense of familiarity whilst singing 'syllables in harmony'				X		Reflecting on the comments from the group.				X
Music as a kind of wrapping to appreciate more, to facilitate communication			X			Resonating with someone else, sensing this in the music		X		X
You feel you exist behind the music, you can touch others through the music.			X							
Feeling listened to. Feeling safe and respected.			X	X						

Discovery of new things: accessibility to new experiences	**X**	**X**	**X**	**X**	**X**	**Fun, motivating**	**X**	**X**	**X**	**X**
Cognitive productive aspect: it gave me an idea to use my mind		X		X	X	Fun and playful	X	X		X
It is possible to acquire skills: there is some learning possible in singing					X	Enjoyable therapy			X	
Initial dislike of own voice: process of relating to it		X			X	Something new and appealing due to love for music			X	
Community activities more accessible. Greater confidence in socialising.	X	X		X	X	Motivation to play more at home when needing to process difficult feelings			X	
Link with previous musical experiences: reconnection and building a musical self	X	X	X			Wanting to learn an instrument		X		
Music always felt inaccessible in the past					X					
Enjoyed or valued the carol singing	X		X	X	X					
Emotional resonance with pre-composed songs	X									
Sense of enlightenment and self-help				X						
Balance in the frame and therapist management (frame GVI)	**X**	**X**	**X**	**X**	**X**	**Sharing the space and therapist management (frame GMT)**	**X**		**X**	**X**
Variety of activities		X		X		Sense of balance in the frame (i.e. more talking towards the end)			X	
Balance between talking and singing	X	X	X			Therapist's soft authority: difficult things were contained, focused.	X			
No pressure to achieve. Felt in control.	X		X		X	Insightful therapist capable to manage the group			X	X
It was safe			X		X					
Easy and accessible	X	X			X					
Therapist playing piano felt as calming and trustful			X							
Importance of musical quality	X									
Well managed and controlled process	X									
Difficulty around the technique (GVI)	**X**	**X**	**X**	**X**	**X**	**Difficulty around the technique (GMT)**	**X**	**X**		**X**
Singing as mimicking, sense of copying rather than finding own range.			X			Doing the singing (in the assessment) was mortifying		X		
Wondering about own talent. Expectation of 'getting voice back'.		X	X		X	Limiting expressiveness in the instruments		X		
Singing felt chaotic, 'didn't know where to go'. Difficult following different people.			X		X	Uncomfortable to share the poem		X		
Improvisation and songwriting not very helpful: less involvement in improvisation	X					Feeling exposed and embarrassed when therapist commented on individual playing				X
Difficulty with the non-verbal free improvisation				X		Positive challenge when playing on one's own, but it got better				X
Sensory overload: too loud and too much light.			X			Wanting more instruments			X	
Need for longer sessions				X	X	It would be good to have more information about MT at the beginning	X			
Would have liked more technique and tuition		X				Some people were too dominant		X		
Too much talking at times				X						
Feeling exposed			X							