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COMMUNITY MUSIC AND INTERPERSONAL FUNCTIONING, AMONGST PEOPLE WITH COMPLEX MENTAL HEALTH NEEDS

SECTION A:
How does participation in group music interventions impact the interpersonal functioning of those with complex mental health needs living in the community?
(An empirical review)
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SECTION B:
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Department of Applied Psychology

CANTERBURY CHRIST CHURCH UNIVERSITY

DECLARATION FOR MAJOR RESEARCH PROJECT

Candidate name Deanna L. Hall……

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed …….....**.....** (candidate)

Date .....

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed ..... (candidate)

Date .....

Signed ..... (supervisor)

Date .....

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be made available to external internet users through the CCCU institutional repository and the British Library EThOS service, and for the title and abstract to be made available to outside organisations.

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SUMMARY OF MRP PORTFOLIO

Section A is a critical review of empirical literature pertinent to the impact of community music projects on the interpersonal functioning of those with complex mental health needs living in the community. An overview of the evidence concerning the interpersonal impact of arts and music in community mental health is presented. Five studies which evaluated how community music project participation impacted interpersonal functioning amongst people with complex mental health needs, living in the community is synthesised and critically assessed. The reported findings of these studies were also considered in light of attachment and cognitive theories pertaining to interpersonal function. Implications for future research and clinical practice are discussed.

Section B presents a qualitative study exploring the interpersonal experiences of ten outpatients with complex mental health needs participating in a community music project. Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) was utilised in analysing participant's accounts, which were gathered from semi-structured interviews. The interpersonal experiences of participants were conceptualised as 6 master themes. These themes are discussed in relation to existing literature. Clinical implications for assessment, formulation, and intervention planning, concerning clients with complex mental health needs are highlighted. Further longitudinal, qualitative research in this area is recommended.

Section C involves a critical appraisal of the qualitative study presented in section B. Reflections and discussions concerning acquired research skills, changes that could have been made to the study, and clinical and research implications are presented.

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SECTION B

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SECTION A

How does participation in community music projects impact the interpersonal functioning of those with complex mental health needs living in the community?
(An empirical review)

Word count:

5497 (plus 330 additional words)

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Abstract

This review evaluates empirical literature concerning the impact of community music projects participation on the interpersonal functioning of people with complex mental health needs (PWCMHN) living in the community. Key concepts are defined and psychological models that provide insights into the development, maintenance and impact of interpersonal dysfunction amongst this client group are discussed. An overview of the evidence base for the interpersonal impact of the arts and music in community mental health is provided. A synthesis and critique of empirical literature examining the interpersonal impact of music group participation among PWCMHN in the community involved five studies. The literature involved evaluations of community music projects producing anecdotal and quantitative data.

Literature was considered in light of psychological models and identified limitations in the evidence base. Findings suggested that music group participation benefited the interpersonal functioning and social inclusion of PWCMHN living in the community. However, gaps in understanding how musical activity and interpersonal experience contribute to the benefits reported. The evidence base involves a paucity of research, methodological limitations and a lack of qualitative studies. Research concerning how PWCMHN living in the community, experience interpersonal functioning within community music groups is required.

Introduction

People with complex mental health needs (PWCMHN) require support from several services to manage multiple chronic mental health and social problems (Rankin & Regan, 2004). The incidence of complex need is impossible to determine due to the nature of complex needs; multiple health and social problems may not be constant over time (Rankin & Regan, 2004). Furthermore, the incidence of multi-agency has not been adequately recorded (Keene, 2001).

The Royal College of Psychiatrists (RCP), (2005) identify those with chronic psychosis, as the largest group of people with complex mental health needs. This is largely due to the high levels of comorbidity and multi-agency support required by these clients. The incidence of psychosis in the UK is estimated to be 4.1 (per 1000) (Kirkbride et al., (2011). Studies suggest up to 60% of those with psychotic disorders also have PD (Casey, 2000).

PWCMHN are often treated in the community but experience poor interpersonal functioning, which exacerbate their mental health difficulties (RCP, 2005; Perkins & Repper, 1996). Several studies indicate musical interventions improve interpersonal funct0ioning and psychological well-being amongst the general population and some patient groups (Mössler, Chen, Heldal, Gold, 2011). Accordingly, musical group activities are often provided in the community for individuals with mental health needs (Clift & Morrison, 2011). However, it is unclear how these interventions impact the interpersonal functioning of PWCMHN. The present paper aimed to review pertinent empirical evidence concerning the impact of music group interventions on the interpersonal functioning of PWCMHN living in the community. Research and clinical implications of the review will also be identified.

The review begins with an introduction to the concept of complex mental health needs and its relation to interpersonal difficulties. A critique of psychological theories concerning the origins and impact of interpersonal difficulties amongst PWCMHN will follow. An overview of the evidence base for the interpersonal impact of the arts and music in

community mental health will preface a critique of studies concerning the impact of music groups on the interpersonal functioning of PWCMHN living in the community. A discussion of clinical and research implications will follow.

Complex mental health needs

PWCMHN have severe mental health problems which are chronic, interlocking, and multiple, spanning health and social difficulties. They often require long-term support from several services (Rankin & Regan, 2004; RCP, 2005). The RCP (2005) identified the largest group of adults with complex mental health needs as "those with treatment-resistant psychotic illnesses who require high degrees of support […] for these patients, co-morbidity […] is more often the norm than the exception." (p.6). This group of clients will conceptualise the term complex mental health needs for this review.

Complex mental health and social exclusion

Social exclusion refers to non-participation in social, economic and cultural areas of life due to constraint as opposed to choice (RCP, 2009). Social exclusion is common amongst PWCMHN (RCP, 2009). Although PWCMHN can be treated in the community, unemployment, discrimination, stigmatisation and loss of social status may impede social recovery, exacerbating their mental health problems (Perkins & Repper, 1986; RCP, 2009).

PWCMHN experience poor social networks involving unsupportive or unhelpful relationships (Buchanan, 1995). These network characteristics suggest impairments in interpersonal functioning (any process occurring between two or more individuals, Forchuk, Jewell, Schofield, Sircelj & Valledor, 1998) may cause social exclusion amongst these clients (Clifton, Turkheimer, & Oltmanns, 2009).

The social inclusion of people is often understood in line with social capital concepts. Although definitions of social capital differ they focus on the productive benefits of social relations. Putnam (1995) defined social capital as "features of social organization […] that facilitate coordination and cooperation for mutual benefit" p. 67). He conceptualised social capital, as consisting of bridging capital (connections with people from different communities) and bonding capital (connections with people who share your community) (Putnam, 2000).

Psychosis-personality disorder (PD) comorbidity in complex mental health

The term psychosis denotes a disorder of the mind. Impairments in reality testing manifest as hallucinations, delusions, disorganised speech or catatonic behaviour (Shahrokh & Hales, 2003).

Drug use, genetics, and stressful major life events have been identified as psychosis vulnerability factors (The Sainsbury Centre for Mental Health, [SCMH], 2003). Migration and parental unemployment are among the indicators of social exclusion and are associated with increased vulnerability to the disorder (Cantor-Grae & Shelton, 2005; Wicks, Hjern, Gunnell, Lewis, & Daman, 2000).

Psychosis forms part of various diagnoses including schizophrenia, schizophreniform disorder, schizoaffective disorder, brief psychotic disorder, and delusional disorder. It can also be seen in other disorders including major depressive disorder, post-traumatic stress disorder, PD, and bipolar disorder (American Psychiatric Association [APA], 2000; Cardinal & Bullmore, 2011).

In response to a lack of specificity between psychotic disorders, theorists have suggested psychotic experiences occur on a continuum (Esterberg & Compton, 2009; Strauss, 1969) as opposed to a categorical pathological state. Medication, early intervention, art

therapy, cognitive behavioural therapy (CBT) and family therapy are current treatment options (National Institute for Health and Clinical Excellence [NICE], 2011).

PD is characterised by rigid or maladaptive, personality traits, leading to functional impairment (e.g. social or occupational) or internal distress (APA, 2000). Clinicians often experience difficulty diagnosing PD, due to an overlap of PD symptoms with other pathology (Rowosky & Gurian, 1992). Also, diagnostic items often reflect indifferent social contexts rather than PD pathology (e.g. avoids occupational activities, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, 2000).

Individuals with PD comorbidity often receive only the co-morbid diagnosis (e.g. psychosis), unless PD is deemed directly responsible for their presentation (e.g. self-harm, Zimmerman, 1994). PD comorbidity is associated with non-engagement in psychotherapeutic treatments, illness chronicity and poor treatment response (Vine & Steingart, 1994; Fiorot, Boswell & Murray, 1990; Bailey, 1998). Those with comorbid PD also experience poorer social functioning than those with single mental state disorders (Tyrer & Seivewright, 2000; Tyrer & Simmonds, 2003). Studies estimate the incidence of psychosis in the UK is estimated to be 4.1 (per 1000) (Kirkbride et al., (2011) and suggest up to 60% of those with psychotic disorders also have PD (Casey, 2000).

It is impossible to determine the prevalence of complex mental health needs in the UK due to inadequate recording of the incidence of multiple health and social care service use (Keene, 2001). Furthermore the relationship between multiple service use and personal circumstances results in changes in the level of need people require over time (Rankin & Regan, 2004). However the RCP, (2005) suggest that those with chronic psychosis-PD comorbidity often experience complex mental health needs.

Theories of interpersonal functioning and complex mental health

Whilst difficulties in psychosocial functioning are well documented amongst PWCMHN (Sayce, 2001) and are fundamental to the conceptualisation of PD (Skodol et al., 2002), recognition of the role of interpersonal functioning in psychosis is a recent development (Read, van Os, Morrison, & Ross, 2005). Several psychological theories provide frameworks by which the development and impact of the interpersonal difficulties associated with PD and psychosis can be understood. Some of these concepts are reviewed below.

Cognitive theory

Cognitive theorist Aaron Beck (1991) proposed in response to the automatic perceiving, recalling, interpreting and storing of information from the environment, humans elicit cognitions, emotions and behaviours. Garety, Kuipers, Fowler, Freeman and Bebbington, (2001), proposed a cognitive model of positive psychotic symptoms. They suggested biopsychosocial vulnerability predisposes an individual to misinterpret cognitive disturbances and anomalous experiences as being external in origin.

The model also proposed that individuals with psychosis may have formed negative beliefs about others and the self, (e.g. "others are untrustworthy") due to difficulties in early interpersonal experience (e.g. trauma/abuse). These beliefs are associated with emotional distress and influence appraisal processes and information gathering styles. Resultantly, difficulties in understanding the intentions of others and social situations develop, which negatively impact an individual's interpersonal functioning.

Pretzer and Beck (2005) suggest interpersonal dysfunction associated with PD comorbidity may develop through interactions with parents and socio-cultural environments. The response of others to a child's behaviour reinforces their "interpersonal strategies" (p.70), which holds information about how to respond during interpersonal activity. If

dysfunctional interpersonal behaviours or conflicting interpersonal strategies are reinforced, dysfunctional beliefs and assumptions may develop. Consequently, "misperceptions and misinterpretations" of the behaviours of others occur, leading to the difficult emotions and maladaptive interpersonal behaviours seen in PD (Pretzer & Beck, 2005, p.51). These behaviours may elicit bad treatment from others confirming the individual's dysfunctional beliefs and maintaining interpersonal difficulties (Beck, et al., 2003).

There is an extensive amount of empirical evidence supporting Beck and Pretzer, (2005) and Garety et al., (2001). Traumas/negative interpersonal events and negative beliefs and cognitions about the self and others have been associated with psychotic symptoms and PD (Read, Van Os, Morrison & Ross 2005; Paris, 1995). However, the theories do not acknowledge motivational systems that influence human interpersonal interactions, ensuring care and protection, such as attachment (Gilbert, 2009).

Attachment theory

Attachment theory proposes people need to form close bonds with others (attachment) and that attachment behaviours are utilised in modulating interpersonal distress in childhood and adulthood (Bowlby, 1953, 1969, 1980). Bowlby posited "internal working models" (internal representations of the self and others in relationships) influence interpersonal behaviours and methods of regulating interpersonal distress. Models are informed by early interpersonal experience with a significant other. Sensitive, responsive caregivers, nurture a secure attachment style, characterised by a capacity to manage distress, positive self-image, and comfort with autonomy in forming relationships (Berry, Barrowclough & Wearden, 2008). Contrastingly, unresponsive, insensitive caregivers nurture insecure attachment styles characterised by an escalation of distress to encourage others to meet needs (insecure-anxious

or ambivalent attachment) or relationship avoidance, and low affect levels (insecure-avoidant attachment) (Shaver & Mikulincer, 2002).

Attachment theory has conceptualised the interpersonal difficulties seen in psychosis as adaptive insecure attachment strategies, developed in response to previous interpersonal experience (Dozier, Stovall, & Albus, 1999). Avoidant attachment styles are hypothesised to be a predictor of the paranoia and interpersonal distrust seen in psychosis (Freeman, Garety, Kuipers, Fowler, & Bebbington, 2002).

Bateman and Fonagy (2004), offer a mentalisation (the understanding and knowledge of the mental states of the self and others) based theory of PD, which draws on Bowlby's attachment theory. They proposed insecure attachments involve inconsistent emotional interactions between caregiver and child. Individuals with PD experience caregivers as inefficient in understanding their experience because reflecting or mirroring of understanding back to the child is done poorly. Later interpersonal experiences involve difficulties understanding the feelings and motivations of others as well as their own. Consequently, the ability to recognise and cope with strong emotions is underdeveloped.

Insecure attachment strategies have been associated with psychosocial dysfunction in schizophrenia and PD samples (Dozier et al., 1991; Dozier, 1990). Empirical studies highlight the role of trauma and negative interpersonal experience in psychosis (Read, Van Os, Morrison & Ross 2005). However, attachment theories do not acknowledge cultural and class influences on attachment (Bifulco et al., 2004) or the role of genetically/biologically based differences, (e.g. temperament) in interpersonal development (Raby et al., 2012). Furthermore, childhood relationships with significant others are emphasised (Bowlby, 1980), disregarding the possible impact of peer/sibling relationships and adolescence/adulthood attachments on internal working models (Field, 1996; Harris, 1998).

Community Psychology

A major tenet of community psychology holds that a person's functioning and health can be understood through their social contexts (Orford, 2008). Empowerment has held a prominent position in the field. Definitions of the term stress the obtaining of control, mastery, influence or power. Community psychology recognises that socio-economic arrangements of power are related to psychological distress and adversity (Goldberg & Huxley, 1992). Accordingly, those with little power (e.g. poverty with lower socioeconomic status and deprivation), experience negative effects on their health and increasing an individual's power and control has positive effects (Orford, 2008). Hagan and Smail (1997) identified social life and other proximal terrains as power resources available to an individual (figure 1) stating, "the ability to involve and influence others to obtain solidarity with them in the achievement of desired goals is definitive of power" (p. 263). They also identified subdomains which make-up each terrain and highlighted that an individual's ability to exercise control over power resources would impact their ability to effectively deal with circumstances.

However, Hagan and Smail's (1997) proximal terrains do not allow for an individual's agency. It is important to note that a person is not just a mere "cipher of social sources" (Fryer 1998, p.81). Clinical community psychologist Fryer (1994) proposed that a person chooses to engage in "self-selected, goal directed behaviour" (p. 12) and it is the psychologist's role to promote an individual's ability to modify disadvantageous social circumstances. As PWCMHN hold a vulnerable and marginalised position within society, it seems interventions aimed at enabling individuals to improve their social functioning may contribute to the empowerment of this group.

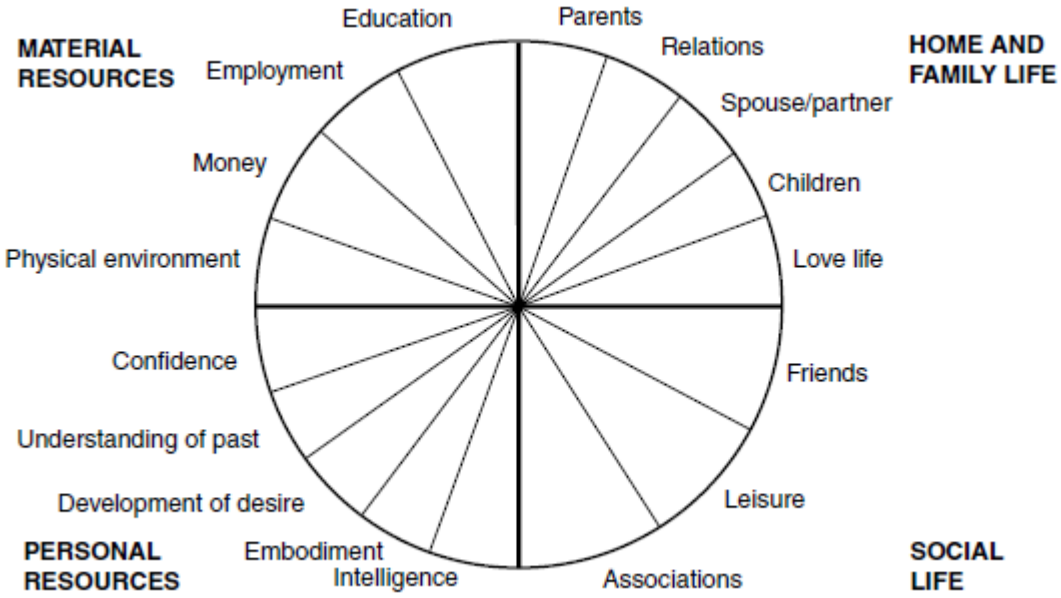

Figure 1. Proximal Terrains of Power (adapted from p.262). Adapted from "Power-mapping–1. Background and basic methodology", by T. Hagan & D. Smail 1997, Journal of community and applied social psychology, 7, p. 267. Copyright 1997 by John Wiley & Sons Ltd.

An overview of the evidence base for the interpersonal impact of the arts and music in community mental health

The arts and interpersonal functioning in community mental health

A number of reviews have summarised the evidence concerning the impact of participation in the arts (drawing, writing, music, photography) on those with mental health problems (Angus, 2002; White, 2003; Staricoff, 2004) and reported several benefits including increased communication with others, improved mental well-being, independence and self-esteem.

Community art projects provide art based group activities to those living in the community (Angus, 2002; Heenan, 2006). Community music projects are one type of community art project, providing group music based activities in largely two forms. "Music projects" do not

require established psychotherapeutic techniques, whilst "Community music therapy" is provided by trained music therapists utilising established psychotherapeutic techniques (Odell-Miller, 1995).

Policy statements and related governmental reviews have highlighted the potential for community art projects to improve social inclusion amongst those with mental health problems (Social Exclusion Unit (SEU), 2004). Significant improvements in social inclusion were found amongst 68 service users with various mental health difficulties following 6 months community art project attendance (involving music activities but drawing and painting activities were dominant) (Hacking, Secker, Spandler, Kent & Shenton, 2008). Art projects have also been shown to facilitate personal, social and occupational opportunities for participants amongst mental health service-users (Stickley, 2010).

In response to these findings, community art projects for the mentally ill have increased in number (Art Council England, 2007). Early studies of art groups and their contribution to reducing social exclusion amongst the mentally ill often ignored aspects of diversity (ethnicity, age, class and gender) that are related to decreased social capital (Kagan, Sixsmith, Siddiquee, Bol & Lawthom, 2005). Descriptive outcomes with little use of solid and rigorous qualitative analysis were offered (Angus, 2002). A review of the evidence base for community based arts participation in health (White, 2003) highlighted that practitioners seeking to evaluate the activity of community art projects often fail to state clear aims for projects. This leads to the use inappropriate methods to evaluate activity (e.g. using quantitative methods when qualitative methods are more appropriate). Subsequent studies have involved critical consideration of methodologies whilst also contributing to the evidence base (Kagan, et al., 2005; Clift, et al., 2009).

The psychology of community based music and interpersonal functioning

Laiho (2009) reviewed literature on music participation and theorised group music activities promote interpersonal functioning in nonclinical populations through emotional reflection, identity development and development of relationship skills. These factors are also key aspects of psychological theories of interpersonal functioning in personality disorder and psychosis.

Studies indicate that people often participate in musical activities for emotional benefits such as enjoyment (Lull, 1987). In a survey of choral singers in the UK, Germany & Australia, Clift & Hancox (2010) reported that singing made singers feel happier and improved their mood. Empirical research has illustrated that music participation allows individuals to reflect on feelings, making them conscious to the self (Laiho, 2002). Denora (1999) completed interviews with 52 women on their music consumption and related reflective practice. Music consumption facilitated acknowledging and inducing emotions, and reviewing autobiographical self-experience. These aspects of music consumption may enable emotional regulation development (Ahonen, 1993).

Music participation may allow individuals to consolidate their identity, strengthening their self-image and validating their emotions (Laiho, 2009). North, Hargreaves & Neill, (2000) requested 2465 adolescents to rate their agreement with 12 statements concerning why they listened to music. Items referring to "pleasing people", "being trendy/cool" and "creating an image" (p.263) received the highest agreement ratings. This finding was not significant but may suggest music allowed the adolescents to portray an image to the outside world.

Laiho, (2009) proposed music activities can provide a way of getting attention, approval and topics for conversations encouraging social interaction. Extensive social interaction and trust in others as well as the self is required in group music-making

(Galleway, 1986). In a systematic review of empirical research concerning group singing Clift, Nicol, Raisbeck, Whitmore, & Morisson (2010) reported an increase in social behaviours. Music participation has also been shown to facilitate acceptance and cohesion within groups (Christenson & Roberts, 1998). An increased sense of community was found amongst social workers who participated in group drumming activity (Mashi, Macmillian & Viola, 2012).

The group format may be a key factor in how music groups facilitate interpersonal functioning. Group psychotherapeutic interventions have shown efficacy in treating disorders characterised by interpersonal dysfunction (borderline personality disorder) and is a recommended treatment (NICE, 2009). Wells (1990) hypothesised that groups provide clients with opportunities to learn, practice flexible behaviours and be gracious in acknowledging mistakes. However, group interventions have been shown to involve greater drop-out rates and less efficacy than individual interventions (Cuijpers, van Straten & Warmerdam, 2008). Wells (1990) suggests that PD shame based identities may be sensitive to judgemental attitudes from other group members and responses to judgements may be magnified.

Music, interpersonal functioning and community mental health

It has long been substantiated that music can be used to induce mood states (Smith & Morris, 1976) leading researchers to investigate the efficacy of music as a therapeutic tool, especially for those who are unresponsive to verbal psychotherapeutic interventions (Gold, Solli, Krüger & Lie, 2009). Participation in "music projects" has been related to improvements in social networks and group cohesion amongst traumatised and marginalised groups living in the community (sex workers and homeless men), (Bailey and Davidson, 2002; Venkit Godse & Godse, 2012).

Relatively few studies have examined the effects of music projects in community mental health; the studies that exist consistently suggest reductions in marginalisation can be gained from these activities (Coffman, 2002; Clift et al., 2008, 2010). For example, Winkelman, (2003), reviewed literature on substance abuse drumming circles in both residential and community settings. He concluded that among other benefits drumming participation alleviated isolation, and created a sense of self-connectedness. In the only study on the effects of group singing on service users with severe and enduring mental health issues, social benefits, including meeting more people and feeling a sense of social acceptance, were identified (Clift & Morrison, 2011).

Several reviews have indicated that music therapy has a positive effect on the social functioning of those with various mental health problems (Gold, Voracek, & Wigram, 2004; Gold, Wigram, & Elefant, 2006). Two reviews have evaluated the effect of music therapy specifically on clients with psychosis and serious mental health disorders (Mössler, Chen, Heldal, Gold, 2011; Gold, Solli, Krüger, Lie, 2009). The reviews identified 15 studies of group interventions between them. Music therapy significantly improved interpersonal functioning in studies which involved the highest numbers of sessions. However, the studies reviewed were all quantitative and utilised music therapy interventions. Inpatient samples were predominant with varying diagnoses and chronicity.

A critique of empirical literature concerning the impact of group music interventions on interpersonal functioning amongst PWCMHN living in the community

Rationale and objectives

PWCMHN (chronic psychosis and possible comorbidity: RCP, 2009) experience difficulties in interpersonal functioning, which contribute to an exacerbation of their mental health

problems and social exclusion. Theorists suggest difficult interpersonal experiences inform understanding of interpersonal interaction, influencing the behaviours, which contribute to interpersonal dysfunction. Whilst empirical research suggests group music interventions may improve interpersonal functioning amongst those with mental health difficulties, few studies have included PWCMHN living in the community. The current review aims to evaluate the empirical evidence concerning the impact of music group interventions on the interpersonal functioning of PWCMHN living in the community. The implications of the review will also be considered.

Methodology

Cochrane Database of Systematic Reviews (2005 – Feb 2013), Ovid Medline (1946- Feb 2013), PsychINFO (1806-Feb 2013) and Google Scholar databases were searched for derivatives and synonyms of the terms "Music", "Community", "Psychosis" and "interpersonal", in the title, abstract or keywords. Articles were excluded if they were not peer reviewed or not written in English. Articles which involved outpatients with complex mental health needs (treatment resistant or chronic psychosis RCP, 2009), music interventions and an evaluation of interpersonal function were included (Appendix 1).

Review

Five articles met the inclusion criteria (Appendix 2). None of the articles utilised qualitative analysis methods. Two studies presented anecdotal evidence, which were included because of the paucity of research in this area. Three articles involved quantitative analysis (1 randomised controlled trial and two repeated measures design).

The quantitative studies were critically appraised in line with the systematic method of evaluating quantitative studies presented by Papworth and Milne (2001) (Appendix 3).

Anecdotal studies which presented data in qualitative form (quotes) were critically appraised in line with Yardley's (2000) criteria for evaluating the validity of qualitative research (Appendix 3).

The articles are synthesised below according to the type of community music project employed. Firstly, three studies that evaluated "community music therapy" interventions will be followed by reviews of two studies involving "music projects".

Community music therapy

Using a repeated measures design Troice and Sosia (2003) examined the perceived usefulness of music participation amongst 15 adult outpatients diagnosed with chronic schizophrenia in Mexico. Participants attended an average of 35.8 music therapy sessions involving improvisational music-making and were facilitated by a music therapist, (although therapeutic issues were not verbally facilitated by the therapist). Participants completed questionnaires designed by the authors before and after treatment. Fifty-three percent indicated that working with music had helped them in relating to peers before treatment. This rating increased non-significantly to 60% at the end of treatment. Another high rating factor was to have fun (53.3% before, 80% after). The author concluded participants perceived relating to others to be a substantial achievement associated with sessions.

This study utilised a convenience sampling method, increasing the possibility of bias in the sample. As no control group was recruited, it is also difficult to establish if the perceived achievement in relating to social peers participants reported occurred due to time or medication. The collection of follow up data would have clarified whether the findings were maintained once the intervention ended.

The questionnaire participants completed involved a limited number of options from which to indicate what they felt they achieved. Furthermore, the measure was unstandardized

and its validity and reliability were not established. Cognitive difficulties are a characteristic of psychosis requiring clear introduction to measures. No information concerning how the unvalidated self-report measure was administered or introduced to clients was provided. However, the author made conservative conclusions, not inflating the impact of their results.

Odell-Miller (1995) reported a survey of benefits obtained from group music therapy attendance for 10 outpatients with long-term chronic mental health problems in the UK. Three of the participants had a chronic psychotic disorder. The music therapy group was facilitated by a music therapist and involved improvised music-making.

The author reported the views of therapists and the team providing treatment. Reports stated participants benefited from music therapy by gaining self-confidence and security, insights into their effects on others, made relationships and became more integrated Participants with chronic psychosis had attended the group from 5 months to 3 years, either once or twice a week.

The author concluded that music therapy provided a good long-term therapy for people with chronic mental health difficulties, enabling them to leave old patterns of relating behind and facilitating community living. However, this study seems to have been designed with a focus on finding outcomes illustrating the effectiveness of the group.

The sample may have been unrepresentative and biased as the author selected participants who illustrated the "most common reason for referral to the service". Similarly, the therapists and team members were asked to state the benefits of treatment only. No negatives were presented. The possible vested interests or bias related to the views expressed were not considered. Although some short quotes were provided no qualitative analysis was applied.

Despite these weaknesses the author did not over inflate the generalizability of the findings. A clear theoretical underpinning for community music therapy was presented however, no theory linking the intervention and the interpersonal functioning findings were reported. The study did illustrate that music therapy is able to engage clients with complex mental health needs for long periods of time. This is an important contribution as non-engagement in services is a well-documented characteristic of complex mental health problems (Rankin & Regan, 2004).

de l' Etioile (2002) used a repeated measures design to examine the effects of a short term music therapy group for 8 adults with chronic psychosis living in the community within the USA. Diagnosis included bipolar disorder, schizophrenia, and schizophrenia with comorbid substance abuse. One hour sessions of music therapy occurred once a week for 6 weeks. They involved group singing, listening to music, song writing, improvisational music-making and facilitated reflection on music experience, emotions and behaviour. Participants completed a self-report measure of "curative factors" developed by the authors, before and after treatment. Ratings of 8 out of 10 curative factors increased non-significantly after treatment. Ratings of factors concerning interpersonal functioning (cohesion - feeling a sense of belonging, alturism – learning that one can be helpful to others, and interpersonal learning - learning from attempts to relate to others) increased non-significantly.

Unfortunately, this study involved a short intervention, which may have been insufficient for the development of curative factors. Furthermore the small sample size (8) may have contributed to variability in scores and only enough power to detect large effect sizes. A non-standardized measure was used with no tests of reliability or validity completed. Again follow-up data and a control group were not utilised by the author. However, a clear

description of the intervention employed was presented, enabling reproducibility of these findings in future research.

Studies of community music therapy interventions suggest PWCMHN can engage in this form of music therapy for long periods of time. They may develop the ability to relate to others through the gaining of self-confidence and learning from interpersonal experiences gained during group participation. A sense of belonging and insights into their effects on others may also occur. However, the studies employed non-validated and biased data collection techniques suggesting the findings are unreliable. Also, little understanding of the nature of the interpersonal experience gained and how it may facilitate the benefits cited are offered.

Music projects

Leung, Lee, Cheung, Kwong, Wing, Kan and Lau (1998) completed a double blind controlled trial of the effect of Karaoke singing compared to simple singing in China. Eight male participants diagnosed with chronic schizophrenia who attended a psychiatric rehabilitation centre, were "chosen" and randomly assigned to a karaoke (practised karaoke) or a non-karaoke (simple singing) group. Groups were matched in age, sex and duration of illness. Both groups were facilitated by an occupational therapist. Participants attended 45 minute sessions twice a week, for 6 weeks and completed performances for other clients.

Pre and post intervention measures of social interaction included the Interaction Anxiousness Scale (IAS; Leary, 1993) and the Nurse Observation Scale for Inpatients modified for day patients (modified NOSIE; Honigfeld, Gillis, Klett, 1965). A non-significant increase within groups occurred across all scales. However, in week 6 the karaoke group scored significantly higher than the simple singing group on the "starts up a conversation" with others section of the modified NOSIE. The authors concluded that

karaoke is better than simple singing in improving social interaction amongst those with chronic schizophrenia. The study's findings suggest participation in singing interventions improve social interaction.

This is a well-designed study with several strengths. The use of a control group limited the number of alternate explanations of results. The experimental groups were also randomly allocated reducing bias. This was the only study to report details of the medication participants were prescribed during the study. This is of importance in intervention trials as neuroleptics may reduce the negative symptoms exhibited by those diagnosed with schizophrenia, impacting social function. Weaknesses include a lack of clarity concerning the recruitment of participants (participants were "chosen" by the authors), a small sample size, and the use of self-report rating scales which have doubtful validity for the culture in which they were used. However, the small sample size and short intervention duration (6 weeks) suggest the study's significant findings may be noteworthy.

Longhofer and Floersch (1993) described an African drumming program involving drumming singing and dancing for those with severe and chronic mental health problems in America. Forty-five clients of a community mental health centre attended at least once. Participants were diagnosed with schizophrenia, and manic depression, one participant had a multiple personality disorder diagnosis. The sample included a near 50:50 ratio of African-Americans and Hispanics to European-Americans. No other demographics were provided. Ten clients attended consistently once a week over 6 months. An anthropologist, a social worker, and two professional musicians facilitated sessions.

Sessions involved discussing cultural aspects of the music and ideas for future performances. New arrangements were taught, practised and then performed. The authors reported group experiences enhanced interpersonal skills and facilitated a sense of

community. Music performance improved confidence and enabled bridging capital development.

This article seemed to be concerned with illustrating the efficacy of the program provided. Although sociocultural factors associated to the intervention was presented the article lacked objectivity as the data and conclusions were drawn from the author. Little information was provided about participants (e.g. duration of illness, prevalence of diagnoses within the sample), limiting the extent conclusions could be made concerning PWCMHN and the impact of the intervention. Strengths of this study include the thorough and clear description of the intervention, enabling reproducibility in the future. This was also the only study reviewed that included a diverse sample suggesting cross-cultural generalizability for its findings.

The findings of the studies evaluating music projects suggest improvements in interpersonal functioning and bridging capital result from music project participation. These findings were found in multi-cultural samples suggesting music projects have cross cultural efficacy. However, several of the limitations seen amongst the studies involving community music therapy are relevant here. Non-validated and biased data collection techniques and a lack of service user perspective limit the reliability of the findings reported. The studies make little contribution to understanding how the benefits reported are obtained. Furthermore, the paucity of research in this area requires only conservative generalisations to be drawn.

Clinical and Research Implications

The findings of the studies reviewed suggest PWCMHN living in the community experience improved interpersonal functioning in response to music intervention. This has also been observed amongst inpatients with less complex mental health problems (Gold, Voracek, & Wigram, 2004; Clift & Morrison, 2011).

Several clinical implications are identified from this review. Improvements in interpersonal functioning were seen regardless of type community music project intervention employed or length of participation. However, bridging capital development was reported to occur in response to music project participation but was not reported in response to community music therapy. Bridging capital seemed to occur in response to musical skill development and performance opportunities, and is often viewed by authors as likely to promote social inclusion (Hacking, Secker, Kent, Shenton, Spandler, 2006). These musical activities may make important contributions to interventions aimed at improving social inclusion. Music projects also showed cross cultural benefits. This is important as BME groups experience increased prevalence of psychosis (Castle, Wesseley, & Der, 1991).

When provided with interpersonal experiences via community music projects, interpersonal functioning amongst PWCMHN improved and a sense of belonging developed. The interpersonal difficulties seen amongst PWCMHN may be associated with a lack of opportunities to gain interpersonal experience. The British Psychological Society (1995) stated clinical psychologists should acknowledge social influences in the expression of psychological difficulties and mental health recovery. Accordingly, interpersonal experience should be considered in client assessment and intervention rationales. This is highly applicable when working with clients in the community. Community psychology aims to promote the ability of clients to change disadvantageous social contexts such as social inclusion (Fryer, 1994).

Mental health professionals should acknowledge that due to the limited social networks of PWCMHN their interactions with these clients may provide one of limited opportunities for interpersonal skill development (Adshed, 1998). Contacts should be undertaken with consideration of this issue. On a structural level clinical psychologists should

acknowledge that music groups make a contribution to the recovery process and support their provision.

Research implications should not be considered without acknowledging that the evaluation of community art groups in mental health has well documented difficulties. These difficulties were observed in the studies reviewed (e.g. use of inappropriate research methodology and non-standardised assessment tools [White, 2003; Angus, 2002]). The impact of these difficulties on the reliability of findings, may be exacerbated by characteristics of the clients, such as comorbidities (undiagnosed or not) (Aldridge, 1994).

There are several options for future research as the evidence base is developed including addressing the methodological limitations highlighted above. The extent to which music participation contributed to improvements is not clear. Would the same improvements occur if participants had attended another type of group? Research clarifying the processes by which music group participation may impact interpersonal functioning should be considered. None of the studies considered theoretical concepts related to interpersonal functioning, which may have informed their understanding of findings.

Qualitative research utilising rigorous analysis techniques should also be employed. These techniques may provide insights into how group music activities facilitate the benefits reported. Focusing only on the effects of music groups lends to a "black box" conceptualisation of the intervention when evidence reviewed suggests music groups do more than one thing (Campbell et al., 2000). Furthermore, given the variability of interpersonal experience seen amongst PWCMHN (Aldridge, 1994; RCP, 2009), responses to the music group interpersonal process amongst this client group may be individual in nature.

The results of the present review emphasise the importance of the interpersonal experiences in influencing interpersonal functioning amongst PWCMHN. This is also the case within pertinent psychological theories (Bowlby 1980; Garety et al., 2001). Qualitative

methods would enable the in-depth examination of the experience of interpersonal functioning within community music groups. Insights into the role of "music" in interpersonal interactions, and the impact of musical skill development on bridging capital would be gained. Understanding these experiences and the mechanisms underpinning them may aid the clinical efficacy of community music projects and accordingly the empowerment of PWCMHN (Noordsy, Torrey, Mueser, Mead, O'Keefe & Fox, 2002; Orford 2008).

Limitations of the review

The reliability of the review is limited as the studies included are of poor quality. Qualitative analysis methodologies were not employed, data collection often involved non-validated questionnaires and biased sampling techniques were often used with the "agenda" of researchers seeming to underpin research objectives. These limitations reduce the generalizability of the review which is already limited, due to a lack of UK research and studies involving participants who do not reflect the ethnic and class diversity associated with mental illness in the UK (Kagan et al., 2005).

Conclusions

Empirical research suggests that PWCMHN living in the community experience improvements in interpersonal functioning in response to music group participation. However, the evidence is questionable due to methodological limitations, poor generalizability and a paucity of research. Accordingly useful conclusions cannot be made from this review. More research is required which attempts to address these limitations. Closer attention to individual interpersonal experience in music group participation may inform music groups and clinical practice aimed at improving interpersonal functioning and social inclusion amongst PWCMHN.

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SECTION B

The interpersonal experience of those with complex mental health needs participating in a community music project: An interpretative phenomenological analysis (IPA)

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Abstract

Background: Although participation in community music projects (CMP) has been associated with improved interpersonal function amongst clinical and non-clinical populations their effects on outpatients with complex mental health needs are not clearly understood.

Aims: The current study aimed to explore how outpatients with complex mental health need experience, perceive, understand and respond to interpersonal interactions whilst participating in a CMP.

Method: Participants included 10 outpatients with complex mental health needs, who had attended a CMP for at least 6 months. They completed a semi-structured interview concerning interpersonal experiences and the project's impact (if any) on such experiences. Interpretative Phenomenological Analysis was utilised (Smith, Flowers, & Larkin, 2009).

Results: Interpersonal experiences of participants were conceptualised as master themes involving hope for social interaction, non-musical interpersonal experience, musical interpersonal experience, wider community experience, belonging, esteem and positive identity.

Conclusion: Interpersonal learning, bridging capital and the development of self-concept components may be experienced in relation to CMP participation. The importance of social context assessment to client formulations and interventions and the need for further longitudinal, qualitative research in this area is implicated.

Declaration of interest: None

Keywords: IPA, complex mental health, psychosis, community music, community mental health

Introduction

People with complex mental health needs experience severe and long-term needs which are multiple and interlocking. The needs of this client group require high levels of support spanning mental health and social difficulties (Royal College of Psychiatrists [RCP], 2009; Rankin & Regan, 2004).

Social exclusion is common amongst those with complex mental health needs (RCP, 2009). High levels of unemployment, discrimination and stigmatisation constrain the extent to which these clients can participate in social, economic and cultural areas of life (Sayce, 2001). Exacerbated mental health problems and impeded social recovery occur in response (Perkins & Repper, 1986; RCP, 2009).

Psychosis is characterised by impairments in reality testing which manifest as hallucinations, delusions, disorganised speech or catatonic behaviour (Shahrokh & Hales, 2003). A large proportion of adults with complex mental health needs are individuals with chronic psychosis (RCP, 2005). Comorbidities such as personality disorder (PD) are common amongst those with chronic psychosis. Personality disorders involve patterns of personality which lead to functional impairment (interpersonal or occupational) or internal distress (APA, 2000). Although rarely diagnosed in clinical settings (Zimmerman, 1994), Casey (2009) reports a rate of 60% psychosis-PD comorbidity suggesting this comorbidity is prevalent amongst people with complex mental health needs.

Attachment and cognitive theories of psychosis and PD suggest the interpersonal dysfunction associated with complex mental health needs may be related to poor interpersonal experiences (e.g. traumas, abuse, insensitive or unresponsive care and invalidation of emotions). These experiences inform a person's understanding of themselves and others in relationships, influencing their interpersonal functioning. Difficulties in grasping the emotions and intentions of others and regulating their own emotions in response

to interpersonal interactions occur (Bowlby, 1969; Bateman & Fonagy, 2004; Garety, Kuipers, Fowler, Freeman & Bebbington, 2001; Pretzer & Beck, 2005). Emotional reflection, identity development and relationship skills are identified as factors influencing the development and maintenance of interpersonal dysfunction. Empirical evidence and theorists suggest group music participation improves social functioning by facilitating the development of these factors (Blandford & Durate, 2004; Laiho, 2009). Studies have also found that participating in music activities improved social networks, alleviated isolation and facilitated a sense of social acceptance (Christenon & Roberts, 1984; Winkleman, 2003) which may also aid the social functioning of participants.

Several reviews suggest that music therapy (music interventions utilising established psychotherapeutic techniques) has a positive effect on the social functioning of samples with psychosis and serious mental health problems (Mössler, Chen, Heldal, Gold, 2011; Gold, Solli, Krüger, Lie, 2009). These reviews have largely involved inpatient samples although the deinstitutionalisation of the UK mental health system (Department of Health, 1999) has resulted in a high proportion of those with complex mental health difficulties receiving community treatment (RCP, 2005).

Community music projects (CMP) provide community based group music activities in largely two forms. Music projects, which do not require music therapists and the application of, established psychotherapeutic techniques, and community music therapy, provided by trained music therapists utilising established psychotherapeutic techniques (Odell-Miller, 1995).

CMPs have been found to improve social function and group cohesiveness amongst non-clinical populations, marginalised people, and those with severe mental health difficulties (Bailey and Davidson, 2002; Venkit Godse & Godse, 2012; Clift & Morrison, 2011). However, only five studies concerning the interpersonal efficacy of CMP amongst

people with complex mental health needs living in the community were identified by the author of the current paper.

The studies suggest participation in CMP improves interpersonal functioning in outpatients with complex mental health needs. Increased ability to interact socially and a sense of belonging were identified as outcomes (de l' Etioile, 2002; Troice & Sosa, 2003). Interpersonal experiences gained during participating in CMP, were shown to contribute to social improvements (Longhofer & Floersch, 1993; Odell-Miller, 1995). However, the nature of these experiences is unclear. Music project participation was also related to bridging social capital development (developing connections with people from different communities; Putnam, 2000), suggesting this intervention may promote social inclusion amongst people with complex mental health needs (Longhofer & Floersch, 1993; Leung, Lee, Cheung, Kwong, Wing, Kan & Lau, 1998).

The evidence base is in need of development. Studies concerning the interpersonal impact of CMP amongst outpatients with complex mental health needs focus on the effects of these interventions. It is unclear how the reported benefits are gained. The individual interpersonal process involved is mostly ignored and there tends to be poor inclusion of service user perspectives. Furthermore, quantitative studies are characterised by non-validated data collection techniques, and anecdotal studies that may present data in qualitative form do not utilise qualitative analysis techniques.

Further understanding of how music projects benefit interpersonal functioning and bridging social capital amongst this population may improve the efficacy of these interventions. Individuals may also be empowered through improvement of their social resources (Hagan and Smail, 1997; Orford, 2008). Additionally, research practices which attend to the experiences of service users, would resonate with government initiatives (Department of Health, DoH, 2011), and current research trends.

The present study

This study aims to explore how outpatients with complex mental health needs experience interpersonal functioning whilst participating in a CMP. The study aims to answer the following questions:

How do outpatients with complex mental health needs living in the community experience interpersonal functioning whilst attending a community based music project?

How do outpatients with complex mental health need understand these interpersonal experiences?

How do outpatients with complex mental health needs respond to these interpersonal experiences?

Complex needs music project

The complex needs music project was provided by an assertive outreach team (AOT), supporting those with complex mental health needs in the community. The project had begun 4 years prior to the present study. Although the majority of attendees were under the care of the AOT, the project was also open to the general public. Members met once a week and included at least 10-15 service users and 3-6 members of the general public per week.

Two community psychiatric nurses (CPNs) who were AOT staff members facilitated the weekly meetings. Accordingly, the facilitators were generally aware of the mental health history and current presentation of service users attending the project. The majority of service user attendees had been diagnosed with a psychotic disorder. The facilitators felt attendees displayed PD pathology although they had not received a PD diagnosis.

The project was held in the large rehearsal room of a music studio, no agenda or use of psychotherapeutic practices were utilised. Access to a variety of musical instruments and microphones were provided and were used to create music and song. A communal lounge

where attendees could socialise or have refreshments was also provided. The group also made trips to a recording studio where they recorded songs and had completed an album. Attendees regularly performed songs at the local town hall and community centre for the general public.

Method

Design

Semi-structured interviews were conducted with participants and then analysed using interpretative phenomenological analysis (IPA) (Smith, Flowers, & Larkin, 2009) in this qualitative study. IPA provides an idiographic and phenomenological examination of the meanings that experiences and events hold for participants (Smith & Osborn, 2007). It was chosen as the analysis method because the study aimed to explore how people with complex mental health needs experience and understand their interpersonal interactions whilst attending a community music group. Another objective of the project involved considering how the efficacy of music groups and clinical practices for people with complex mental health needs may be improved. This objective is supported by philosophical elements of IPA such as the double hermeneutic.

Table 1. Participant characteristics

Pseudonym	**Age**	**Gender**	**Ethnicity**	**Diagnosis**	**Time attending group (months)**	**Contact with MHS (years)**	**Living situation**
Marcus	34	Male	Asian	Schizophrenia	8 months	9	Assisted community living
Alesha	27	Female	Black British	Schizoaffective disorder	15 months	9	Independent community living
Dave	45	Male	White British	Paranoid Schizophrenia	11 months	22	Assisted community living
Derek	50	Male	White British	Schizophrenia with comorbid substance abuse	8 months	31	Independent Community living
Elizabeth	53	Female	White British	Schizophrenia	42 months	22	Assisted community living
Frank	58	Male	White British	Paranoid Schizophrenia	9 months	29	Assisted Community living
Matthew	43	Male	White British	Schizoaffective disorder with comorbid PD	18 months	17	Living with family
Nigel	30	Male	White British	Schizoaffective Disorder	36 months	10	Independent community living
Sarah	33	Female	White British	Schizophrenia	24 months	15	Assisted community living
Sam	29	Male	Mixed heritage	Schizophrenia	7 months	10	Living with family

Participants

Ten service users, under the care of a NHS trust AOT who regularly attended the aforementioned CMP, were recruited to the study (Table 1.). Inclusion criteria included chronic mental health history involving a diagnosed psychotic illness; regular attendance at

the community music project for at least 6 months, living in the community/outpatients; English speaking; aged 18-65; Exclusion criteria were: the presence of a life threatening or severe physical illness and acute mental illness. All participants were unemployed.

Interviews

The semi-structured interview schedule was guided by the study's aims (Smith et al., 2009). It involved questions concerning participant's experience of the group, their experience of relationships with others and their experience of the group's impact (if any) on their interpersonal relationships (Appendix 4). The schedule was piloted and developed in consultation with three service users. The results of the pilot indicated the interview was understood and easily responded to by individuals with complex mental health needs and PD. When asked pilot participants did not report fatigue, confusion, or distress in response to the interview.

Ethics

An NHS Research and Ethics Committee, and Research and Development department of the relevant NHS trust approved this study (Appendix 5&6). All identifying information including the names of participants, and third parties mentioned in interviews, have been modified or replaced with pseudonyms.

Procedure

Group facilitators identified participants who fulfilled the inclusion criteria and supplied them with the information sheet and a verbal description of the study. Participants who gave consent to be contacted were approached individually at a music group meeting by the researcher and given the opportunity to ask questions. Informed consent to take part in the

study was obtained (Appendix 7) and an appointment was made to complete the interview. A letter was sent to each possible participant's care-coordinator advising them that their client was being asked to participate in the study. Participants were seen within their service's setting.

Ten participants provided demographic information and completed the 20–30 minute interview. Interviews were recorded, transcribed and anonymised for analysis.

Data Analysis

In line with IPA techniques (Smith et al., 2009), transcripted interviews were subjected to initial noting in which language and semantic content were examined (Appendix 7). The notes and interview were then re-examined and "emergent themes" which appeared to capture the "psychological essence" (p .92) of the participant's experience were identified.

Connections across emergent themes were searched for and drawn together under superordinate themes, which highlighted the most important or interesting aspects of the participant's account. This was completed for each transcript/case individually producing 10 tables of superordinate and emergent themes (Smith et al., 2009).

Consideration of the thematic connections, illumination, and potency of superordinate and emergent themes across each table was completed (Smith et al., 2009). The identified patterns formed master themes, which captured the important and most salient features of the accounts provided by this group of participants (Appendix 9).

In line with the hermeneutic circle analysis involved moving back and forth through the data as new ways of thinking occurred. The double hermeneutic was also employed as the author made sense of the participants as they made sense of their interpersonal experiences. Participant's original experiences were reconstructed and the author aimed to follow participant's comments without anticipation (Smith et al., 2009).

Quality Assurance

Bracketing. The researcher had participated in choirs. Furthermore, the facilitators of the music group advised that attendees often expressed a need to protect the group from interference from outsiders, they felt more relaxed amongst professionals if introduced to them by those they trust (i.e. the group facilitators), and if the professional was perceived to have a genuine interest in music. Thus, the researcher attended the group for a session prior to commencing participant recruitment and was introduced to all attendees. The researcher had experiential knowledge of the community music group and theoretical knowledge of complex mental health needs. In line with Elliot, Fischer & Rennie, (1999) it was deemed important that the researcher recognise that her personal anticipations and theoretical perspectives involved positive views of community music projects.

Several methods of facilitating "bracketing" of prior assumptions were undertaken to minimise their influence on data collection and analysis (Fischer, 2009).

- Participants were encouraged to speak honestly about the group and discuss difficulties as well as positives.
- Data analysis was approached from a position of constant recognition of the influence the researcher's perspective may have on their interpretation and understanding of data (Elliot et al., (1999).
- A reflexive diary was completed throughout all stages of the study (Appendix 10) to acknowledge possible biases and sustain objectivity (Koch & Harrington, 1998).

Credibility checks. Initial coding and identification of the emergent themes from the two pilot interviews were fed back to the pilot participants and their comments were sought.

They reported the themes captured their experience of interpersonal interactions in the community music group.

Independent data audit. Samples of initial noting, emergent themes, and superordinate themes were discussed with an academic supervisor with research experience of IPA. The content of data was firstly deemed satisfactory, for IPA methodology, and secondly interpretations were discussed and explored to further expand the analysis. These interpretations and the resulting conclusions were deemed plausible.

Results

Six master themes emerged from the data: "hope for social inclusion," "non-musical interpersonal experiences," "musical interpersonal experiences," "wider community interpersonal experiences," "belonging" and "interpersonal esteem". The following account explores how outpatients with complex mental health needs experience interpersonal functioning in CMPs in terms of these themes. Insights into how CMPs may impact interpersonal functioning within this client group are also highlighted.

Master themes and the subthemes, which formed, will be presented and supported by verbatim[1] interview extracts with pseudonyms. The number of participant accounts, which were indicative of each theme, is stated within the theme's title.

[1] [ ] interpolation added by author
["yes"*]* interviewers words
… omission of text in quote for clarity

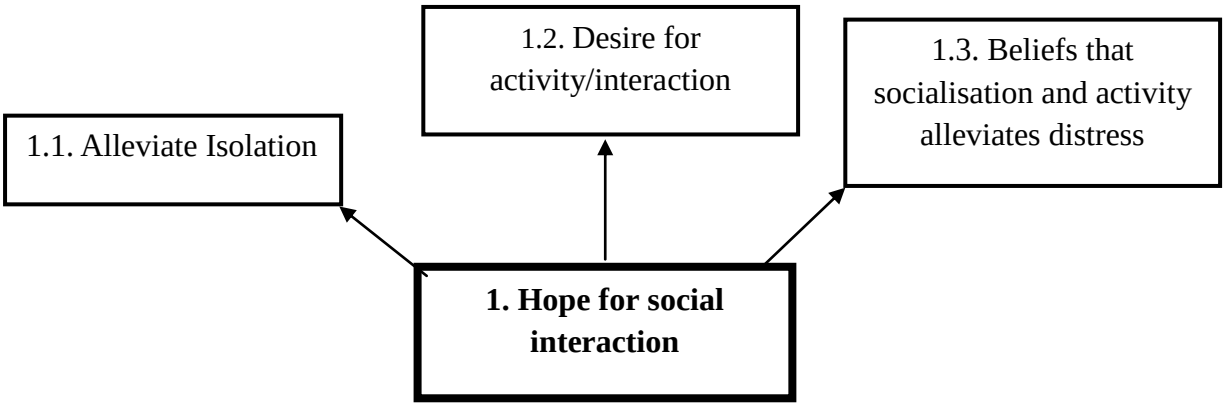

Figure 1. Hope for social interaction. This figure illustrates the master theme "hope for social interaction" and its components.

1. Hope for social interaction

This master theme describes a desire to interact with others socially. Participant's accounts suggested that wanting to alleviate distress, desire for activity and interaction and a belief that interaction alleviates distress were components of this desire.

1.1 Alleviate isolation (9/10).

This theme highlighted the isolation experienced by participants and the desire to alleviate it.

"I don't really have relationships." (Sarah)

"I don't really talk much so I come and I talk." (Frank)

Dave seems to experience difficulty enjoying social contact with others, which may be connected to the isolation he experiences.

"I want to be around people but I never really enjoy it [pause] it makes me uncomfortable, but I hope it will get better. I hope to find it easier." (Dave)

Despite finding it uncomfortable to be around people Dave still desired contact with others. Derek may have experienced isolation as a by-product of recovery. As a recovering substance abuser he may have distanced himself from friends who still abused drugs, causing isolation.

> *"Well I don't really know too many people. I don't have any friends. I've got family and that's all really [pause]. All of my past friends are all on drugs."*

The group seemed to be experienced by most participants as a way to alleviate the isolation they felt:

> *"I'm not alone when I'm here."* (Frank)

> *"It's very difficult and I feel lonely … things like this are life lines."* (Dave)

Dave's suggests he perceives the group as a supportive entity helping him through a life threatening or at least dangerous situation which he struggles with: loneliness.

1.2 Desire for activity (7/10).

Participants suggested that the group fulfilled a desire/need for something to do as Dave stated:

> *"Well it gives me something to do. Somewhere to go."*

For others like Nigel it seemed that having activities that occurred outside of the home was important.

*"I mea*n I look forward to this every week*, getting me out like."*

For some participants this theme seemed to be related to the alleviate isolation theme. Participants may have viewed participating in activities as an opportunity to alleviate isolation.

"It's good for me to get out of the house and socialise with people." (Alesha)

1.3 Beliefs that socialisation and activity alleviate distress (7/10).

This third subtheme relates to both the alleviate isolation and the desire for activity subthemes. It is possible that these factors are experienced as important to participants because they believe these subthemes aid in alleviating distress. The accounts of some participants suggested that activity and social experiences made them "better" or kept "sickness at bay".

"I like socialising. I don't really like being alone. It helps me get better." (Sarah)

"I just enjoy meeting people … I think conversation is good if you got an illness." (Derek)

Nigel suggested he experienced psychological distress in response to boredom, inactivity and isolation.

> *"If I sit indoors all day long staring at the same four walls it's enough to make anyone go bloody mad."*

Similarly when Derek provides a narrative of feeling unable to be active or socialise with others ("zombie") in response to antipsychotic medication he is left psychologically distressed ("horrible").

> *"The injections were horrible. I couldn't think it was like I was a* zombie [pause]. I *was dribbling all over myself… it was horrible you know."*

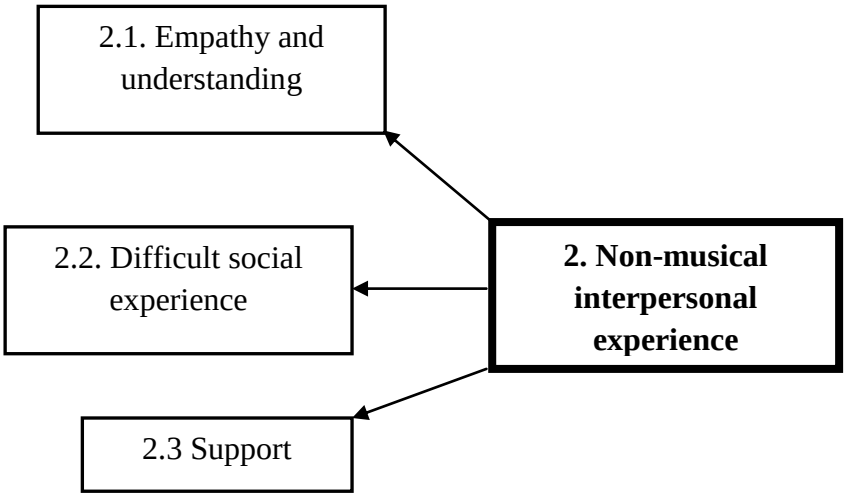

Figure 2. Non-musical interpersonal experience. This figure illustrates the master theme "Non-musical interpersonal interaction" and its components.

2. Non-musical interpersonal experience

Participants provided rich accounts of their interpersonal experiences in the group, which did not involve music. This theme conveys the positive and difficult interpersonal interactions participants experienced when attending the music group but were not directly involved in music activity. Participants also conveyed reflections on the emotions and mental state of others.

2.1 Empathy and understanding (6/10).

Participants expressed understanding and empathy for other group members. They seemed to not only consider the emotions of others but also hypothesised about their mental state. Nigel proposed appropriate responses to the behaviours of others in light of his empathic considerations.

> *"Sometimes people don't wanna t*alk. [pause] I think he felt paranoid. He thought *people didn't want to speak to him cos he hadn't come for a couple of weeks."*

Some participants made empathic connections between their own experiences and those of group members.

> *"I imagine that they're* [the other group members] just looking for something to do *like me."* (Dave)

Frank not only made connections between his own experience and that of others but used that connection to inform how he should interact with others in the future.

> *"Well a lot of the people, maybe like myself are a bit paranoid, don't trust people and are extremely vulnerable. That means I have to be careful that I don't hurt their feelings."*

2.2 Difficult social experience (8/10).

Attending the group seemed to involve experiencing and managing difficult social situations for many participants. Overcoming aspects of social anxiety were part of group attendance for some participants. Dave found ways of managing the uneasiness he felt around other people.

> *"I feel a bit uneasy around people… I don't like to go somewhere and not do anything* so I take my scrabble with me and maybe someone will play a game of scrabble with *me."*

As a recovering substance use abuser Derek may have experienced situations with drugs and alcohol as a threat to his sobriety. He seemed to manage this situation by identifying his own limits concerning interpersonal interaction.

> *"Well sometimes they talk about drink and sometimes I've had them here and they've been smoking cannabis and that. I can't handle that I keep well away from all that…. I don't like to listen to that. I can't trust that."*

Difficult social experience seemed to be associated with the quality and quantity of interpersonal experience participants gained. Feelings of rejection and disappointment were expressed.

> *"There's a little short guy who came in earlier just at the end there like and I spoke to him like. But I don't know I feel like [Pause} every time I talk to the guy [Pause} I feel like he's just trying to ignore me."* (Nigel)

> *"There's people here can't speak a word to you and don't know you just grunts and how good is that for me."* (Matthew)

2.3 Support (5/10).

Participants suggested that they received support from other music group members. The support provided involved the provision of small practical services such as transportation.

> *"… Everyone is nice [pause] they take care of me, give me a lift home."* (Sarah)

Participants also seemed to experience emotional support through sharing thoughts, feelings and experiences.

> *"It's* nice to come here and get help when you need it [pause] when you need to chat *to someone about things".* (Alesha)

Sam felt that the group's facilitators were trying to help him; suggesting he had learnt to trust that they had good intentions towards him.

> *"The thing is they're always trying to help [facilitators] even when they are annoying you [pause] to be honest it's nice they give a shit*."

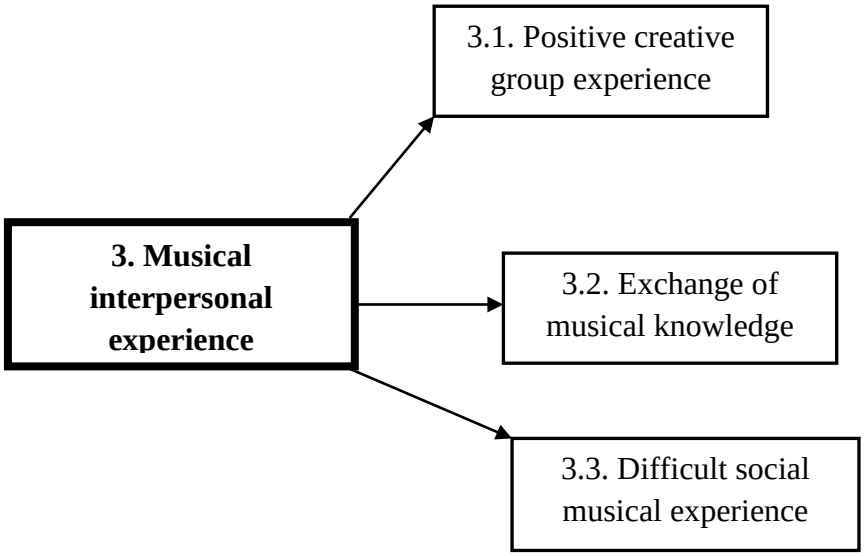

Figure 3. Musical interpersonal interaction. This figure illustrates the master theme "musical interpersonal interaction" and its components.

3. Musical Interpersonal Experience

Participants provided accounts of their interpersonal experiences involving music. These accounts seemed to be more difficult to explain than their interpersonal experiences not involving music. Participants provided longer accounts and took frequent thoughtful pauses. This theme involves both positive and difficult interpersonal experiences.

3.1 Positive creative group experience (4/10).

Participants suggested that creating music in the group felt good.

> *"It feels great [singing in the band] changes how you feel on a physical level you know because it increases endorphins. That helps me more than medication."* (Alesha)

For some the fact that music making was not a solo experience seemed to contribute significantly to the enjoyment of this activity.

> *"Playing together with other people always feels good because your part of something."* (Marcus)

Alesha and Frank further explained that the group creative experience required work and "listening" to each other. When these difficulties were overcome participants enjoyed the experience. Positive emotions and a sense of achievement occurred after listening to each other and developing a shared understanding or becoming "in tune".

> It feels good when everything is working well and [pause] Um it sound like it makes *sense [pause] but sometimes everyone does things and it sounds like they're not* listening to what other people are playing. I felt a bit frustrated then but not as much *as I used to now."* (Alesha)

> *"After a while extremely positive [making music with the group] when you sort out* what your listening to [pause] everyone, gets in tune with one another and in line with *each other."* (Frank)

3.2 Exchange of musical knowledge (6/10).

Interpersonal interaction between participants seemed to involve exchanging musical knowledge. For some participants this may have involved letting other group members know about music they listened to:

> *"It's like there's a guy that com*es [pause] the old boy, and like he brings tapes in and I put them on CD for him and I sort of [pause] I do a couple of copies of it and bring *it here and they listen to it."* (Nigel)

> *"Sam showed me some music on phone."* (Derek)

Participants may have been able to portray an image of themselves through sharing their musical tastes and knowledge.

> *"Have you heard of dollar? …They sold a lot of records in the 80's they were on Eurovision."* (Sarah)

Some participants deemed the experience of sharing musical knowledge with each other as a learning opportunity.

> *"You can learn a lot about music here because everyone knows so much."* (Sam)

> *"I have learnt so much about music from the guys." (*Elizabeth)

The sharing of musical knowledge may have provided participants with positive self-regard or self-confidence as they held knowledge that others were appreciative of.

3.3 Difficult social musical experience (3/10).

Participants also experienced difficult social situations, which arose when they were involved in musical activity. Alesha described feeling that her musical expression was imposed upon. She also found it difficult to share opportunities for musical expression with others.

> *"You have people that want to sing when you're trying to sing and that can b*e irritating or trying to play a different song to what your singing that can be difficult to deal with. [pause] Really hard work sometimes.

Matthew and Frank may have experienced feeling that their musical efforts were dismissed or not appreciated by other group members. Participants seem to have experienced musical activities, as opportunities to express emotions and achieve positive regard from others. When these opportunities were denied them difficult situations arose.

> *"It's very difficult sometimes I've come in here and picked up a guitar and started* playing and people walk in, take one look and walk out again. I mean what does that *do for me?"* (Matthew)

> *"I was playing a song that I wrote [pause] … he got upset and got angry with me* [pause] shouting *and stuff. You know he just kind of lost it for no reason. I, I, I, don't like that [pause] I like coming here to do better on the guitar."* (Frank)

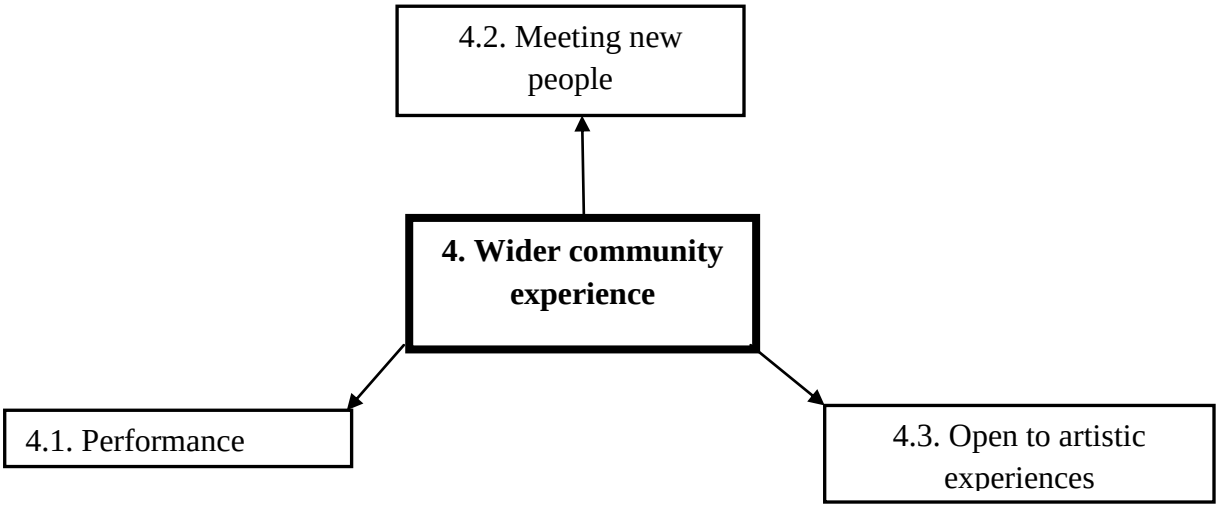

Figure 4. Wider community experience. This Figure illustrates the master theme "Wider community experience" and its components.

4. Wider Community Experience

Participant's accounts of their interpersonal experiences within the CMP involved experiences with people who did not have contact with mental health services. These accounts involved performing, meeting new people and becoming open to other artistic experiences.

4.1 Performance (5/10).

Participants experienced performing together for the general public. This seemed to involve positive interactions amongst group members on stage as well as positive responses from the audience.

*"*I can have a jam with F*rank and John .We do these gigs that always go down well."*

(Matthew)

"It's great when you're up there … it feels good when the audience sing along with you." (Elizabeth)

"We had such a good vibe on stage. The people really responded." (Sam)

4.2 Meet new people (5/10).

Participants described interacting with members of their community they had not met before. Alesha's account suggests this was an exciting occurrence for her and one she appreciated.

"Being in the group…. You get to meet all kinds of people from different backgrounds and um [pause] it's just really lots of different kinds of people". (Alesha)

Matthew suggested meeting people who were not service users was an important factor in his contact with people from the wider community.

"It's just good to not just be around people who are crazy [pause] sorry but we are. It's nice that every kind of person is here."

4.3 Open to artistic experiences (5/10).

Participants suggested that participating in the music group made them more open to artistic experiences.

"The group really highlighted to me that I need to express myself and erm I think that's something that I need to do more of." (Dave)

Elizabeth and Nigel suggested that attending the group had led to them undertaking more artistic activities. Elizabeth had joined an art group in which she painted.

> "*I'm more or less on the artistic side of life since I've been coming here, I've been* doing a lot of paintings, not paintings but yeah [clears throat]. We have an art group at my home every Tuesday morning."

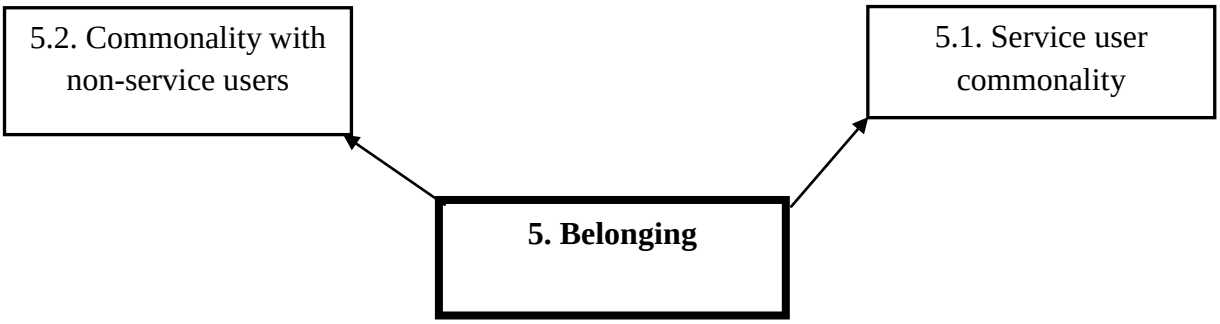

Figure 5. Belonging. This Figure illustrates the master theme "Belonging" and its components.

5. Belonging

This master theme involves experiences of attending the music group which involved participants feeling a sense of belonging. Experiences involving finding commonalities with service users and non-service users, and feeling supported by others are sub-themes which contribute to this master theme.

5.1 Service user commonality (6/10).

Participants' comments on their relationships with other group members conveyed a sense of commonality amongst service users.

> *"The group is good for that. It's kind of good because we all understand something about each other because we all have had some of the same problems."* (Sam)

Derek was one of 2 service users who referred specifically to mental health diagnoses as an attribute that service users had in common. Derek seemed to feel that commonality did not only involve mental health but also a desire to get better.

"Well you notice you've got something in common [pause] you all have an illness, you're all trying to get better so you try and keep up the groups and that."

Nigel's comments suggest that the commonality felt amongst service users enabled him to make allowances for behaviours of other group members that he would not usually tolerate.

"People take the piss out of me here, but it doesn't bother me, cos we're all in the same boat, aren't we?"

5.2. Commonality with non-service users (5/10).

Participant's comments on their relationships with other group members also conveyed a sense of commonality between service users and those who were not service users. Most participants seemed to frame this commonality in the normalisation of mental health difficulties by suggesting everyone has "problems."

"You see it in the group. All kinds of people come. But they all have problems even if they aren't on clozapine." (Dave)

"Even if you haven't got paranoid schizophrenia [pause] people have problems don't they." (Frank)

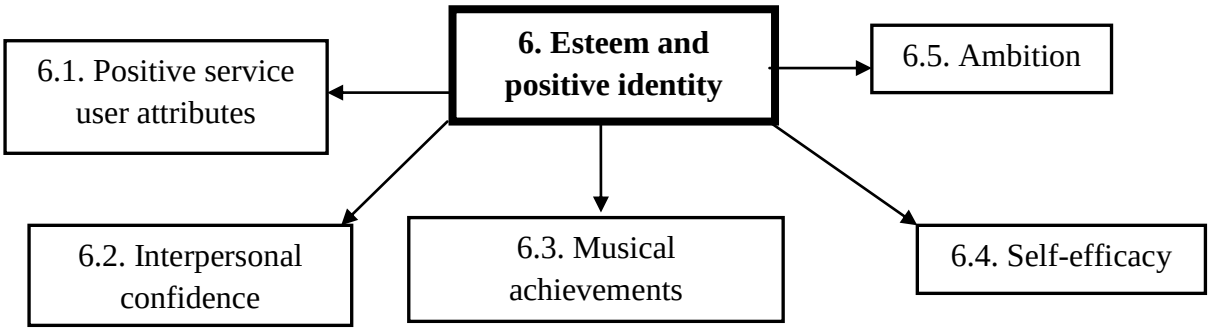

Figure 6. Esteem and positive identity. This Figure illustrates the master theme "Esteem and positive identity" and its components.

6. Esteem and positive identity

This master theme involves experiences described by participants that seemed to denote the building of self-esteem and the establishment of a positive identity. Experiences involved acknowledgement of positive service user attributes, the development of interpersonal confidence, musical achievements, self-efficacy, and ambition.

6.1 Service user capabilities (5/10).

Participants seemed to hold positive perspectives concerning the abilities of service users. Matthew pointed out the musical capabilities of service users.

"Service users really can play. I've heard them they can write songs."

Derek may have experienced his participation in interpersonal interaction when attending the project as an indication of his recovery from mental illness.

"Yeah you know on the ward [pause] the people do all kinds of shit [pause]

some people are having it really bad like [pause] the people who come here *[pause] I mean we all have our shit, but it's not bad like that. At least here um [pause] you can talk a bit more".*

6.2 Interpersonal confidence (3/10).

Some participants commented that they felt more confident about engaging in interpersonal activity.

"I still feel like it's hard around people but it's easier than it was." (Dave)

Some participants seemed to have developed the ability to adapt to those around them. They may have learnt how to identify what was appropriate behaviour in interpersonal situations.

"Like I can just talk to people more easy…. Everyone has something they wanna talk about but I guess som*etimes they don't wanna talk."* (Alesha)

Alesha may have developed the ability to consider how other people may be feeling or what they may be thinking and had changed how she approached her interactions with others in response.

["If anything what have you learnt about other people since joining the group?"] *"Be more tolerant of others … you really just have to be more patient and* understanding of what other people may be going through [pause]. I take my time *now. I don't just get angry and say things back* [pause]. I like just let people just do *whatever they need to do to get things out of their system."*

6.3 Musical achievements (6/10).

Participants seemed to associate a sense of achievement with musical activities. For Matthew, several factors contributed to making his experience of attending a music studio important to him. Participating in a professional musical activity seemed important to him.

> *"That CD came out, that was really good. Professional recording, that was the first time I'd ever been in a professional recording studio [pause]. That was brilliant."*

Matthew's pride seemed to be related to others appreciating his work.

> *"Well because I went into a professional recording studio ...laid down piano beats,* and everybody thought it was really good [pause] so [pause] Yeah definitely a feather *in my cap."*

Participants also seemed to feel that they had developed skills in response project participation.

> ["If anything what have you learnt about yourself since joining the group? "]
>
> *"I am learning I'm fast learner. I'm a fast learner very fast."* (Marcus)
>
> *"Its [the group] made me sharper musically"* (Frank)

6.4 Self-efficacy (5/10).

Participants seemed to have developed a belief in their ability to succeed or cope with difficult situations. Many participants believed they would be able to improve their musical abilities.

> *"I learnt if I could practice a bit more I'd be able to play better."* (Nigel)

Participants also seemed to believe they could manage their mental health problems and related interpersonal difficulties.

> *"If I'm ill and someone else is ill we will probably [pause] something might happen and I will clash with them. It happens a lot when I'm not well [pause] best I hang back." (Alesha)*

> *"I think you gotta know when's good for you to co*me and when not [pause] if you unwell and you*'re just gonna cause trouble or something it's best to stay at home."* (Sam)

Derek related learning he has will power with attending the group. He may have experienced not interacting with group members who used drugs as confirmation of his ability to overcome his addiction.

> *["Do you think you've learnt anything about yourself since coming here?"]*
> *"I've realised I have got will power [pause] Over the years I've doubted that, I thought I'm just always gonna fall back into the drugs and that."*

6.5 Ambition (4/10).

Some participants expressed musical ambitions during the interview.

> *"Singing, I hope to make it you know [pause] I, I, I [stuttering] hope to make [pause]* Take it t, t, [stuttering] you know make um [pause] try and make, take the matter *further is what I mean."* (Elizabeth)

Frank seemed to be inspired by observing the talents of other group members.

> *"I'm not* as *good as them but I'm better since coming here. I want to learn how to do* better, I am not *great with my chords I should be a lot better."* (Frank)

Discussion

The results of IPA suggest outpatients with complex mental health difficulties attending the music project held a desire for social interaction. Through musical and non-musical interpersonal experiences, connections were made with the wider community and self-concept components; belonging, esteem and positive identity were experienced. These self-concepts informed each other and interpersonal experience (Figure 7).

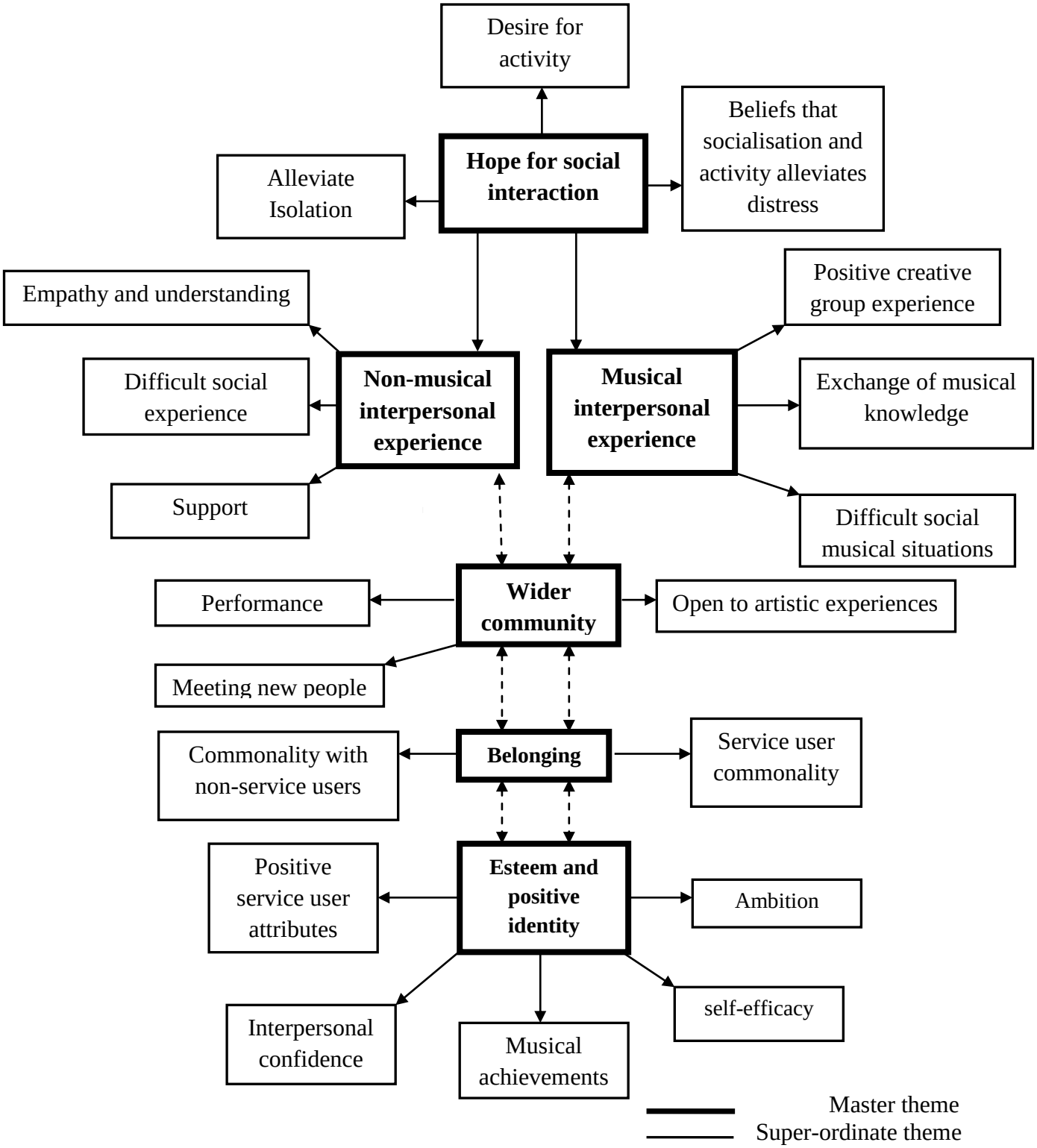

Figure 7. Interpersonal functioning experience in community based music projects amongst people with complex mental health needs.

Hope for social interaction

The participants communicated that they were isolated and desired social interaction. Although this is not discussed in empirical literature concerning outpatients with complex mental health and CMP these experiences are well documented amongst people with other mental health problems (Perkins & Repper, 1996). The idea that people strive to create and maintain interpersonal bonds with others is not new (Freud, 1930; Maslow, 1968; Bowlby, 1969).

Community psychology theorist Fryer (1994, 1998) proposed people choose to participate in goal directed social behaviours. Accordingly, ingratiation and impression management studies suggest people will employ overt behaviours to improve inclusionary status (Schlenker, 1980; Gordon, 1996). Community clinical psychologists Hagan and Smail (1997) theorised associations between psychological distress and poor socioeconomic status and psychology's adoption of intrapersonal approaches to recovery (e.g. gain insight via psychodynamic approaches or change thoughts and beliefs via cognitive behavioural therapy), may cause service users to feel responsible for their social position and associated psychological distress. This may explain why participants continued to participate in interpersonal interaction although this was difficult for them.

Non-musical interpersonal interaction

Participants suggested interpersonal experiences which were not associated with musical activities involved considering the emotions and motivations of others and relating their considerations to their own emotional experiences (empathy). Empirical research has illustrated that CMG participation may facilitate empathy amongst outpatients with complex mental health needs (Odell-Miller, 1995; de l'Etiolie, 2002).

As psychological models propose difficulties understanding the feelings and motivations of others may lead to difficulties in interpersonal functioning (Bateman & Fonagy, 2004; Pretzer

& Beck, 2005), the empathy for others participants experienced, when attending the project may have positively impacted their interpersonal functioning.

Participants experienced difficult social interactions in the group but this deterred none from attending. Instead they seemed to display interpersonal learning; finding ways to manage situations. This was not reported in any of the literature concerning complex mental health and CMP although gaining experiences in relating to others (or interpersonal learning) was identified (de l'Etiolie, 2002; Troice & Sosia, 2003). Group interpersonal interactions may have facilitated interpersonal learning (Wells, 1990). Interpersonal learning has also been shown to contribute to improved self-esteem (Gallagher, Tasca, Ritchie, Balfour, Maxwell, & Bissada, 2013).

Psychological theories of interpersonal functioning (Bowlby, 1969; Pretzer & Beck, 2005) suggest a person may learn how to respond during interpersonal activity from their previous interpersonal experiences. The interpersonal experience gained by participants in the CMP may have positively impacted their interpersonal functioning.

Positive social interactions in the form of support were also experienced. Studies of service user experience of depression and alcoholism support groups has linked support with awareness of commonalities involving, suffering and social learning potential (Gould & Clum, 1993). Participants may have experienced a sense of belonging gaining a shared understanding or empathy for each other.

Musical interpersonal experience

Participants engaged in sharing their musical knowledge and preferences. This was not reported in other studies of interpersonal functioning and CMP participation amongst outpatients with complex mental health needs. Establishing musical preferences has been found to enable image portrayal in non-clinical samples (North, Hargreaves & Neill, 2000).

Group members also shared their musical knowledge with each other. The value their musical knowledge held within the group and the ability to portray an image through musical preference may have contributed to positive self-regard and identity development.

Participants experienced positive emotions in response to collaborative music participation. CMP have been shown to improve low mood amongst outpatients with complex mental health needs (Troice & Sosa, 2003). Group singing has also been shown to improve mood and counteract depression, anxiety and life-stress in non-clinical populations (Clift & Hancox, 2010; Von Lob, Camic & Clift, 2010).

Participants indicated that the positive emotions associated with collaborative music making occurred once their music making became "in tune" with each other. Participants learnt to hear and understand each other's musical contributions enabling the creation of a harmonious sound. This may be indicative of subtle changes in empathic consideration and interpersonal interaction. Collaborative music making has been found to promote comradeship and concern for the feelings of others (Megginson, 2000).

Participants also experienced difficult musical interpersonal interactions. Participants managed these difficult interactions. In line with other studies of CMP and interpersonal functioning amongst PWCMHN, musical interpersonal experiences may have provided participants with opportunities for interpersonal learning (de l'Etiolie, 2002; Troice & Sosia, 2003).

As with the non-musical interpersonal experiences of participants, their musical interpersonal experiences involved interpersonal learning. In line with psychological models these experiences may have positively impacted their interpersonal functioning (Bateman & Fonagy, 2004; Pretzer & Beck, 2005; Bowlby, 1969).

Participants also seemed to have experienced musical activities (which involved performance), as opportunities to express emotions and achieve positive regard from others,

building their confidence. This is supported by Longhofer and Floersch (1993), they reported that outpatients with complex mental health needs experienced improved self confidence in response to musical activities in CMPs.

Wider community experience

Participants seemed to develop bridging capital in response to music project participation. Research concerning the participation of outpatients with complex mental health needs in music projects also reported this finding (Leung, et al., 1998; Longhofer & Floersch, 1993). This has not been reported in studies of community music therapy interventions within this population. Bridging capital development has been linked to musical skill development and performance. Participants enjoyed interacting with audiences whilst performing. Bowman (2005) proposed music experience "is an enactment of self-expression and self assertion" (p.162). These experiences may have provided participants with opportunities to develop positive identities and self-confidence whilst consolidating and gaining interpersonal skills.

Participants communicated considering attending other community art projects was part of their experience of music project attendance. This was not referred to in other studies of music project participation amongst those with complex mental health needs. Art projects have been shown to improve well-being and facilitate social opportunities for participants with mental health problems (Hacking, Secker, Spandler, Kent, & Shenton, 2008; Stickley, 2010). If participants chose to attend art projects their social network may further widen.

Belonging

A sense of belonging or group cohesion has been reported in studies of CMPs and complex mental health (Odell-Miller, 1995; de l' Etioile, 2002; Longhofer & Floersch, 1993). However, these studies did not consider how belonging was experienced. Participants primarily experienced commonality with service users and non-service users, which allowed them to feel that they belonged to the group. Participants focused on the idea that "problems" were a common occurrence and something all group members experienced. Gaining awareness of commonalities within groups has been linked to feeling supported (Gould & Clum, 1993). Identifying commonalities may have enabled shared understanding or empathy between service user and non-service user group members facilitating bridging capital development.

Esteem and positive identity

Participants associated esteem and positive identity with attending the project. Although identity development has not been observed amongst outpatients with complex mental health needs in response to CMP participation self-confidence has (Longhofer & Floersch, 1993; Odell-Miller, 1995). Longhofer and Floersch, (1993) proposed that self-confidence occurs in response to musical skill development, while Odell-Miller, (1995) suggested it developed in response to learning relationship skills. The IPA indicated participants gained interpersonal learning in response to musical and non-musical interpersonal activities contributing to interpersonal confidence or self-esteem (Gallagher, Tasca, Ritchie, Balfour, Maxwell, & Bissada, 2013).

In line with Longhofer and Floersch (1993), participants experienced ambition, self-efficacy and achievement, in relation to their musical experiences. Participants wanted to improve their music skills and become entertainers. They viewed the skills they had learnt as achievements and acknowledged their role in achieving their ambitions. Several studies

suggest self-efficacy is related to the gaining of musical skills (McPherson & McCormick, 2006). Bandura, (1999) proposed experiencing difficult tasks as something to be mastered as opposed to something to be avoided marked self-efficacy.

Participants also communicated a developing positive identity. This seemed to be created and sustained through the interactions involved in collaborative music-making between group members. Participants were able to establish an identity through sharing music preferences (North, Hargreaves & Neill, 2000). They were also able to gain positive self-regard through experiencing others appreciating their musical knowledge. This may have been further facilitated by musical skill development and performance (Bowman, 2005). Feeling that they belonged to a group of talented musicians may have also positively impacted the identity of participants.

As it has been proposed that identity informs expectations concerning the motivation of others and how adaptive coping strategies are employed to manage interpersonal distress (whether through negative beliefs, or internal working models), it is possible the sense of identity participants developed in the group influenced their interpersonal functioning (Bowlby 1969; Pretzer & Beck, 2005).

Methodological considerations

The study's findings suggest CMP participation is associated with improved interpersonal functioning and has supported previous research (Odell-Miller, 1995; Troice & Sosa, 2003). The interpersonal experiences participants gained through attending the group facilitated the development of important self-concepts (belonging, esteem and positive identity), and interpersonal skills which informed functioning. Furthermore, bridging capital was found to occur in response to musical activity or performance (Longhofer & Floersch, 1993; Leung, et al., 1998). The IPA highlighted the nature of the interpersonal experiences gained. This was

absent from all other studies of interpersonal functioning in response to CMP amongst this client group.

However, there are several limitations to the methodology employed. As this is the only qualitative study to explore how those with complex mental health needs experience interpersonal functioning whilst participating in a CMP a credibility check of findings is not possible (Elliott et al., 1999).

The facilitators of the music project believed the participants displayed PD symptoms although they had not received the diagnosis. Comorbid psychosis-PD diagnosis is often complicated by overlaps in diagnostic symptom presentation (Rowosky & Gurian, 1992). Undiagnosed comorbidities may have caused variations in interpersonal abilities in the sample and made the sample less homogeneous (Tyrer & Seivewright, 2000). Although Smith et al., (2009) state IPA requires homogeneous samples this is a characteristic of complex mental health (RCP, 2005).

Seventy per cent of the sample consisted of white British men which may not reflect the ethnic diversity seen amongst those with complex mental health needs (Kagan, Sixsmith, Siddiquee, Bol & Lawthom, 2005). Consequently, the generalizability of the study's findings to different ethnic groups and females is limited. Further limitations to generalizability may have occurred due to a sampling bias. As all participants had chosen to participate in the CMP prior to their recruitment to the present study, clients who had an interest in music or group activities may have been more likely to be included in the sample than those who did not. However, it is important to note that in line with IPA the study aimed to understand experience rather than gain generalisations (Husserl, 1927).

Clinical implications

Clinical implications exist for assessment, formulation and interventions involving those with complex mental health needs. Participants who engage and benefit from CMP have a desire for social interaction. Willingness to engage in interpersonal functioning should be assessed before inviting clients to attend CMPs. This may reduce participants feeling intruded upon and possible disengagement from services (Catty, 2004), improving the efficacy of this intervention.

Gaining interpersonal experience and the nature of those experiences seemed to be associated with the interpersonal functioning and social inclusion of participants. Assessments and resulting formulations should consider the nature and degree of social experience participants attain as this may be associated with their bridging social capital and interpersonal activity.

Mental health professionals may need to acknowledge that due to the limited social networks of outpatients with complex mental health needs their interactions with these clients may have a significant impact on their interpersonal learning (Adshed, 1998). Contacts should be undertaken with consideration of this issue.

The findings of the present study suggest that clients with complex mental health needs respond positively to community interventions. Community based clinical psychology practice may provide opportunities for the promotion of social resources (e.g. social capital, esteem, positive identity) which may positively impact the ability of those with complex mental health needs to effectively deal with their difficult circumstances (Hagan & Smail, 1997). Group psychological interventions may want to consider utilizing musical activities. The findings of the present study suggest discussing and performing music may facilitate esteem, positive identity and bridging capital.

Research implications

Musical activity experiences seemed to influence identity development. The current study does not consider if positive identities had been formed before attending the group due to previous musical experiences. This may have affected interpersonal functioning experiences during music project attendance. A longitudinal study with additional client groups may allow clarification of the role of music activity and how the results found are sustained over time.

This qualitative study provided insights into the nature of interpersonal experiences outpatients with complex mental health needs gained during CMP participation, (e.g. difficult interpersonal experiences, sharing musical knowledge). These insights were not gained from previous research in this area, none of which utilised qualitative analysis methodologies. Focusing only on the effects of music groups may lend to a "black box" conceptualisation of CMPs (Campbell et al., 2000). Further qualitative studies may provide greater understanding of the several factors involved in the interpersonal processes occurring in CMP participation and the many factors which result.

Conclusions

The project aimed to understand how outpatients with complex mental health needs experience interpersonal functioning, how interpersonal functioning is understood and how it is responded to, whilst attending a community music project. The present study supports previous research suggesting participation in community music projects, may improve interpersonal functioning amongst those with complex mental health needs. Insights in to the nature of the interpersonal experience gained and how that experience may contribute to improvements in interpersonal functioning is provided. Improved interpersonal functioning may be explained in part by a desire for social interaction, which may have facilitated

interpersonal activity. Interpersonal learning occurred through non-musical and musical interpersonal experiences. Music performance, music skill development, and the sharing of musical tastes and/or knowledge, may have informed interpersonal learning, bridging capital development, and components of self-concept (e.g. esteem and positive identity). Longitudinal research is needed to better understand how this process might further develop and be sustained over time.

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SECTION C:

CRITICAL APPRAISAL

Word count: 1992 (plus 24 additional words)

Department of Applied Psychology

CANTERBURY CHRIST CHURCH UNIVERSITY

1. **What research skills have you learnt and what research abilities have you developed from undertaking this project and what do you think you need to develop further?**

This project required that I develop and consolidate a number of research skills**.** The skills I feel I had not acquired previously include writing an ethical approval application, analysing qualitative data, and writing up research to a publishable standard. This was the first time I completed a research project on my own and I think this impacted my confidence causing me to doubt my abilities as a researcher. I realised that as participants had found in the research project I had undertaken, when I had completed research projects as part of a team my interactions with other researchers developed my esteem and encouraged me to form an identity as a researcher. I found it difficult to maintain enthusiasm for the project near the end and at times felt unclear about its direction. Writing and then presenting my ethics proposal to a NHS REC committee alone was intimidating, but it allowed me to acquire the ability to communicate and discuss my ideas clearly with academics, clinicians and members of the public.

My previous research experience has primarily involved functional magnetic resonance imaging (fMRI) and extrapolating neuropsychological test batteries to fMRI paradigms. Before I began this training programme I had never completed a qualitative study. To be honest I thought little of qualitative research, viewing its contribution to empirical understanding as supportive in nature. During my time on this training programme I was exposed to scientific philosophy and realised I had held a positivist view of science (Ponterro, 2005). The Major Research Project (MRP) offered an opportunity for me to gain further insights into constructivist and interpretative approaches.

Interpretative Phenomenological Analysis enhanced my understanding of the qualitative methods and the interpretative approach. Through the reading of core texts and discussing the approach with members of my cohort, I realised that I would have to ask myself, how my own understanding and experiences of group music activity may impact on the research. I had not considered how my experiences would impact my research before. Doing so was an eye opening process leading to the acknowledgement that my experiences may bias my analysis of interviews.

"Bracketing" (Fischer, 2009) became an important aspect of the research process and one I felt intrigued by, especially as I began making sense of how participants were making sense of their experiences (Smith, Flowers & Larkin, 2009). Discussions with my supervisor, the reflective journal and credibility checks became an important part of the research process.

The process of designing and conducting the interview was also a learning experience for me. The cognitive difficulties that are associated with psychosis were evident during interviews. Brief questions with frequent prompts were employed without biasing the data (Fatourous, Bergman, Preisler, & Werbart, 2006).

I have enjoyed my IPA experience and have warmed to interpretivism. I hope to further my understanding and one day attempt a grounded theory study. I have gained a respect for qualitative research and the efforts researchers make to ensure that bias does not effect their interpretation of the data they collect. I hope through developing my knowledge of qualitative methodologies I will become a better researcher in the future.

2. If you were to do this project again, what would you do differently and why?

My interest in complex mental health needs developed from my clinical experiences working for Assertive Outreach Teams with clients who had complex mental health needs characterised by psychosis (RCP, 2005). Many of this client group also had personality disorder. I became particularly interested in the racial make up of this client group, as a high proportion of the clients I had, encountered were ethnic minorities (Kagan, Sixsmith, Siddiquee, Bol & Lawthom, 2005). As I expected, a high proportion of clients that met the criteria for this study were ethnic minorities. However, they did not wish to participate in this research study. I have considered several reasons why this may have been. As I am an ethnic minority also, I believe participants may have feared judgement from me. It is possible that as there are few clinical psychologists who are ethnic minorities it is possible potential participants may have been unsure of how a black clinical psychologist would view them. They may have wondered if a black clinical psychologist would allow cultural beliefs to guide their understanding of the comments participants provided. They may have also wondered (as clients have expressed to me in the past) "what kind of ethnic minority becomes a clinical psychologist?" perceiving me as an anomaly that cannot be trusted. I wondered whether employing a different recruitment strategy (e.g. introducing the study to each attendee and supplying them with an informed consent sheet myself), would have enabled ethnic minorities to be more comfortable with me and so able to participate in the study. I am aware homogeneous samples are preferable to IPA (Smith et al., 2009). Maybe more purposive sampling, (e.g. exploring how the musical interests of Black and Asian clients influence their interpersonal functioning would have), would have allowed me to gain greater access to ethnic minorities with complex needs.

Participants seemed to be processing thoughts about their interpersonal functioning during the interview. Acknowledging what their experience of mental illness and

interpersonal functioning had been and what it had become, seemed to take place at one point or the other during each participant's interview. After the interview had ended, but before participants had departed from the meeting, I enquired if participants had found anything difficult about the interview. I also reminded them that they could speak to their care-co-ordinator if they had found any part of the interview upsetting. I received no feedback suggesting any participants had found the interview upsetting. However, it occurred to me that participants may have had further thoughts relating to our conversation after our meeting and a follow up interview may have captured those thoughts.

Whilst completing the study I became aware of data that was not captured in the interview. For example, on meeting with some of the clients I learned that some were trained musicians and others were not. I wondered how this had impacted the interpersonal functioning in the group. Did participants who were more able musically find it easier to interact socially? Unfortunately only one participant talked about their experience as a musician. Some participants displayed cognitive difficulties. I wondered if this impacted their experience of music making participation or interacting with other group members. None of the participant's responses suggested they had any awareness of their cognitive difficulties or how they may impact their interpersonal functioning. The interview was designed to gain insights concerning the experience of interpersonal functioning and participants responded with what they felt was relevant at the time of interview. However, had I allowed myself to express my curiosity further would the data gathered have been richer?

3. Clinically as a consequence of doing this study would you do anything differently and why?

Whilst participants believed that gaining social contact would reduce the psychological distress they felt, they did not seem to acknowledge the relationship between the loneliness they experienced and their psychological distress (Weeks, Michela, Peplau, Bragg, 1980). Participants seemed more comfortable associating the "going mad" with inactivity. The importance of social contact for service users is highly relevant to any clinician providing an intervention. I think in future the psychological assessments I complete will involve a higher level of curiosity concerning the social context of clients and the impact of that context on their mental state.

Participants also clearly wanted to gain social contact. In my experience of working with assertive outreach teams (AOT) (a high proportion of clients with complex mental health needs are treated by AOTs; Royal College of Psychiatrists, 2005), I rarely observed mental health workers asking clients if they wanted contact with others.

AOTs often provide group activities for service users in an attempt to encourage social activity (Cupitt, 2010). In my time I have facilitated pool, afternoon tea, bowling and football groups. Clients were invited to attend groups and were told attending would allow them to stay active and feel better. Whilst research supports this claim and advice, I wonder if clients attend groups that aim to encourage social activity when they do not wish to engage in interpersonal contact, would the efficacy of the intervention or group reduce? As with psychotherapy it may be that a person's wish to participate may influence the process and outcome of the intervention.

The findings of the current study highlight the positive impact of interpersonal experiences, clients have within group activities. In the current study participants described difficult interpersonal situations. One such situation involved a recovering drug abuser being

invited to participate in drug use by another service user. This had occurred several months before the study took place. The facilitators of the music project and the CMHT had been informed and the music project returned to the drug free environment it had been originally. However, the participants had, had to manage difficult interpersonal situations before clinicians were able to ensure the project was drug free. Whilst the study's findings suggest interpersonal learning, positive identity and self-esteem may have occurred in response to these experiences, the following questions arise: What if participants had not been able to manage these difficult interpersonal situations? What effects would that have had on their recovery?

Before inviting clients to participate in group projects it may be important to consider a client's social context, if they desire social interaction, in what stage of the recovery process they are in and how their presence within the group may impact other clients.

4. If you were to undertake research in this area what would the research project seek to answer and how would you go about doing it?

The results of the current study indicate that interpersonal experiences may provide interpersonal learning. Music project participation may have positively affected how people with complex mental health needs manage difficult interpersonal experiences through interpersonal learning. However, it is not clear how this learning occurred and developed. If given the opportunity, I would complete a project concerned with the examination of personal change related to managing difficult interpersonal situations throughout a course of music project attendance. IPA would provide a phenomenological understanding of participant experience and reactions to difficult interpersonal functioning throughout a course of music project attendance.

Focus groups would be required to identify difficult interpersonal situations that were common to music project attendance for those with complex mental health difficulties. The focus group alone may provide mental health workers with insights into how difficult interpersonal situations may develop and turn into conflict. Vignettes depicting the identified difficult interpersonal situations would be created. These would be used as prompts within a semi-structured interview aimed at gaining insights into how people with complex mental health needs would experience difficult interpersonal situations. It would also be important to elicit how participants experienced the characters in the vignettes.

Participants would be interviewed three times including; on joining the project, at three months after joining the project and at six months after joining the project. They would also be asked to keep a diary to supplement data acquired in response to the interviews. This would allow any "real life" experiences of interpersonal difficulties to contribute to the "richness" of data collected. Participants would be asked to make entries no more than once a week in verbal or written form.

Data gathered from each participant would be analysed individually as longitudinal case study. This would be followed by cross case analysis producing super-ordinate themes.

It is hoped that the research project would provide insights into the process by which people with complex mental health needs learn to manage difficult interpersonal experience. Previous research has indicated a dose-dependant relationship between music therapy and interpersonal functioning improvements amongst those with schizophrenia (Gold, Solli, Krüger, Lie, 2009). This project may highlight if a similar pattern of dose dependence occurs amongst people with complex mental health needs attending community music projects.

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DEANNA HALL BSc Hons, MSc

SECTION D:

APPENDICES

Department of Applied Psychology

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix 1: **Search strategy**

Table 1. Electronic databases searched

Electronic Database	**Search period**
Evidenced Based Medicine Reviews (EBM) – Cochrane Database of Systematic Reviews	2005 to Feb 2013
Ovid Medline	1946 to Feb 2013
PsychInfo	1806 to Feb 2013
Google Scholar	

Search terms

The following terms were searched for in the title, abstract or keywords of articles:

Music OR Music Making OR Musical OR Singing OR Song OR Dancing OR Dance OR Band OR Choir OR Orchestra OR Instrument

AND

Community OR Outpatient OR Daycentre OR Public Health

AND

Interpersonal OR Social OR Relationship OR Communication OR Interaction OR Friendship OR Social Inclusion OR Social Exclusion

AND

Complex Mental Health OR Psychosis OR Psychotic OR Schizophrenia OR Schizophreniform OR Schizoaffective OR Delusional OR Bipolar disorder

Exclusion and inclusion criteria

The articles' abstracts were manually examined for relevance to the review as exclusion and inclusion criteria were applied.

Exclusion criteria:

- Non-peer reviewed articles

- Not written in English

Inclusion criteria:

- People with complex mental health needs (PWCMHN), (treatment resistant or chronic psychosis RCP, 2009).
- Music interventions
- Outpatient (receiving community care) participants
- Evaluation of interpersonal functioning

Inclusion/exclusion criteria relaxation considerations

The author considered relaxing the inclusion criteria of this review to include articles involving participants with severe mental illness and inpatient samples. It was deemed that relaxation of the criteria was not justified for following reasons.

1. The conceptualisation of this review occurred in response to clinical observations that following the deinstitutionalisation of the mental health system (Department of health, 1999), many people with complex mental health needs (PWCMHN) were receiving community based care (Royal College of Psychiatrists [RCP], 20005). Current NHS commissioning objectives involve improving the social inclusion of PWCMHN and the evaluation of community based interventions (Joint Commissioning Panel for Mental Health, 2012) aimed at PWCMHN. A review focused on evaluating the efficacy of community based interventions for PWCMHN would resonate with these objectives.

2. Recent reviews concerning the efficacy of inpatient and community based music interventions for those with severe and chronic mental health illnesses (including psychosis) were identified (Mössler, Chen, Heldal, Gold, 2011; Gold, Solli, Krüger, Lie, 2009). These reviews drew conclusions concerning interpersonal functioning. The present review would not have made any significant contributions to current knowledge if articles involving inpatient samples and participants with severe mental illness met criteria for this review.

Flow chart of literature search:

Terms referring to music = 353815

↓

Terms referring to music AND community = 40609

↓

Terms referring to music AND community AND interpersonal = 26533

↓

Terms referring to music AND community AND interpersonal AND complex =1793

↓

Application of exclusion criteria

↓

Non peer reviewed articles (207 screened out) = 1586

↓

Not written in English (8 screened out) = 1578

↓

Application of inclusion criteria

↓

Complex mental health needs (1542 screened out) = 36

↓

Music interventions (13 screened out) = 23

↓

Interpersonal functioning (7 screened out) = 16

↓

Outpatients (14 screened out) = 2

Following the application of exclusion and inclusion criteria only 2 articles met criteria for this review. The reference sections of these articles were examined and a further 3 articles were identified. Therefore a total of **5** studies were reviewed.

Appendix 2: Articles in review

Table 1. Table of reviewed articles N=5

Study	**Design and study Quality**	**Duration**	**Participants**					
			Clinical condition and setting	Demographics	Intervention		Comparison	Social Outcome
					Type	No. of sessions		
Odell-Miller (1995) (UK: England)	Descriptive	From 2 to 4 years	Diagnosis: schizophrenia, personality disorder, manic depression, comorbidity across diagnosis History: chronic	N = 10 Age = 31 – 53 Sex = 70% male	Practical music-making Facilitator: Music therapist	Differed among cases (once or twice a week, individuall y and in groups week)	Baseline	Therapists and team views on benefits of intervention: -Needed by others -resume societal roles (employment) -close relationships -insight on their effect on others -integration into society.
Troice & Sosa (2003) (Mexico)	Pre & Post measures	6 months	Diagnosis: Schizophrenia History: chronic	N = 15 Age = (M=32.1) Sex = 67% male	Improvisational music making Facilitator: Music therapist	40 (twice a week)	Baseline	Self- report music measure designed by authours Results: – 60% reported "the work with music helped me to relax and relate to my peers". -"the work with music helped me to talk about my feelings diminished by 20%.

Study	**Design and study Quality**	**Duration**	**Participants**					
			Clinical condition and setting	Demographics	Intervention		Comparison	Social Outcome Scales
					Type	No. of sessions		
Leung, Lee, Cheung, Kwong, Wing, Kan, Lau (1998) (China)	Randomised controlled trial	6 weeks	Diagnosis: Schizophrenia History: chronic Mean duration = 8.8 years Groups Matched in age sex and duration of illness Mean Neuroleptic dosage = 431mg	N = 8 Age = 17-50 (M =30.3) Sex = 100% Male	Karaoke singing and simple singing Facilitator: occupational therapist	12 (twice a aweek)	Karaoke singing vs simple singing	Self-report measures - Interaction anxiousness scale (IAS). Audience anxiousness Scale (AAS). Index of self-esteem (ISE). Nurse Observation Scale for inpatients modified for day patients (NOISE). Intra-class correlation co-efficient = IAS (0.78), AAS = (0.95) ISE (0.68). Not reported for the NOISE. Non-significant Resuts: Improvement on scales across groups. Karaoke = significantly higher on AAS and "start up a conversation with others " section of the NOISE.

Study	**Design and study Quality**	**Duration**	**Participants** Clinical condition and setting	Demographics	Intervention Type	Intervention No. of sessions	Comparison	Social Outcome Scales
de l'Etoile (2002) (USA)	Pre – post measures	6 weeks	Diagnosis: Schizophrenia, Bipolar disorder, and schizophrenia with comorbid Substance abuse. History: Chronic, clinical history of 10 – 20 years. All had previous therapy.	N= 8 Age = 40 – 45 Sex= 75% male	Music listening and lyric analysis, instrumental improvisation, song-writing, group singing. Reflection on impact of music. Facilitator: Music therapist and mental health therapists.	6 (once a week)	Baseline	Self-report measure: Curative factors questionnaire created by author. Included several factors related to interpersonal functioning. Results: Non-significant increase on 8 out of 10. Group cohesion most notable increase.
Longhofer & Floersch (1993) (USA)	Descriptive	6 months	Diagnosis: Schizophrenia, manic depression, multiple personality disorder. History: severe and enduring	N= 45 attended at least once. Sex: 58% male Ethnic Ratio = African American and Hispanic : European Americans (50:50) 15 core members	Teaching of African drumming singing and dancing. Facilitators: 1 anthropologist, 1 social worker and musicians.	24 (once a week)	Baseline	Authors comments on the outcomes of the group: Provided participants with a meaningful group role and access, through performance, to other community institutions. increased their self-esteem, built a supportive peer group, and fostered skill development.

Appendix 3: Method of critical appraisal

Critique of quantitative studies:

The quantitative studies were critically appraised in line with the systematic method of evaluating quantitative studies presented by Papworth and Milne (2001). The method involved an examination of the internal, external and construct validity of each article by considering if threats to hypothesis and methodological validity occurred. Threats to hypothesis validity concerned the extent to which the research hypothesis fit with theory and statistical analysis. Threats to methodological validity concerned factors associated with research design quality.

Critique of anecdotal studies presenting data in qualitative form:

Anecdotal studies which presented data in qualitative form (quotes) were critically appraised in line with Yardley's (2000) criteria for evaluating the validity of qualitative research. Yardley presents four characteristics of good qualitative research. The characteristics include sensitivity to context (e.g. sensitivity to participants perspectives and relevant literature), commitment and rigour (e.g. methodological competence or skill), transparency and coherence (e.g. demonstration of reflexivity and transparency in the process of data collection), and impact and importance (e.g. the socio-cultural and theoretical impact of the research).

Appendix 4: Semi-structured interview schedule

05/12/2011 –Version 1

Semi-structured Interview Schedule

Introduction:
Hello, as you know my name is Deanna Hall. Thank you for taking the time. We plan to be here for no more than 30 minutes. The interview will be recorded as per your information sheet. All the information you provide during this interview is confidential. The audio-recordings will be kept safe and only the research team will hear them. If you become distressed by the questions I am asking at any point please let me know and we can take a break. Remember you are free to withdraw from this study at any time. Any questions before we start?

Demographics:
Participant No.:
Gender:
Ethnicity:
Length of time in contact with mental health services:
Living circumstances:
Diagnosis:

Common prompts that will be used throughout the interview include: Please give me an example of that. How do you feel about that? How was that for you? What do you think about that?

1. **Experience of the group**
   Can you tell me what being in the group is like?
   Prompt: What do you do when you attend the group? Why have you continued to attend the group?
   Prompt: In what ways is the group important to you? What does the group mean to you?

2. **Experience of relationships with others**
   Can you tell me what it is like being around the other members of the group?
   Prompt: What does it feel like to make music with the other members of the group?

   What is your experience of others in the group like? What is your experience of those outside the group like? What is important to you about being with other people? What is important to you about not being with other people?
   Prompt: How do you feel about the relationships you have? What do your relationships mean to you?

3. **Impact of group on interpersonal relationships.**
   How do you feel about yourself in relation to the group? Has that changed at all, or not?
   If any, what things have you learnt about yourself since participating in the group? If any, what have you learnt about other people since joining the group?

   How does it feel to be with others since experiencing the group?

   Is it the same as before or is it different? How is it different?
   Prompt: What do you make of that? How would you explain it?

Appendix 5: NHS Research and Ethics Committee (REC) approval

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Appendix 6: Research and Development (R&D) approval

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Appendix 7: Study information sheet & informed consent form

Study information sheet.

Exploring the relationship between interpersonal relationships and participation in a community based music group

The study mentioned above, is being undertaken by a student on a degree program. I would like to invite you to take part in it. Please read the information below in order that you have a good understanding of what the study would involve for you and also why I am doing it. If you have any questions feel free to contact me at the email address below, or ask someone at your service to put you in contact with me.

What is this study about?

Research suggests that community music projects like the [redacted] group can encourage people to have good relationships. This study aims to understand how people with complex mental health needs (long-term psychosis with possible comorbidity), and also attending the [redacted] music group experience their relationships with other people.

Why have I been chosen?

Everyone who attends the [redacted] music group and experience complex mental health needs will be asked to take part in the study. [redacted] facilitators will access your NHS notes in order to confirm your diagnosis and the length of time you have been in contact with mental health services.

What is the purpose of the study?

Many community art projects like the [redacted] music group hope to encourage good relationships, and other positive experiences that help people gain a sense of well-being. Individuals who have been with complex mental health needs often experience difficulty making friendships. This can lead to isolation, low mood and poor well-being. This study aims to understand how those with complex mental health needs and attending the [redacted] music group experience their relationships with other people.

What are interpersonal relationships?

An interpersonal relationship is “an association between two or more people”. The association can be based on attraction, love, friendship, work, worship or any other social purpose. We have interpersonal relationships with lots of different people including family members and the lady that sells us milk once a week from the local corner store**.**

Do I have to take part?

No. This is entirely voluntary and you are free not to take part if you do not wish to. |If you decide not to take part it will not affect the care you receive from [redacted] or your involvement in the [redacted]. If you do decide to take part I will ask you to sign a consent form stating that you agree to take part in the study and you understand what the study involves. Even after you sign the consent form you are free to withdraw from the study at any time.

What will happen if I do agree to take part?

If you do agree to take part you will complete a 45min – 1hour interview about your experience of the group and interpersonal relationships. The interview will take place at the [redacted] The lead researcher on the project (Miss Deanna Hall) will complete the interview with you. The interview will be recorded so that none of the information you provide will be forgotten or lost. You will not be asked to provide any personal information about your relationships or people that you know. However, if you feel you do not wish to answer a question you are free to do so.

Is this study confidential?

Yes. The interview will take place in a private room, where you will not be over heard by others. Only the research team will have access to the audio-recordings of the interview and these recordings will be destroyed as soon as the study is completed. Any information that is shared during the interview will not be mentioned to anyone else. However, if you reveal information that makes me worried that you might be a danger to yourself or others I may have to share this with relevant others. This will be discussed with you before the information is shared. Information that will be used from the interview for the study will not include any information that will identify participants.

Your care coordinator will be told that you have agreed to take part in the study so that he she can provide you with support or advice should you want it. If you would like support during the interview you can invite a carer, partner, or your care coordinator to attend with you and be present throughout the interview.

What will happen to the audio recording?

The recording of the interview will be destroyed within 3 months of the study's completion. The typed interview will be analysed by Miss Deanna Hall and her two research supervisors, and kept on a password protected CD. The CD will be held in a locked cabinet at the [redacted]. It will be held in a secure filing office and destroyed 10 years after the study is completed. This is in line with the University's guidelines for protection and confidentiality of research data and complies with the Data Protection Act.

What are the possible risks and benefits of taking part in the project?

It is possible that you might find talking about some of your interpersonal relationships difficult. The research team do not wish to cause you any distress. I hope the interview have a welcoming and kind atmosphere. If you do not feel comfortable talking to me about any difficult issues that arise during the course of the interview please do not hesitate to contact your care co-ordinator or the facilitators of the [redacted] ([redacted]) for further support. Please remember that any information that is shared during the interview will not be shared with others. You also have the right to withdraw from this study at any time.

What will happen to the results of the study?

I will provide you and all other participants with a short summary of the results. The findings will be written up and submitted for assessment as part of the lead researcher's academic thesis. It may also be submitted for publication in a peer reviewed Journal. The write up will include direct quotes from the interview. Again, your contribution will not include any information that would identify you. If you would like a copy of the final paper you are welcome to have one.

Who is the funding this study?

This study is funded by Canterbury Christ Church University. The study is being conducted as part of the researcher's clinical psychology doctoral qualification.

Who has reviewed this study?

The National Health Service (NHS) Research Ethics Committee (REC) has reviewed and approved the study on 9th of March 2012 ([redacted]).

What if I want to make a complaint about the research project?

If you would like to make a complaint about any aspect of the research project please contact [redacted]

If you would like any other information feel free to contact Miss Deanna Hall (lead researcher) at [redacted] at any time.

Exploring the relationship between interpersonal relationships and participation in a community based music project

Please tick all boxes that apply

Contact Researcher: Deanna Hall

1.	**I confirm that I have read and understand the information sheet for the above studyand have had the opportunity to contact Deanna Hall to ask questions.**	☐
2.	**I understand that my participation is voluntary and that I am free to withdraw at any time.**	☐
3.	**I understand that the interviews will be audio-recorded.**	☐
4.	**I agree for anonymous written extracts from my interviews to be included in study reports/ publications.**	☐
5.	**I agree for my care – coordinator to be informed that I will be taking part in the above study.**	☐
6.	**I give permission for my NHS notes to be accessed in order to confirm my diagnosis and the length of time I have been in contact with mental health services**	☐
7.	**I agree to take part in the above study.**	☐
8.	**I would like to invite my carer, partner or care-coordinator to attend the interview with me.**	☐

_____ _____

Name **Date**

_____ _____

Signature **Contact phone number**

Appendix 8: Interview transcript and initial noting sample

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Appendix 9: Table of master themes

Theme 1: Hope for Social Inclusion

Subthemes	Participant	Example quotes.
1.1. Isolation	Derek	"Well I don't really know too many people. I don't have any friends. I've got family and that's all really…. All of my past friends are all on drugs."
	Nigel	"If I sit indoors all day long staring at the same four walls it's enough to make anyone go bloody mad."
	Dave	"I want to be around people but I never really enjoy it… it makes me uncomfortable, but I hope it will get better. I hope to find it easier."
	Derek	"Well rehab wanted me to get involved with things. It stops me being isolated. I'm in agreement I think it does help me."
	Derek	"The group gives you company, someone to talk to have a laugh with make you feel good."
	Frank	"I don't really talk much so I come and I talk."
	Frank	"I'm not alone when I'm here"
	Dave	It's very difficult and I feel lonely … things like this are life lines.
	Sarah	"I don't really have relationships"
	Sarah	"Well I socialise more which I don't always get the chance to do."
	Sarah	I like socialising just over the past couple of years I like socialising with other people [pause] in the group. Did you not like socialising with people before? No I didn't like it.

	Nigel	I only really have my sister. I don't really have a lot of people [pause]. I like being with my sister.
	Marcus	"Well it gets me out the house [pause] meet people."
	Matthew	Do you have people you can talk with outside the group? No… I live alone.
	Alesha	I could be practising at home… but then again it's not social interaction is it.
	Alesha	It's good for me to get out of the house and socialise with people. I prefer the group because of the diversity that's here and to be with other people.
1.2. Desire for activity/interaction	Dave	"Well it gives me something to do. Somewhere to go".
	Dave	"When we come here we have something to do."
	Nigel	"I mean I look forward to this every [week], getting me out like."
	Nigel	"Gets me out of the house…. You know meet people."
	Frank	"I'm always nervous when I go to some place so don't go out much. Once I have a chat with someone I usually calm down a bit."
	Sarah	"It [the group] keeps me active, keeps my mind and my body active, stimulated."
	Nigel	"Well it gets me out the house meet people."
	Nigel	"You know it's good for me to keep busy and do things I enjoy".
	Nigel	"Basically well I mean you know I get out

		[pause] you know once or twice a week and then the only other time I get out is when I come here".
	Marcus	"It's [the group] something positive [pause] its good. To do the time occupy my mind with t to do the time and occupy my mind with the right things."
	Matthew	"It's therapeutic [pause] gets people out of the house".
	Alesha	"It's good for me to get out of the house and socialise with people".
1.3. Beliefs that socialisation and activity alleviates distress	Frank	"Well it's very important to me [the group]. It means I don't stay at home and get morosely depressed."
	Nigel	"Really it just gets me out of the house [pause] You know breaks my day up. So I'm [pause] You know [pause] Well if I don't I get a, a, bit depressed and quiet I get a bit down."
	Frank	"Well I tend to get upset when I'm alone. I have things that make me sad. I hear people saying things. If I come to the group, keep busy, do things it's easier."
	Matthew	"It's a nice focus to come innit, to have a regular slot in your diary where you can chill out have a cup of tea and have a natter to someone"
	Sam	"If I am having difficulties at home I do feel better after playing…. When I get back home."
	Sarah	"Yes that's it, it keeps me active and going. It's good for our mind…. Physically active, mind stimulated keeps sickness at bay."
	Sarah	"I like socialising. I don't really like being alone. It helps me get better."

	Nigel	"If I sit indoors all day long staring at the same four walls it's enough to make anyone go bloody mad."
	Derek	"I just enjoy meeting people."
	Derek	"The injections were horrible. I couldn't think it was like I was a zombie [pause]. I was dribbling all over myself… it was horrible you know."

Theme 2: Non-musical interpersonal experience

Subthemes	**Participant & location in transcript**	**Example quotes.**
2.1. Empathy and understanding	Nigel	"When Andrew was all causing trouble he was like upset... I think he should have been just left alone. Sometimes people don't wanna talk. I think he felt paranoid. He thought people didn't want to speak to him cos he hadn't come for a couple of weeks.
	Frank	"Well a lot of the people, maybe like myself are a bit paranoid, don't trust people and are extremely vulnerable. That means I have to be careful that I don't hurt their feelings. It took me sometime to be aware of that.
	Dave	"I imagine that they're [the other group members] just looking for something to do like me."
	Matthew	"In fairness their doped out of their heads [service users] then they've not had a good life, [pause] and they know it as well as I do. [pause] I haven't had a good life either."
	Derek	"Oh he was just mouthing off being an idiot [pause] I think he had his own stuff

		you know sometimes people get upset like they think people are angry with them."
	Derek	"Everyone is okay it's just sometimes people have a bad day."
	Alesha	"People find this kind of social stuff difficult."
	Alesha	"Could you imagine if I'm ill and they're ill everyone would feel down and angry [pause]. You'd be asking for trouble."
2.2. Difficult social experience	Matthew	"It's a bit difficult… I've known some of these people for 20 years. It's good to see people but on the other hand it's [pause] I don't know it's difficult."
	Marcus	"I feel a bit uneasy around people. It's not their fault it's me… I get paranoid because of my mental health…. Hoping after I'll be better with people."
	Frank	"They have an audience people come to watch [pause] but I, but I tend to shy away from it."
	Dave	"I feel a bit uneasy around people… I'm taking my time with it doing it slowly… I don't like to go somewhere and not to do anything so I take my scrabble with me and maybe someone will play a game of scrabble with me."
	Dave	"It's probably important to be around people but I like being around people because people forget you. I don't like being to close to people because sometimes I get too attached."
	Sarah	"I don't like it when people ask how I am [pause] or how I'm doing? That kind of thing … If I want to talk like that then I would say and you wouldn't have to

		ask”
	Nigel	“There’s a little short guy who came in earlier just at the end there like and I spoke to him like. But I don’t know, I feel like … every time I talk to the guy … I feel like he’s just trying to ignore me.”
	Matthew	“There’s a guy Alan out of services, he just, he just some time ago he came up here just pushing all his dope… the whole place degenerated in a dope den.”
	Matthew	“There’s people here can’t speak a word to you and don’t know you just grunts and how good is that for me.”
	Alesha	“I hate drugs you know, I really hate drugs, I’m so glad they don’t have it here anymore [pause] They had to ban it because people were smoking it so much [pause] I can’t stand drugs it just ruins peoples life.”
	Alesha	“Sometimes I feel weird when like I have had an argument with someone and then come back and see them but it’s usually alright.”
	Derek	“Well sometimes they talk about drink and sometimes I’ve had them here and they’ve been smoking cannabis and that. I can’t handle that I keep well away from all that…. I don’t like to listen to that. I can’t trust that.”
2.3. Support	Derek	Well they give their point of view. Their understanding [pause] you know it’s good for people [pause] To you know tell people. They tell me things too.”
	Sarah	“Good everyone is nice [pause] they take care of me, give me a lift home.”
	Frank	“They’re all telling me to go even further [pause] I should make more use

	Sarah	of my degree. It's a good degree."
	Alesha	"It's so bad if Nathan didn't give me a lift I wouldn't come."
	Derek	"The people who run it [the group] do a lot they give up a lot of their free time to make sure we have this."
	Sam	"They are always welcoming [facilitators] even if you don't come a couple of times."
	Sam	"The thing is there always trying to help [facilitators] even when they are annoying you [pause] to be honest it's nice they give a shit."

Theme 3: Musical interpersonal experience

Subthemes	**Participant & location in transcript**	**Example quotes.**
3.1 Positive creative group experience	Alesha	"It feels good when everything is working well and [pause] Um it sound like it makes sense [pause] but sometimes everyone does things and it sounds like they're not listening to what other people are playing. I felt a bit frustrated then but not as much as I used to now."
	Frank	"After a while extremely positive [making music with the group] when you sort out what your listening too … everyone gets in tune with one another and in line with each other."
	Frank	"People have the difference but the music evens it out... its positive".
	Alesha	"When I feel, I don't know distressed [pause] I can let go with music."
	Alesha	"It feels euphoric [singing in the band] .Especially when I'm having a bad day. It cheers me up I feel good in my mind body and soul."
	Derek	"It feels great [singing in the band] changes how you feel on a physical level you know because it increases endorphins. That helps me more than medication."
	Marcus	"It feels good cos you all doing it…[making music]"
		"Playing together with other people always feels good because your part of something."

3.2. Exchange of musical knowledge	Nigel	"It's like there's a guy that comes [pause] the old boy, and like he brings tapes in and I put them on CD for him and I sort of [Pause] I do a couple of copies of it and bring it here and they listen to it."
	Frank	"We talk a lot about music that we like. About how to play songs. It helps to bond."
	Frank	"He had the album I don't have. He learnt chords off it. He brought it in so I could learn too."
	Sarah	"Have you heard of dollar? … They sold a lot of records in the 80's they were on Eurovision."
	Frank	"Do you know Nina Simone?" *"Of course I do she's great."* "Lena Horne?" *"Yes she was an actress and singer."* "She had a band well they had a band you should listen to it."
	Derek	"Sam showed me some music on phone."
	Elizabeth	"I have learnt so much about music from the guys."
	Elizabeth	"I think that it's so great that people know so much here and are willing to share their knowledge."
	Sam	"You can learn a lot about music here because everyone knows so much."

3.3 Difficult social musical experience	Alesha	"You have people that want to sing when you're trying to sing and that can be irritating or trying to play a different song to what your singing that can be difficult to deal with. [pause] Really hard work sometimes [pause]."
	Frank	"I was playing a song that I wrote [pause] Just to warm up he got upset and got angry with me [pause] shouting and stuff. You know he just kind of lost it for no reason. I, I, I, don't like that [pause] I like coming here to do better on the guitar."
	Matthew	"It's very difficult sometimes I've come in here and picked up a guitar and started playing and people walk in, take one look and walk out again. I mean what does that do for me."
	Alesha	"That's really what makes me feel frustrated I think [pause] because sometimes I got it in my head that I want to do things in a certain way. [pause] I want to make what I'm doing flow and someone else wants to sing or something when I want to and I can't."

Theme 4: Wider community experiences

Emergent themes	**Participant (P) & location in transcript**	**Example quotes.**
4.1. Performance	Sam	"Like since I've been coming to this place like, I've learnt a few things [pause] to get out there you know."
	Sam	"It was good one of the best experiences I have ever had. I played on the album….. I think everyone really enjoyed it. We all went together. It was great. I had never been in a studio before. It's so clever."
	Matthew	"I can have a jam with frank and John. We do these gigs that always go down well."
	Alesha	"Oh it was, lots of people turned up a great turn out I sang this song it's a cover of the beatles".
	Elizabeth	"It's great when you're up there… it feels good when the audience sing along with you."
	Sam	"We had such a good vibe on stage. The people really responded."
	Marcus	"I love it when we do gigs [pause] maybe because I do gigs with other groups [pause]. It feels electric like we're all together."

4.2. Meeting new people	Alesha	"Nathan brought his friend who's a guitarist. He was the most amazing guitar player I had ever seen.
	Sam	"I have met people from all walks of life and it feels really good".
	Alesha	"Being in the group …. You get to meet all kinds of people from different backgrounds and um [pause] it's just really lots of different kinds of people."
	Alesha	"I meet all kinds of people at the gigs. People from all over the country."
	Alesha	"I wouldn't usually get to know people from [pause] you know not like us, but you meet people from all different walks of life and that's what makes it special."
	Matthew	"It's just good to not just be around other people who are crazy [pause] sorry but we are. It's nice that every kind of person is here."
	Sam	"They got a new guitarist to play with us on stage. He's really cool knew exactly what he was doing he really got us all going and we had such a good vibe on stage."
	Elizabeth	"Well you meet people who are in the industry. You know people who do this for a living have a drink with them and stuff [pause] you can have a chat about music."
4.3. Open to artistic experiences	Elizabeth	"I'm more or less on the artistic side of life since I've been coming here, I've been doing a lot of paintings, not paintings but yeah [clears throat]. We have an art group at my home every Tuesday morning"
	Nigel	I'm so much better since coming here [at performing]. Pulled together in about a year got about 5 or 6 gigs.
	Sam	Really I need to be more creative, it helps

		me.
	Alesha	I'm more confident about the group… it helps me improve more confident and do more artistic stuff. Like what? Oh I draw gonna try and get into some pottery.
	Alesha	There's a dance group near me my sister goes I wanna go too I'm creative like that.
	Derek	I used to make things out of metal you know go on scrapheaps things… maybe I should do that again?
	Sam	The thing is I never used to do these kind of things before now I paint and draw.
	Dave	"The group really highlighted to me that I need to express myself and erm I think that's something that I need to do more of."

Theme 5: Belonging

Emergent themes	**Participant & location in transcript**	**Example quotes.**
5.1. Service user commonality	Nigel	"Well you notice you've got something in common…. You all have an illness, your all trying to get better so you try and keep up the groups and that …. That's why you keep coming…. "
	Frank	"Most people here have got similar problems. If anyone's gonna understand it's me."
	Sam	The group is good for that. It's kind of good because we all understand something about each other because we all have had some of the same problems"
	Sarah	"I like socialising like-minded people. We have the same problem. We all have something in common."
	Sarah	"Were all the same here cos we have the same thing."
	Alesha	"The group is good for that. It's kind of good because we all understand something about each other because we all have had some of the same problems."
	Nigel	"People take the piss out of me here, but it doesn't bother me, cos were all in the same boat, aren't we? You know what I mean"
	Derek	"Sometimes people are a bit weird but you know it's gonna happen cos it's the group…we have schizophrenia."
	Derek	Well you notice you've got something in common [pause] you all have an illness and your all trying to get better so you try and keep up the groups and that.
	Sam	If you're unwell and you're just gonna cause trouble or something it's best to stay at home…. I think the service users get it we know what it's like. They don't really understand that part of it.

5.2. Commonality with non-service users	Dave	"Were all the same" *"Can you tell me some more about that?"* "We all have our problems things we worry about."
	Dave	"You see it in the group. All kinds of people come. But they all have problems even if they aren't on clozapine."
	Sam	"We have problems just like everyone else has problems. It's just they just say we have paranoid schizophrenia [pause] Yeah [pause] paranoid schizophrenia…."
	Derek	You realise as you get older. people there have the differences but the music evens it out… its work, its positive which is unlike some of these other groups
	Frank	Whether you have paranoid schizophrenia or not you have to cope and sometimes they make you react.
	Frank	Even if you haven't got paranoid schizophrenia [pause] people have problems don't they.
	Nigel	Other people erm well, basically were near enough all in the same boat in a way.
	Nigel	[Describing a conversation with a woman who asked him about if he had a mental illness when attending his CMHT] "I goes look I'm no different to you the only difference that I've got is I'm a bit crazy and I said don't judge me cos I'm you know got a mental illness like, you know different."
	Matthew	"Cos everybody goes through their shit don't they? I mean everybody's that's here."
	Derek	"Like I said talking and well you realise that the staff are helping people….. They aren't well, trying to make things bad for you. They're trying… you know cos, I would just be alone."

Theme 6: Esteem and positive identity

Subthemes	**Participant & location in transcript**	**Example quotes.**
6.1. Positive service user attributes	Derek	"Yeah you know on the ward [pause] the people do all kinds of shit [pause] some people are having it really bad like [pause] the people who come here [pause] I mean we all have our shit, but it's not bad like that. At least here um [pause] You can talk a bit more".
	Matthew	"Service users really can play. I've heard them they can write songs."
	Frank	"Some people here are really quite excellent musicians [pause] they really know what they're dooooiiingggg."
	Alesha	"You see the thing is everyone that comes has their gifts to bring [pause] no matter. I have met drummers, like really good drummers, rappers, and saxophonists."
	Marcus	"You know I had no idea people did this. It really is amazing everyone has talents they bring."

6.2. Interpersonal Confidence	Dave	*"Have you learnt anything about other people since being in the group?"* "Well not really just that I can be okay around people [pause] as long as I have my scrabble."
	Elizabeth	"I'm more confident I can sort of adapt to people more."
	Alesha	"Like I can just talk to people more easy…. Everyone has something they wanna talk about but I guess sometimes they don't wanna talk."
	Alesha	*"If anything what have you learnt about other people since joining the group"?* "Be more tolerant of others … you really just have to be more patient and understanding of what other people may be going through [pause]. I take my time now. I don't just get angry and say things back [pause]. I like just let people just do whatever they need to do to get things out of their system."
	Elizabeth	"I just feel more comfortable around people, Easier to have a chat."
	Dave	"I still feel like it's hard around people but it's easier than it was."
6.3. Musical Achievements	Matthew	"That CD came out, that was really good. Professional recording, that was the first time I'd ever been in a professional recording studio [pause]. That was brilliant."
	Matthew	"Well because I went into a professional recording studio …laid down piano beats, and everybody thought it was really good [pause] so [pause] Yeah definitely a feather in my cap."
	Frank	"You see as I said I get depressed. So it's nice having achieved something. If I am having difficulties at home I do feel much better after playing when I get home."
	Frank	"Its [the group] made me sharper musically"

	Marcus	"I am learning I'm fast learner. I'm a fast learner very fast."
	Matthew	"This is … studios, professional studios."
	Alesha	"I sing [pause] um [pause] Nathan and John say I'm really good."
	Derek	"Telling people what I do. You know about the music [helps him improve]."
	Derek	"I'm recording a song for the album that I wrote [pause] Frank's gonna play guitar".
	Derek	"Are you coming [to the recording studio?" *"No I can't make that".* "You should come [pause] I'm on the other CD as well."
6.4. self-efficacy	Alesha	"Because I am different from other people I have my own things that I need to work on that I need to do and sometimes you can't do those things in a big group".
	Derek	*"Do you think you've learnt anything about yourself since coming to the group or not."* "I've realised I have got will power…. Over the years I've doubted that, that I thought I'm just always gonna fall back into the drug and that."
	Sam	"I should be a lot better I have lots of guitars … I should practice more."
	Nigel	"I learnt if I could practice a bit more I'd be able to play better."
	Alesha	"Maybe I have to find what I will be good at. It's like you can have two children and one child will start to walk before the other but the other one says more than the one that is walking. Eventually the one that is saying more will start to walk and the one that is not saying much will start talking more [Pause] So it just takes time to find your way. "
	Alesha	"I really need to come more regularly if I want

		my voice to get better."
	Alesha	"If I'm ill and someone else is ill we will probably [pause] something might happen and I will clash with them. It happens a lot when I'm not well [pause] best I hang back."
	Derek	"Well if I don't want to go I don't go [have a drink or take drugs]. I never go… Yeah I don't do that I don't want to be back in that."
	Nigel	"I like music that's why I'm here I'm doing me. You know sometimes you just have to do you [pause] instead of being worried all the time about what other people think."
	Elizabeth	"I think I can do anything I can put my mind to. I [pause] a lot of people wouldn't have thought I would be up on stage singing. If I want to this properly I can If I work at it."
	Sam	"I think you gotta know when's good for you to come and when not [pause] if you unwell and your just gonna cause trouble or something it's best to stay at home."
6.5. Ambition	Alesha	"Yep I wanna be able to sing like him he says if I practice I can get better um [pause] I I [stuttering] really can't wait to do it,."
	Elizabeth	"Singing, I hope to make it you know [pause] I, I, I [stuttering] hope to make um [pause] try and make, take the matter further is what I mean."
	Elizabeth	"I think I can do anything I can put my mind to. I [pause] a lot of people wouldn't have thought I would be up on stage singing. If I want to this properly I can, If I work at it."
	Nigel	"Well like I wanna do better on my guitar and coming here makes me better."
	Frank	I'm not good as them but I'm better since coming here. I want to learn how to do better, I am not great with my chords I should be a lot better.
	Alesha	Do you need to know my stage name?

		If you want to give it yes. It's important to have a stage name so people know who you are.
	Nigel	I think the group should do more gigs. We could really make a name for ourselves if we did.

Appendix 10: Reflective diary extracts

This has been removed from the electronic sample

Appendix 11: Instructions for authors of Arts & Health: An International Journal for Research Policy and Practice

Section B was formatted in line with the instructions for authors provided by the journal Arts & Health: An International Journal for Research Policy and Practice.

Manuscript preparation
1. General guidelines

The journal will only accept manuscripts prepared in accordance with APA style guidelines.

Research and Policy Manuscripts
Each issue will publish several articles focusing on original research. A wide range of research approaches and methodologies will be considered including: empirical studies of arts and health interventions; ethnographic and exploratory research; documentary and policy analysis; case studies; and reflexive practitioner evaluation.

Each issue will also seek to address policy issues relating to arts and health. Articles reporting original research on policy issues at global, national, local or institutional levels will be encouraged as well as scholarly accounts of implementation issues and critical analysis of a wide range of policy issues.

Guidelines for research and policy articles
A typical article will not exceed 6500 words including abstract and references. Contributors should include a word count with their manuscript.

- Papers are accepted only in English. There is no preference regarding American/British English spelling and punctuation.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgments; appendixes (as appropriate); references; table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- All research papers must contain a structured abstract that is divided into the following sections: Background, Methods, Results, Conclusions.
- Each paper should have 3 to 5 keywords .
- Section headings and subheadings should follow APA style guidelines.
- All the contributors of a paper should include their full names, affiliations, postal addresses, telephone and fax numbers and email addresses on the cover page of the manuscript. One author should be identified as the Corresponding Author.
- Please supply a short biographical note for each author
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.
- When using a word which is asserted to be a proprietary term or trade mark, contributors must use the symbol ® or TM.

Additional guidelines for original research papers
While these guidelines are not intended to be prescriptive it is important that authors of original research also take into consideration the following points:

Title page:

- The title of the article should convey something specific about the topic
  a. The role of service user participation in a community based visual arts and health programme: an ethnographic case study.

Main part of manuscript:

- Background. This should establish the context and rationale for the research and provide an overview of the paper. It should also provide a critical account of current relevant research, showing how evaluation of its strengths, limitations and gaps supports the rationale for the current study.
- Research approach and methodology. This should begin with a statement of the research aims and objectives. As well as informing the reader about the rationale for the approach taken this section should provide a critical account of the methods used. It should address the responses by the researcher/s to any methodological or ethical challenges they faced during the study.
- Results. This should outline the main findings from the research.
- Discussion/conclusions and implications. This should situate the research findings within the broader context of current knowledge as well as addressing the implications of the study for research, policy and practice.
- References
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2. Style guidelines

- Description of the Journal's article style
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Appendix 12: Summary of findings to the NHS Research and Ethics Committee (REC) and Research and Development (R&D).

Summary report for study [redacted]

Study title: The interpersonal experience of those with complex mental health needs participating in a community music project: An interpretative phenomenological analysis (IPA).

Study rationale & aims:
People with complex mental health needs experience multiple and interlocking needs which are severe and long-term. These clients require long-term support from social and mental health services. A large proportion of adults with complex mental health needs are individuals with chronic psychosis and comorbid pathologies such as personality disorder (RCP, 2005). Research suggests people with complex mental health needs are amongst the most socially excluded within our society. This may be caused by interpersonal dysfunction, resulting in poor social networks (Buchanan, 1995).
Community music projects provide community based group music activities to clinical and non-clinical populations. Participation in these projects has been shown to improve the interpersonal functioning of those with complex mental health needs living in the community (Longhofer & Floersch, 1993; Odell-Miller, 1995). However, the evidence based is weakened by a lack of studies utilizing qualitative methodologies and little understanding of the mechanisms involved in the improvements reported. The study aimed to explore how people with complex mental health needs experience interpersonal functioning whilst participating in a community music project.

Methodology:
Semi-structured interviews were conducted with ten participants who had complex mental health needs (chronic psychosis with possible comorbidity; RCP, 2005). Participants had attended a community music project for at least 6 months. They were under the care of an assertive outreach team (AOT), were unemployed and between the ages of 18–65. Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) was used to analyse the data. This group of clients may have had several co-morbidities including personality disorder. However, these co-morbidities were not diagnosed.

Results:
The analysis indicated that the interpersonal experience of the participants could be understood in the form of 6 master themes:

1. Desire for social interaction
Participants described a desire to interact with others socially. This seemed to involve experiences of isolation, and inactivity. Participants associated these experiences with depression and other forms of psychological distress. A belief that interpersonal interaction and activity would alleviate distress was also conveyed.

2. Non-musical interpersonal experiences
Participants communicated that non-musical interpersonal experiences involved positive and difficult experiences. Empathy and, emotional and practical support between group members was reported. Difficult interpersonal interactions involving other group members (e.g social anxiety, feeling rejected by others or disappointed in them) were also experienced.

3. Musical interpersonal experiences

Participants described interpersonal experiences involving musical activities including creative experiences, which were related to positive emotions and learning to understand and listen to musical contributions from other group members. The musical interpersonal activity also involved sharing musical knowledge. Difficult musical interpersonal experiences occurred also which involved feeling other group members did not appreciate their interpersonal contributions and learning to share opportunities for musical expression.

4. Wider community experience

Participants experienced performing for wider community and meeting people without mental health diagnosis whilst attending the project. They also reported that attending the project had led them to become interested in other artistic pursuits. Some participants joined other community projects involving art.

5. Belonging

Participants communicated a sense of belonging with service user and non-service user project attendees. Participants seemed to experience belonging through identifying commonalities with other group members.

6. Esteem and positive identity

Participants developed positive beliefs about themselves during their time attending the group. This was experienced as acknowledging positive attributes about service users, feeling ambitious and that they had achieved musically. Participants also gained a confidence in their ability to interact with others and their ability to succeed or cope with difficult situations.

Implications:

The findings of this study indicate people with complex mental health difficulties attending the music project held a desire for social interaction. Through musical and non-musical interpersonal experiences, contacts were made with the wider community and self-concepts of belonging, esteem and positive identity were experienced. These self-concepts informed interpersonal interactions and each other.

Clinical implications exist for assessment, formulation and interventions involving those with complex mental health needs. Assessments clarifying if clients desire social interaction may improve the efficacy of music project intervention. Assessments and resulting formulations may want to consider the client's social contexts as this may be associated with their interpersonal functioning. Music activities may facilitate interpersonal functioning, the development of esteem and positive identity, and making connections with the wider community.

Future research clarifying of the nature of interpersonal experiences facilitating interpersonal learning within this client group is necessary. A longitudinal study may allow clarification of the impact of music participation on interpersonal function, and how improvements reported are sustained over time. The present study is the only qualitative study examining interpersonal functioning and CMP participation amongst those with complex mental health needs. Further qualitative research in the area is required.