Report on Arts Therapies Research Project Jointly Funded by Addenbrooke's NHS Trust (AT) and Anglia Polytechnic University (APU)

By

H. Odell-Miller, M. Westacott, P. Hughes, D. Mortlock and C. Binks

December 2001

Title of Research Study:

An Investigation into the Effectiveness of the Arts Therapies (Art Therapy, Dramatherapy, Music Therapy, Dance Movement Therapy) by measuring symptomatic and significant life change for people between the ages of 16-65 with continuing mental health problems.

Summary: Arts Therapies treatments offer patients therapy primarily through non-verbal means i.e. art forms such as music, art, drama or dance movement. They are particularly effective where normal communication is absent or has broken down. This study was a randomised control design with four separate questionnaires to measure their effectiveness. The numerical results were not conclusive, owing to high variability and small sample size, but the qualitative data reveal interesting facets of the process, for example that the therapist and patients perceptions of the treatment coincide in all treatment cases.

1. INTRODUCTION

This document is a summary of the research process. The first section outlines the planning stages and research process leading up to the eventual design and implementation of the experimental research project.

1.1. Previous Relevant Research

Existing literature available in 1997 at the outset of this study suggests that arts therapies in psychiatry are effective in reducing symptoms and bringing about significant change, both anecdotally (Odell-Miller 1991,1995; Payne, H 1993), and in scientific research outcome studies (Hoskyns 1995, Odell-Miller 1995a; Wilkinson *et al.* 1998). In Payne (1993), research in art therapy, dramatherapy, dance movement therapy and music therapy is mostly qualitative in nature. Furthermore, existing scientific outcome studies available in 1997 were mainly concerned with older people over the age of 65, with dementia and related diagnoses (Odell-Miller 1995a, Wilkinson *et al.* 1998). The former is a study about music therapy, and compared levels of engagement between verbal and music therapy based groups. The latter concerns dance and dramatherapy, and looked at the possible reduction of symptoms as a result of the therapy. In both cases results showed positive outcomes but these were not always statistically significant.

It is also relevant to mention that during the period of the current research project in this study, a dramatherapist, Ditty Dokter, was designing and implementing a separate research project in the arts therapies service here, as part of her Doctoral studies. This research is about intercultural arts therapies practice, and uses video analysis and other qualitative methods to look at material. Initially a pilot study took place on an acute admission unit in 1993-1994, and on Mitchell Day Centre 1995-1997. The final research using questionnaires for evaluation by participants took place on the Young People's Unit in 1998-2000. The research is about identifying cultural variables in the consonance between arts therapists and clients. The hypothesis is that arts therapists' and clients' consonance will be adversely or positively affected by individual cultural variables. The research aims to identify these variables specifically in group arts therapies treatment.

In view of the lack of completed outcome research, and in order to respond to NHS developing agendas, there is an urgent need to measure outcome in the arts therapies, with the under 65 population with continuing mental health problems, in psychiatry. Clinical evidence shows that arts therapies interventions bring about change in significant areas identified by this population at the start of treatment (such as cutting down the need for admission, increasing quality of life) and that these interventions also reduce symptoms such as depression and anxiety (Odell-Miller 1995b; John 1992; Davies 1995). There is a requirement both locally and nationally to demonstrate this in a more systematic and scientifically significant way. The study, whilst responding to national agendas, also responds to a directive within AT in 1997 from the mental health services management team to carry out some systematic outcome research in the Arts Therapies service.

1.2 History and Background

Between 1997 and 1999, Helen Odell-Miller started to plan the study, and to seek to obtain funding for an outcome study. She is employed both at APU and at AT, and during this time it was made possible within both settings to use some time to plan and implement the starting-up of the project. A major component of the Department of Health's and NHS Executives strategy has been to promote the development and use of measures of health outcome. At this time, the Severe Mental Illness group which was constituted as part of this process was working on indicators of health outcome, and how to define these. The government is constantly trying to improve psychiatric care and intervention in these categories, and locally priorities for treatments were being challenged. The hypothesis that the arts therapies are beneficial in increasing the quality of life, cutting down symptoms, and in providing specific non-verbal interventions with such patients is fundamental to the study. The study took some time, over two years, to implement. This was partly owing to time constraints and funding issues and also owing to the fact that the research was breaking new ground. Helen Odell-Miller consulted widely on the methodology as the area was new for arts therapies in the UK. These processes are written up in detail in Odell-Miller(1999) and Odell-Miller (2001) but are summarised here in the following section of this report.

2. DESIGNING THE PROJECT

This section describes some of the procedures during the implementation stage, and also some of the clinical and theoretical issues underpinning the project.

2.1 Developing the Structures

Prior to implementing the research project, and setting up a steering group, Helen Odell-Miller and Arts Therapies colleagues had consultations with leading researchers in the adult mental health field- Professor Geoffrey Shepherd and David Ford from the Sainsburys' Mental Health Centre, and Dr Steve Onyett. Dr. Mark Westacott , Clinical Psychologist at Kneesworth House, agreed to be involved in the detailed design of the project. Arts therapists and other colleagues and clinicians, were consulted widely, and this led to the setting up of a Research Steering Group within AT. Members of this are:

Linda Davies -	Manager Psychological Treatment Services (Chair)
David John -	Manager Arts Therapies Service
Helen Odell-Miller -	Music Therapist and Researcher (and Director of Music Therapy MA at APU)
Geraldine Owen -	Consultant Clinical Psychologist
Dr. Nigel Hymas -	Consultant Psychiatrist
Debbra Mortlock	Sept 1998-Aug 1999
Claire Binks	Sept 1999-Dec 2000 - Research Assistants
Philip Hughes	Dec 2000-Sept 2001

2.2. Finding the Appropriate Methodology

It was important for Arts Therapists to set up research in this field in a scientific way without interfering adversely with the therapeutic process. Much debate centred around qualitative or quantitative design, and early on it was agreed that the study should include both aspects. Much thought was given to the design process, and a pilot project was carried out by Helen Odell-Miller. This involved asking systematic questions about the arts therapies and their value to patients as part of an on-going evaluation process, and asking similar questions to arts therapists working in the UK in this field. Finally, in response to service needs, it was decided to look at all the arts therapies together, using a randomised controlled design. This was a design particularly favoured by medical colleagues, and was also a condition for one of the grants to be awarded from the Addenbrooke's Charity Board. Owing to this a qualitative part to the study was built into the design. At all stages the project was put through the Ethics Committee within the Addenbrooke's Trust, and all necessary procedures adhered to. Some details of the process leading up to the final design will now be described.

2.3 Why is this research looking at the arts therapies as an integrated treatment service?

In the very early stages, a single treatment modality outcome study was planned (Odell-Miller 1999). However, it was important to follow changing trends of healthcare delivery and policies of clinical effectiveness, and these have driven the direction of the study. Since the pilot study and previous single treatment modality research in the arts therapies, increasingly in the UK, integrated arts therapies services have been established with a central referral system. The service at AT was a pioneer for this model. Crucial to providing a clinically effective service is the organisational relevance of any evaluation and research. Important questions were seen as: 'How does the particular arts therapy treatment achieve therapeutic outcome for the patient? Understandably, particular media-specific issues are relevant for the professions. However, for service users and providers, and purchasers, the major question is whether or not the particular therapy is beneficial to the patient: Does it achieve relevant clinical outcomes? Does it contribute to quality of life or change for the patient?

Which specific arts therapy benefits which specific diagnostic group is also a crucial question, but this research is also responding to organisational changes. Threats and cuts were around in the trust, and the mental health services were no longer a 'Priority Service', following amalgamation with the acute medical large teaching hospital. A general look at the whole service was therefore essential to save the service before looking at the more specific detail. The concept of Clinical governance was not absolutely defined at the point of beginning the research, but the issues involved in clinical governance influenced the way the research design developed. It was important to consider the design, taking both these general and arts therapy-specific into consideration. The following section describes further the design process.

2.4 Major Issues Considered in the Design

Many people have addressed the problem of how arts therapists carry out research, both in specific and general terms. The dilemma for the therapist is always whether to look at process of outcome, and there is a question about for some about how meaningful outcome can be measured without looking at the art medium (Lee 1995). To illustrate this point further, some examples will be cited, mainly from music therapy research in the U.K. The relevant research pertinent to music therapy in this field of psychiatry falls into two main categories. The first is concerned primarily with using musical parameters to determine outcome (Aldridge 1996) and focusing on musical material to draw conclusions for outcome. (Lee 1995). The second category is of research carried out by music therapists who consider both musical material and outcome from this (i.e. non-musical behaviours and phenomena) as essential in evaluating outcome (Rogers 1995, Pavlicevic and Trevarthern 1989, Bunt *et al.* 1987, Hoskyns 1995). Aldridge (1996) looks at both categories and discusses the importance of recognising the force of the art form for people who communicate non-verbally, whilst maintaining rigorous research methodology. Aldridge and Verney (1988), discuss a proposed design for research with people with anorexia nervosa, and other psychosomatic disorders, which is similar in

respect of asking general questions, to this proposed study. Tang et al (1994) in his study with people with schizophrenia shows that music therapy cut down negative symptoms, increased the ability to converse with others, and an increase in outside events was shown as a result of a randomised trial over a period of one month. This is significant, although both passive listening and active singing of songs is described in the method of music therapy rather than extensive use of improvisation.

Pavlicevic and Trevarthern (1989) showed musical similarities to other behaviours found in other studies with people with schizophrenia, (Fraser et al 1986, Lindsay 1980). However, whilst this confirms the use of music therapy as a possible diagnostic tool, it looks in detail at what happens in music therapy, rather than at outcome related to the life of the patient in general, outside of the therapy session.

Bunt *et al.* (1987) used a questionnaire evaluation method on a residential psychiatric ward, looking at outcome. The methods of evaluation were mainly related to the actual sessions themselves, although one more general question was connected with asking the patients what effects the treatment had on them if any.

In practice, we might find that a meaningful outcome during and following arts therapies treatments, for a person with schizophrenia or manic depression is quite practical, and could be included in quality of life measures as defined by Ford (1995). Areas covered by these are listed below:

General Life Satisfaction
Finances
Religious Beliefs
Legal and Safety Issues
Health
Social Functioning
Mental Health Services
Living Situation
Daily Activities
Work

Whilst we might need to adapt these to include an emotional or psychological component, important questions for this population regarding outcome of arts therapies treatments might be Does it help me feel better about myself? Does it help me relate better to friends and family? Does it help me get a job? Does it keep me out of hospital? These questions often form the basis of less formal on-going evaluation.

In terms of outcome research in the other arts therapies with this population, at the outset of the study only one or two studies were evident, and the most relevant (Wilkinson et al 1998) was with patients over 65.

Other major sources of research considered in addition to music therapy and other arts therapies research is that concerning psychological or action-orientated therapy

treatments/ interventions with this client group. Shepherd et al (1994 & 1996) in two different publications show how important patient involvement is in evaluating treatments and services.

2.5. Process or Outcome?

In studying the existing literature, the arts therapist is faced with a dilemma: whether to look at the outcome of the process itself, and study or analyse sessions in detail, or whether to look at the reflection of change in general areas for the patient. The hypothesis in this study is that both are important, and this is crucial to any study. In terms of the complexity of adults with mental health problems where general life changes are crucial to well-being, it is important to measure generalities in addition to arts media-based parameters, and to use client centred techniques such as questionnaires which clients and their carers answer themselves. Arts-based parameters reflect change, but in isolation do not always verify that other changes have happened, for example quality of life changes, as shown in the clinical examples in Odell- Miller (1999) mentioned previously. The study is also not diagnostically specific. It is recognised that this presents many variables. However, at this stage the arts therapies service did not operate diagnostic-specific treatments. It was therefore thought to be important to look generally at the mental health service population referred to arts therapies together but to maintain information about diagnosis so that diagnostic groups could be looked at retrospectively. It was also hoped that the study might lead to some significant diagnostic-specific outcomes, or indications for further research, as arts therapies are often not mentioned as effective therapies in the literature owing to the lack of outcome studies. One example of this is in found in a review of effective psychotherapy treatments for with people with schizophrenia (Roth & Fonagy (1996). Family intervention programmes aimed at modification of the support network of the schizophrenic person, and cognitive- behavioural treatment of acute symptoms are mentioned as effective treatments but not arts therapies. However, arts therapies are mentioned as treatments of choice for patients in a recent DOH survey 'Treatment Choice in Psychological Therapies and Counselling' (Parry *et al.* 2000). All this leads to the recognition of the need for outcome studies in the arts therapies. A discussion about the clinical considerations, how these led up to the design now follows.

2.6. Anecdotal Single Case Study Evidence

Anecdotal evidence from single case studies is often seen by therapists as convincing in terms of the efficacy of the treatment, and the following example illustrates the positive and negative aspects of this in terms of research design. Some cases were examined retrospectively as part of the pilot project, looking at outcome in relation to reason for referral. A very interesting phenomenon, is illustrated in the final vignette in Odell-Miller (1999p.133). Four years after the beginning of his therapy, towards the end of treatment, the patient is talking about one of the issues he mentioned on the original referral form. He filled in his own referral form, and wrote as reasons for wanting therapy: “Coming to terms with my personal problems” He also wrote ” Some problem

expressing myself, I would rather leave a situation than deal with it " His key worker, and the patient himself, also had a notion that music therapy would help because of a constant underlying affect of rage towards everyone coming into contact with him. The clinical excerpt described in (Odell-Miller ibid) shows the patient has developed insight into these problems which were originally articulated by him. The vignette described is part of a normal session, and was examined as part of the pilot study for this research. It shows a way forward in how to ask the right questions when designing the research tools. For example we can see that the patient is able to use the therapy to explore the very issues he mentioned at the start of therapy, and that the therapist thinks that the patient's anger towards others has subsided. Other team members think that there is a direct link between this change and his involvement in music therapy. They report that he seems easier to get on with, and less angry. There are also other major changes which have taken place over the period of therapy, for example, he has improved his access and relationship to his children. These changes cannot be attributed to music therapy, without the patient being part of the research, but we can learn from this that we need to design questionnaires relating to expectations of patients, and to design questions which should be asked of the therapist and patients. The PQRST questionnaire described in section 3 is ideal in this respect.

The therapist/patient relationship is often reported by arts therapists as a crucial tool in bringing about an 'effective' treatment outcome. Rogers (1995) writes that it is essential to pay attention to the client/therapist relationship. She points out that client and therapist may have radically different ideas about whether the relationship, or the arts therapy process (music therapy in this case) as a whole is making the most impact on the client. In view of this, she points out that unless the client is involved in evaluation, the research could be entirely based upon the subjective views and aims of the therapist. This again influenced the design. We were particularly keen to use the PQRST measure because it allows people to think of their own goals and also is more suitable for severe mental health problems, than for example the CORE measure which was not designed for people with psychotic symptoms. The qualitative interview design was therefore developed in order to gather data from both patients and therapists about the process, as shown in section 5.

2.7 Further Qualitative Considerations

Owing to the reasons stated above, it was decided this project would be concerned with outcome, how to define it and how to measure it. Outcome is defined as the effect or result of an event or of circumstances. Therefore, we must assume that in discussing outcome in arts therapies we are relating the particular outcome to the events or results of music therapy. In the pilot project the questions which formed the basis of the qualitative part to the study were formulated as described in detail (Odell-Miller 1999), and are summarised here:

What are the benefits to you of this therapy? In your life in general?

Are there any changes you have experienced which you could attribute to this therapy?

What is different about this group music therapy (or other arts therapy) in what it offers you to other treatments/ forms of help?

What makes the group play music (or use another arts medium), and stop talking?

From the material gained, during the pilot study these issues were grouped under headings, and a topic guide was developed which formed part of the main qualitative interview which was carried out, as demonstrated in the research design. For example topics were relationships, non-verbal interaction, self-expression and access to feelings. The point here is that whilst it is clear that music, art, dance or drama, and the 'arts' relationship is a major vehicle for change and development, this cannot be deduced from purely listening to the music or examining the art form. In highlighting issues in more detail, we begin to see the way that the art form and the whole person are inextricably bound up, and that we cannot separate one from the other. It is also important for fund holders, managers and other colleagues to be able to generalise and articulate expected outcome.

3 METHOD

3.1 Introduction

As discussed above, it was decided to use a randomised controlled trial (RCT) design for this study: patients in both the treatment group and the control group took part in the study for six months. The patients in the treatment group had arts therapies input over the six months (and this would typically continue after the study period), while the control group was eligible for treatment after their participation. Patients were referred in the usual way to AT and KHH, All potential participants for the study were screened by arts therapists to assess their suitability for an arts therapies treatment. Arts therapies treatments include, art therapy, music therapy, dramatherapy or dance-movement, offered in either an individual or group setting. Any patients regarded as unsuitable for arts therapies treatment were not approached further by the research team. The plan was that the interviewer would be blind to the outcome of randomisation. (in practice this was difficult as patients would often reveal this information in discussion inadvertently). Following agreement that the referrals were appropriate, the patients would be approached at that stage to see if they would agree to take part in the research. If informed consent was received, patients would be allocated to either group in chronological sequence of their referrals: two successive patients would go to the treatment group, then two to the control group, and so on. The randomness of this process depends on the random arrival over time of patients to the service; this was felt to be a valid assumption.

The measures chosen for this study were four questionnaires, designed to measure patients' psychological wellbeing from various perspectives. The PQRST questionnaire was filled in by the patient every month over the 6-month participation (i.e. 7 times from beginning to end), while the other 3 (HAD, CORE and LSP) were filled in by the patient or carer three times (the beginning, middle and end of the period). There was also a qualitative component to the research; the patients in the treatment group were interviewed after their participation, on their experience of therapy, and the comparison with talking therapies. The next section will introduce the different questionnaires and indicate the reasons for their inclusion in the study.

3.2 The Measures

The four measures are now described briefly to indicate the kinds of variables they are intended to measure. Overall, it was felt they gave a good mix of measures based on personal issues (PQRST), the overall level of distress or severity of symptoms (HAD and CORE), and an objective measure of the patient's presentation, by a third party (LSP).

(1) PQRST (Personal Questionnaire Rapid Scaling Technique (Mullhall 1978)). This questionnaire is based on five issues, which the patient identifies as important. In our application we used a 14-page version of the questionnaire ("PQ14"), rather than PQ10, the 10-page version. The issues were framed in a 'quantifiable' way, e.g. "My level of confidence is.." or "The amount of time I feel unable to do

anything is..". A set of 9 adjectives was used to describe the level of each of these 'variables', ranging from "absolutely none" through "little" and "considerable" to "maximum possible". For each of the 14 pages, patients were asked to choose between pairs of adjectives for each issue. A score was then calculated for each issue, ranging from zero (if the patient always chose the 'low' adjective) to 13 (if he/she always chose the 'high' adjective). If the issue was framed in such a way that a decrease was desirable (as in the second of the examples above), then the score was subtracted from 13. Finally the total score for the 5 issues would be calculated, and would thus be in the range 0-65.

The reason this measure was included is that it should identify the issues that are directly relevant to the patient, which might not always be the case for standardised questionnaires. This focus on the patient as an individual also accords well with the aims of therapy, to explore personal issues.

(2) HAD (Hospital Anxiety and Depression Scale). This measure is well-used, and has been shown to have validity and reliability (Zigmond and Snaith 1983). It measures anxiety and depression - the patient rates their agreement with a statement (e.g. "I have lost interest in my appearance") by a choice from four alternatives, which translates to a scale from 0 to 3. The 7 anxiety questions and 7 depression questions each give a score between 0 and 21, 21 implying the most unwell. The total of all 14 questions thus ranges between 0 and 42, and is also used as a measure of overall mental distress. The HAD measure was chosen because many of the patients in the referral population do suffer from anxiety and/or depression.

(3) CORE (Clinical Outcomes in Routine Evaluation). This is a 34 item questionnaire, filled in by the patient, which provides an indicator of 'global distress' from the total score. There are also subcategories for the level of symptom severity (12 questions), social and life functioning (12 questions), general well being (4 questions) and risk (to self or others, 6 questions). Participants were again asked to rate their agreement with statements (such as "I have felt terribly alone and isolated"), this time in terms of the frequency with which they had occurred over the past week. Each response translated to a score between 0 and 4, 4 indicating the highest level of mental distress. The average score, also between 0 and 4, was calculated for each subcategory, and for the whole 34 questions. If any 'risk' questions were answered positively, the relevant health professionals were informed.

(4) LSP (Life Skills Profile). This was the only questionnaire not filled in by the patient themselves. It is designed for people with chronic mental illness, to be filled in by a third party who knows the patient well, and can assess their functioning in a variety of areas. In the case of people in the care of the mental health services (the majority of the participants), their keyworker was asked to fill in the questionnaire. Where there was no keyworker, a close family member was usually asked instead. The 39 questions all involved rating agreement with

statements (e.g. "Does this person lose personal property?") on a scale that translated to 1-4. The 39 items divide into 5 sub-categories that assess function in the domains of self-care, communication, non-turbulence, responsibility and social contact. The advantage of this questionnaire is that the keyworker's responses should give an objective measure of how the patient appears to and copes with the outside world.

3.3 The Sample Population

The sample population was patients referred from adult psychiatric services to arts therapies services within either Mental Health Services at Addenbbrooke's NHS Trust based at Fulbourn Hospital in Cambridge or Kneesworth House Hospital in Royston. 45 participants enrolled in the study. Participants were all receiving a normal episode of psychiatric treatment at one of the above centres. All subjects were aged between 16 and 65 with continuing mental health problems and had been referred for arts therapies treatment to the Arts Therapies Service at either Kneesworth House Hospital or Addenbrooke's NHS Trust.

3.4 Demographic Details

30 females and 15 males enrolled in the study; of these, 15 females and 10 males completed all the questionnaires. The mean age of participants was 36.8, ranging from 20 to 60, with a standard deviation of 11.9 years. The participants who completed the questionnaires had a mean age 39.4 years, also ranging from 20 to 60, and a standard deviation of 11.2 years. The employment status and educational attainment of participants summarised in tables 1 and 2 below. The numbers of patients who completed the measures are given for each category, with the corresponding figures for all recruits in brackets.

Table 1: Subjects' Employment Status

Employment Status	No. of Patients
F/T employment	0 (2)
P/T employment	2 (3)
Self-employed	1 (1)
Voluntary work	1 (1)
Student	1 (2)
Housewife	1 (1)
Unemployed	8 (17)
Retired (ill-health)	2 (3)
Retired	1 (1)
Sickness/disability benefit	7 (13)
Sick leave	1 (1)

Table 2: Subjects' Educational Attainment

Educational Attainment	No. of Patients
Non-completion stat. education	3 (8)
Completion statutory education	3 (8)
Further education	12 (17)
Higher education	7 (12)

3.5 Psychiatric Details

The mean length of psychiatric history for all the recruits was 11.3 years, with a standard deviation of 8.9 years; the range was from one month to 33 years. For the subset who completed the questionnaires, the mean length of psychiatric history was 11.6 years with a standard deviation of 9.2 years, and the same range. The sample presented with complex mental health problems and a range of diagnoses illustrated in table 3:

Table 3: Distribution of Diagnoses

Diagnosis	Frequency
Dementia (F02)	1 (1)
Schizophrenia (F20)	9 (12)
Schizoaffective disorder (F25)	2 (3)
Bipolar affective disorder (F31)	6 (9)
Recurrent depressive disorder (F32)	3 (9)
Depression (F33)	3 (6)
Reaction to severe stress (F43)	0 (1)
Eating disorder (F50)	1 (2)
Specific personality disorders (F60)	0 (2)

44% of all recruits had a change in their diagnosis during their psychiatric care; for those who completed, the figure was 56%. All participants had prescribed medication for their psychiatric illness; 76% (67%) were prescribed antipsychotic medication, 20% (20%) neuroleptics and 32% (51%) antidepressants (the figures in brackets refer to all recruits). A referral for arts therapies treatments was most often made by the participant's key worker (CPN, ward nurse or occupational therapist) in consultation with the psychiatrist. Reasons for referral were classified using the categories outlined in Table 4:

Table 4: Reasons for Referral for Arts Therapies

Reason for referral	No. of Patients
Patient's request	8 (14)
Difficult to engage verbally	3 (5)
Needs 1:1 support	1 (1)
Emotional difficulties	2 (3)
Has an interest in the medium	4 (8)
Has benefited from open art in the past	1 (1)
Bereavement	2 (2)
To work through a specific issue	1 (1)
Low self-esteem	2 (4)
Difficulty in managing emotions	1 (1)
Difficulties with relationships	0 (2)
None given	0 (2)
Affect	0 (1)

Patients presented with a variety of problems, which are given in table 5. Most patients had problems in more than one category, so the numbers sum to more than the total number of patients.

Table 5: Currently Presenting Problems

Current Presenting Problems	Frequency
Self-harming	5 (12)
Substance abuse	9 (13)
Delusions	6 (7)
Over-anxiety	10 (19)
Withdrawal	14 (24)
Depression	1 (2)
Somatic symptoms	3 (6)
Suicidal ideation	10 (20)
Inappropriate referral	4 (5)
Affect variation	12 (19)
Hallucinations	3 (5)
Anger	13 (22)
Difficulties with relationships	16 (31)
Incoherent speech	2 (4)
Difficult to engage	12 (15)
Difficulty coping with trauma	5 (13)
Difficulty coping with life events	13 (26)
OCD symptoms	0 (0)
Bereavement	3 (8)

3.6 Further Details of Procedure

Having established their suitability for treatment, patients who agreed to take part in the research were interviewed and completed their first set of measures. The first interview was semi structured and had the following objectives:

- Developing a set of five statements to be used in the PQRST.
- Obtaining the first set of HAD, CORE and PQRST scores.
- Identifying a significant other to complete the Life Skills Profile.
- To establish informed participation in the research in line with Ethics Committee requirements (participants were given an information sheet about the research and asked to sign a consent form witnessed by an observer).

At the next stage participants were randomly allocated to the treatment group or control group. Participants allocated to the control group were placed on a six-month waiting list for arts therapies treatment. The treatment group received a routine arts therapies assessment, which determined the therapy medium. Following assessment participants in the treatment group moved on to an appropriate therapeutic programme of music therapy, art therapy, dance movement therapy or dramatherapy. The rationale for obtaining the first set of scores before assessment was that the assessment itself can often be a therapeutic experience. During the research, all participants concurrently received a standard episode of psychiatric support.

3.7 Diagnosis and Arts Therapy-Specific Input

There was a wide range of diagnosis in the sample, as has been noted above, and also a variety of possible input – individual or group therapy using one of the four different media. Table 6 shows both the diagnosis and the form of therapy input, for all the patients in the treatment group. It would be an interesting question for further research, whether patients with particular diagnoses are offered therapy more often in particular media. It is not possible to draw any conclusions along these lines from the present study; the therapy input often depended on the reason for referral, but also sometimes on pragmatic reasons such as the availability of staff and their time. The table also shows the diagnostic subgroup for each patient, where there is a clear diagnosis. Thus people with schizophrenia are in subgroup S and people with affective disorders in subgroup A; subgroup A is further split into subgroups D (depression) and B (bipolar affective disorder or BPAD). This subgrouping will be referred to again in the results section.

Table 6: Diagnosis Related to Arts Therapy-Specific Input for Treatment Group

Patient Number	Diagnosis	Subgroup	Therapy Input (medium/format)
1	Schizophrenia	S	Art Individual
2	Depression	A/D	Art Individual
3	Depression	A/D	Music Individual
4	BPAD	A/B	DMT Individual
5	Paranoid Schizophrenia	S	Art Individual
6	Dementia		Art Group
7	Postnatal Depression/Schizoaffective disorder/delusional ideas		Music Individual
8	Depression	A/D	Art Group
9	BPAD	A/B	Art Individual/Group
10	Chronic Schizophrenia	S	Music Group

After their participation in the project, patients in the control group were assessed for arts therapy input, with a variety of outcomes, shown in Table 7. Several patients did engage in therapy, while others chose not to. Two patients worked with trainee art therapists for a limited period of time, and one continues to attend a music workshop (this is a 'music activity' group rather than therapy, though it is run by trained music therapists). As in the previous table, the diagnostic subgroup is given where there is a clear diagnosis.

Table 7: Diagnosis Related to Future Arts Therapy Input for Control Group

Patient Number	Diagnosis	Subgroup	Therapy Input (After 6 months)
11	Schizophrenia	S	Art Individual (Student)
12	Depression (drug-related, life stressors)		Declined
13	Schizophrenia	S	Declined
14	BPAD	A/B	Art Individual (Student)
15	Chronic Depression	A/D	Music Group
16	Schizophrenia	S	Art Individual
17	BPAD (prev. borderline p.d.)	A/B	DNA Assessment
18	BPAD	A/B	Drama Individual
19	BPAD	A/B	Not for therapy now
20	BPAD	A/B	Art Group
21	Various symptoms indicative of schizophrenia/p.d./drug abuse		Music Workshop
22	Depression	A/D	Psychotherapy
23	Depression/eating disorder/alcohol abuse		Not suitable now
24	Schizophrenia	S	Therapeutic conversation
25	Schizophrenia	S	Music Group

4. RESULTS AND STATISTICAL ANALYSIS

4.1 Introduction

The numerical data comprised the results of the four questionnaires, filled in for 25 subjects (10 in the treatment group and 15 in the control). For each patient there were seven PQRST questionnaires, and three each of the HAD, CORE and LSP questionnaires. By comparing the numerical scores of the two groups and using standard statistical tests, it was hoped to investigate whether arts therapies input made a (statistically) significant difference to patients' well-being. In the following sections, the tests are briefly explained, and the results given; the various possible explanations for the lack of significant results will be examined fully in the Discussion section of this document.

4.2 Statistical Analysis: HAD, CORE and LSP

The aim of the statistical analysis was to investigate whether there was a difference in the numerical results between the treatment and control group, and whether that difference was significant i.e. more than would be expected due to random variation. For three of the four measures (HAD, CORE and LSP) the ANOVA (analysis of variance) test was used. To show a significant effect of the treatment, it was important to have as many participants as possible, ideally at least 30 in both the treatment and control groups. Unfortunately, it proved difficult to recruit this many participants, and there was a relatively high drop-out rate, so that the final sample numbers were 10 for the treatment group and 15 for the control group.

This implies that it is much more unlikely that any difference could be shown to be due to the treatment, and not due to random variation; there were also many sources of random variation to obscure such a difference. These are examined fully in the Discussion section. So when we conducted the ANOVA tests, and found no statistically significant differences in any of the measures, this was to be expected. The values are given in Table 8: the 'significance level' represents the chance of the particular result due purely to random variation. If this level falls below the 'critical value' of 0.05 (5%), then we would usually be confident in saying the results were 'significantly different'.

In none of the 14 tests did the significance level go below 0.05; the lowest value (0.069) is shown in bold in the table. Had this particular test been regarded as significant, self-care would be implied to be better in the control group than the treatment group at the end of the six months. However, 0.069 is still above the generally accepted critical value, and it is difficult to find an explanation for this as a real effect.

Some visual analysis of the data was also carried out alongside these numerical tests; graphs were plotted of the mean scores for the two groups, as they changed over time. Lines were also added to the graphs for 'mean plus one standard deviation' and 'mean minus one standard deviation'. This provided a view of the spread of variation in each

group, with, in every case, a large overlap between treatment and control – a visual confirmation of the lack of significant difference shown in the ANOVA tests.

Tables 8: ANOVA Results for HAD, CORE and LSP

Measure	Time	Significance Level
HAD Anxiety	1	0.502
	2	0.386
	3	0.889
HAD Depression	1	0.980
	2	0.573
	3	0.432
HAD Total	1	0.729
	2	0.920
	3	0.716

Measure	Time	Significance Level
CORE Wellbeing	1	0.471
	2	1.000
	3	0.436
CORE Problems	1	0.303
	2	0.405
	3	0.886
CORE Feelings	1	0.348
	2	0.606
	3	0.971
CORE Risk	1	0.122
	2	0.725
	3	0.419
CORE Total	1	0.277
	2	0.574
	3	0.948

Measure	Time	Significance Level
LSP Self-Care	1	0.631
	2	0.658
	3	**0.069**
LSP Communication	1	1.000
	2	0.699
	3	0.183
LSP Social Contact	1	0.556
	2	0.560
	3	0.370
LSP Responsibility	1	0.666
	2	0.948
	3	0.399
LSP Non-Turbulence	1	0.198
	2	0.670
	3	0.694
LSP Total	1	0.326
	2	0.936
	3	0.139

4.3 Statistical Analysis: PQRST

Because the PQRST data cannot be assumed to have a metric scale, a non-parametric test, the chi-squared statistic, was used. The test was on a table of mean values for the control and treatment groups, for the 7 times; thus the table was (7x2), containing 14 values, and the degrees of freedom were (7-1)x(2-1), i.e. equal to 6. The test would show whether the time and control/treatment variables had a significant effect; to show this at the 5% level, the value of the statistic would have to be more than 12.592. The actual value of the statistic was calculated to be 1.952, so no significant effect of time or treatment was shown.

5. QUALITATIVE RESULTS

5.1 Introduction

Complementing the quantitative aspect of the study, the patients who were in therapy were interviewed at the end of their six-month participation. A set of questions (see Appendix I) was used, arising from a pilot study. They typically became more of a checklist for the interviewer, in a quite informal style of interview. These questions

focused on the usefulness of the therapy in general, and the importance and use of the arts medium in particular. At the same time, the therapists were asked to produce a report, using the same list of issues as prompts. It was hoped that the two perspectives would reveal something of the arts therapy process, and where it might be distinguished from purely talking therapies.

The aim of the interview, in gleaning the patient's observations about their experience in their own words, has much in common with ethnographic research in the social sciences. Hammersley and Atkinson (1995) give a summary of principles for such interviews, which seem to accord well with the approach taken in this project:

> "Ethnographers do not usually decide beforehand the exact questions they want to ask, and do not ask each interviewee exactly the same questions, though will usually enter the interviews with a list of issues to be covered. Nor do they seek to establish a fixed sequence in which relevant topics are covered; they adopt a more flexible approach, allowing the discussion to flow in a way that seems natural."

5.2 Qualitative Analysis

The aim of gathering the interviews and reports was to obtain two views of the process of an arts therapy, to see what insights they held on the benefits (if any) of the therapy and how they were achieved, and whether there was substantial agreement between the therapist and the client. The first problem was to decide how to analyse the many pages of text, in order to bring this information out.

When analysing the numerical data, a series of well established tools were immediately available; by definition, there are more choices in the analysis of a series of interviews. In the field of social research (sociology and anthropology), many projects are qualitative in nature, and rely on interview data. Approaches to analysing interviews vary from using computer programs to count occurrences of significant words, and then building up overall relationships between factors, to approaches that are interpretative from the beginning. It was decided not to use textual analysis software in this project. This was partly because of the extra time involved, but also because it was felt that in a small sample, where different people expressed concepts differently in any case, a mechanistic approach would not add anything that could not be gained by the professional insights of the researchers.

Hammersley and Atkinson (1995, *ibid*.) do not lay any prescriptive rules for this kind of analysis, which is inevitably subjective, except that the concepts that arise should be rechecked against the data, and/or with third parties (the respondents, or another researcher). In this project, some cross-checking was possible by the two researchers.

> "..the process of analysis cannot but rely on the existing ideas of the ethnographer and those that he or she can get access to in the literature. What is important is that these do not take the form of prejudgments,

> forcing interpretation of the data into their mould, but are instead used as resources to make sense of the data."
> (Hammersley and Atkinson (*ibid.*))

Our chosen procedure was to take most or all of the client's significant quotations from the interview, and arrange them in blocks which seemed to be related (for instance, all the comments about the medium). The therapist's report would be compared with the themes which had emerged, and representative quotations from each block were tabulated with corresponding quotations from the therapist's report. The themes might be different for each client, though we will see that common themes did emerge for the whole research group.

For each client, the demographic data, and the scores from the questionnaires were also summarised, to give a picture of the client, and relate the subjective impressions to the numerical results. Thus a case study was constructed for each client (included in Appendix II), and overall reflections were given to highlight the agreement between the therapist and client, and to try to understand the possible reasons where there were discrepancies.

In the great majority of cases there was agreement between the therapist and client on the important aspects of the therapy, and several themes appeared many times for different clients.

- Rapport with the therapist
- Use of the medium
- The effect of prior experiences of the medium
- Benefits in terms of personal issues

In the following table, all the themes are listed for the different clients. The themes which correspond to the four listed above are marked in bold, while themes which relate to being in a group are marked in italic. The remaining themes are thus more particular to the client, although there is still some overlap - for instance A27, J33, M45 and R18 all mentioned issues around commitment or engagement with the therapeutic process. It is noticeable that some themes were mentioned which would be common to therapy in general - the rapport with the therapist being most obvious, but also other issues such as engagement, and group dynamics (for those clients in group therapy). On the other hand, the use of the medium is clearly the factor which distinguishes the arts therapies from other therapies, and this was a theme for every client, not least because it was a focus of the questioning.

Several clients referred to their past experience of the medium, their relationship to the medium outside the therapy, or even to experience of a different arts medium. While this was strictly irrelevant to the focus on the particular therapy, it happened with more than one of the different interviewers, and apparently came about as a result of setting a context in which 'creative expression' was being discussed. In one case the past experience of the medium was actually perceived as a barrier to using music in the therapy sessions; in others the client perceived that a positive experience of the medium

outside the session was helpful to the therapy. Although most clients recognised that it did not matter what their level of proficiency was, the confusion of arts therapies with an opportunity to learn skills was sometimes in the background. In one case there was a mismatch of expectations: the client definitely wanted to 'learn drawing', and both parties agreed that terminating art therapy was the best course.

These examples give a picture of the added level of complexity which the arts medium gives to therapy, compared to the verbal approaches. However, the added value in terms of another mode of expression was shown in many cases, and the agreement between the clients and therapists on the amount and way the medium was used is striking. The following are quotations from four different clients:

> "I find it easier to paint and chat rather than just chat and look into someone's eyes I guess."
>
> "Sometimes, I can't believe what I've put down. Like one time I put all space and rockets taking off into the future and stuff…. So I think it shows how I can be and how I have been… I'm not very good with words. I think in terms of symbols and I find pictures easier to express things sometimes than, well, using words."
>
> "Sometimes you don't want to say anything about your problems and sometimes you can say it musically, in that way"
>
> "Sometimes it was difficult to communicate verbally amongst the group, it was easier to express yourself up on a wall you know"

Table 9: Qualitative Themes

Client	Themes
F02	**Use of the medium** Preference for Talking **Rapport** **Issues**
C19	**Use of the medium** **Rapport** *Experience of the Group*
T22	**Use of the medium- mix of art of talking** Talking Input from other professionals Mismatched expectations Frustrations at lack of skills (evidenced in music activity group) Skills/Therapy perception would extend to other media
R24	**Use of the medium** **Rapport** *The Group* Dis-inhibition and Creativity Insight Benefits Identity as a musician – so art was perceived as more appropriate for therapy
E26	**Use of the medium – musical interaction** **Use of the medium – enjoyment** **Rapport** **Issues** Delusions Expression of difficult feelings
A27	**Use of the medium** **Rapport** *The Group* **Value of the therapy** Engagement Other input
J33	**Use of the medium – inertness** **Use of the medium – being alive** **Use of the medium – expression/relating to the therapist** **Art in the group** **Rapport – being listened to** **Rapport – attention from the therapist** **Issues – going back to hospital** **Issues – relationships** **Issues – lethargy** Goals Ideas for change

	Change – moving on from hospital *Group – differences/similarities* Commitment
M45	**Use of the medium** Talking as well as playing **Rapport** *The Group* Commitment Difficulty of therapy Relationship to the medium outside the session
E12	**Interest in the medium** **Passivity in the medium** The medium outside the session The medium – feeling unskilled **Rapport** *Group issues – affiliation* *Group issues – openness* *Group issues – groups are difficult* *Group issues – new member* Passivity Withdrawal Gender issues Insight
R18	**Use of the medium** Talking is difficult Art in the past **Rapport** Ambivalence Attendance
L29	**Use of the medium** **Rapport** **Value of the therapy** **Issues** Previous therapy Relationships Passive/Active Issues - Academic Success Issues - Confidence
M31	**Use of the medium** **Use of the medium – difficult feelings on paper** More talking than art **Value of therapy** *The group – other members' absences* *The group – similarities with other members* *The group – trust* *The group - rivalry*

6. DISCUSSION

The study has provided the researchers with much valuable experience, and insights into the value and workings of the arts therapies. This section will highlight some of the findings of the qualitative research, and discuss the possible reasons for the lack of significant numerical results. Other observations from our experience of the project will be given, and positive lessons drawn for the design of future studies.

6.1 The Measures

Firstly, we make some observations on the measures that were used. By definition, a measure of a patient's subjective state of mind is never perfect, and the different questionnaires were designed to focus on different aspects of their presentation. Some of the advantages and disadvantages are pointed out for each measure, based on our experience of using them in the study.

PQRST: The advantage of the PQRST measure (and the reason it was chosen) is that it should identify the issues that are directly relevant to the patient, which might not always be the case for standardised questionnaires. This focus on the patient as an individual also accords well with the aims of therapy, to explore personal issues. A possible disadvantage from this concentration on the patient's perspective was brought out by the several people who chose "The amount of time I believe I will get better is..". The population of referrals to the Arts Therapies Department has a variety of diagnoses, but generally have a severe mental illness, and the reality may be that they are unlikely to recover fully. This issue was treated such that an increase was desirable, as the patient intended, yet the outcome of a successful therapy might well have been to gain the insight that recovery was unlikely, yet be able to live positively with that reality. Another possible disadvantage was the increased complexity (and hence cognitive demands) of the questionnaire compared with the more standard format of the other three. In some cases it is possible that patients found the fairly subtle linguistic distinctions quite difficult.

HAD: The HAD measure was chosen because many of the patients in the referral population do suffer from anxiety and/or depression. However, it is also true that for some patients these symptoms are not particularly apparent; for instance, a person with schizophrenia might not show overt depressive symptoms, as these are often masked by severe psychotic symptoms.

LSP: The advantage of the LSP questionnaire is that the keyworker's responses should give an objective measure of how the patient appears to and copes with the outside world. The disadvantage of course is that the measure can be a few steps removed from issues that matter in the patient's internal world (i.e. the ones that are primarily addressed in therapy). Hopefully there is an indirect effect - if these issues are resolved in therapy, a patient becomes more ready to engage with the world, and there should be outward signs of this. Clearly we could hope for the 'communication' score to increase, but also

perhaps at an even more indirect level, the other categories such as 'self-care' score might improve. Another disadvantage in the application of the LSP in this project has been the fact that keyworkers can change relatively frequently. It seems likely that some extra variability was introduced when this happened – in at least one case, three different raters had to be used for the three questionnaires.

Clearly these observations all had an impact on the possibility of finding a clear difference between the treatment and control group. The more general reasons for the lack of significant results are discussed in the next section.

6.2 Reasons for the Lack of Significant Results

The most obvious reason for the inconclusive nature of the numerical results is the difficulty in recruiting and retaining enough participants in each sample. Patients and their keyworkers were often, understandably, unhappy about the possibility they would have to wait six months for treatment. Once in the study, patients were able to exercise their right to leave at any time, and 20 people did so. In most cases no reason was given and we can only speculate on patients' motives. In general, the effect of a third party asking the patient questions on quite personal issues is an unavoidable extra factor in the design; in the case of the treatment group, of course, this was at the same time as the exploration of issues in therapy. Some patients may have found this difficult, in considering whether to participate, or continue their participation. It is worth noting that other workers on therapy outcome studies have found dropout rate be a problem in establishing significant results (e.g. Jones and Asen 2000).

The fact that some rapport does develop between the participant and researcher, and should be at least acknowledged, is demonstrated by the fact that when a researcher left and was replaced, several patients requested to carry on seeing the previous researcher. Hammersley and Atkinson (1995) debate this question at some length in their chapter on 'field relations', and discuss the merits and difficulties of different positions from total participation to total detachment. Such considerations are of course familiar in the context of therapy – in this project the researcher generally adopted a 'sympathetic, neutral' attitude, seeking to put the patient at their ease, but not seeking to take over the therapist's role. The patients probably identified the researcher partly with the medical/nursing establishment, and/or with academia ("Are you from the University?").

Apart from the small sample size, which in itself made the task of showing a significant difference almost impossible, there were numerous sources of variability, which would obscure any treatment effect. Some of these are listed below:

- age/gender/socio-economic/cultural background of patient
- diagnosis of patient
- different therapists and different arts media (for the treatment group)
- different treatment regimes apart from the arts therapy input
- different raters for the LSP, between patients and sometimes over time
- 3 different researchers over the 28 months when there was patient contact

Some of these sources of variability were unavoidable (the last three). The others were a feature of the design, which sought to achieve ecological validity by testing the effect of the actual service offered by the Arts Therapies Department. This meant taking the population of referrals to that department, rather than a subset (such as people with schizophrenia or depression) and including all the arts media and therapists in the treatments. Considering a subset of referrals by diagnosis, or restricting participation to one arts medium or even one therapist, could have reduced some of the variability, with the cost that any conclusion of a beneficial effect would only be applicable to those conditions. There is also the obvious drawback that such a restriction would have made the recruitment of sufficient participants even more difficult.

Finally, and separate from the variability we have discussed, there is the point that six months may be too short a time to look for positive change from a therapeutic input, given the severity and long-term nature of the conditions represented in the population. This effect might be more important for different diagnostic groups; for instance, people with schizophrenia might take longer to engage in therapy than people with affective disorders.

6.3 Discussion of the Qualitative Data

The qualitative interviews became a rich source of data, though they reflected the many variables in the design as much as the numerical data. In an extended conversation, the personality of the researcher, and their rapport with the patient, became even more pertinent. The three different researchers undoubtedly contributed their own styles; one obvious difference being the fact that the final researcher (PH) was also trained as a music therapist, and naturally used this background in some of the 'follow-up' questions.

Whilst the different research assistants followed the same guide in the interviews, clearly patients' responses varied enormously. Likewise, the different therapists wrote their clinical reports in a variety of styles. This is a reminder of the fact that any therapy is a unique combination of (at least) two individuals, and generalisations must always be circumspect. In the context of this project, some additional variables were present, in that all four possible media (art, dance, drama and music) were used, and there were almost as many different therapists as there were patients in treatment. Apart from the different personalities of the therapists, there were differences in theoretical orientation; although the Arts Therapies Department as a whole would all attach some importance to psychoanalytic ideas, there were variations in the way this was implemented. For instance, two music therapy groups, run by different therapists, feature in the study; one was significantly less directive than the other. One therapist might suggest playing music if she thought it appropriate, while the other would not do so (the instruments were simply 'available', and the decision to play was always the clients'). Clearly, the different roles for music in the two groups might lead to a difference in its perceived importance for the patients, and different answers in the interviews.

This would seem to reflect a difference in the way the psychoanalytic paradigm is applied, when the complicating factor of a second medium is present. In a psychotherapy session only talking is available, and the decision to talk or not is almost always led by the patient. The additional decision, to use the arts medium or not, will be mediated by the patient's relationship to that medium, and their experiences of the medium in the past, which may create barriers to using it in the present. This can be seen as another field to explore in the therapy, or as something to be overcome in order to unlock a possibility of alternative expression. Both approaches are valid, and represent the individual compromises, which therapists make in finding their own theoretical stance.

Linked to this is the degree to which the therapist was involved directly in the medium. The idea of non-disclosure, crucial to preserving the purity of the transference in the psychoanalytic encounter, may be seen as compromised by the arts therapist's artistic expression, and some arts therapists do limit their own participation, rather commenting on and supporting the patient's endeavours. This approach may be more practical, or at least more common, in some media (art for instance) than others (music).

As mentioned in section 5, the clients' comments were grouped into related 'blocks', and tabulated with corresponding quotations from the therapists. Some of the analyses in this form are given as an appendix: in brief, a remarkable degree of agreement was found between the therapists' and the clients' view of their encounters. The reaction of the patient to the medium was important, sometimes very much based on their past experiences. Also, the rapport with the therapist was crucial; in one or two cases there was either quite a fragile rapport, or the client decided to terminate therapy altogether, but even here there was a large measure of agreement between the two parties. In two cases where the client terminated therapy, there was some discrepancy between the perceptions, in that the therapist was able to cite some benefits, which they felt the client had obtained, and which the client did not mention at all. While not dismissing the validity of the client's viewpoint, it is possible in these cases that the disengagement process would lead them to minimise the importance of the therapy, and any benefits while they were engaged. Overall the themes that emerged give an idea of the complexity of arts therapies, but also their value in accessing emotion through an alternative means of expression to words.

7. REFERENCES AND BIBLIOGRAPHY

Aldridge, D. and Verney, R. (1988) 'Creative Music Therapy in a hospital setting: a preliminary research design ' *Journal of British Music Therapy*. 2, 2, 14-18.

Aldridge, D. (1996) *Music Therapy Research and Practice in Medicine*.London: Jessica Kingsley Publishers.

Burgess, R.G. (1984) *In the Field: An Introduction to Field Research*, Allen and Unwin, London.

Burgess, R.G. (1988) Conversations with a purpose: the ethnographic interview in educational research. In *Studies in Qualitative Methodology*, volume 1, *Conducting Qualitative Research*, ed. Burgess R.G., Greenwich, Conn., JAI.

Davies, A. (1995) The acknowledgement of loss in working through depression. *British Journal of Music Therapy* 9(1), pp. 11-16.

Ford, D. (1995) *Quality of Life Measures*. The Sainsbury's Mental Health Centre Publications, London.

Fraser, W. King, K. Thomas, P. Kendell, R J. (1986) 'The diagnosis of schizophrenia by language analysis.' *British Journal of Psychiatry* 148, 275-278

Hammersley, M. and Atkinson, P. (1995) *Ethnography: Principles in Practice*, 2nd edition, Routledge, London.

Hoskyns, S. (1995) 'The use of simple rating scales to assess changes in activity during group music therapy.' In A. Gilroy and C. Lee (eds) *Art and Music: Therapy and Research* . London:Routledge

John, D. (1992) Towards music psychotherapy. *British Journal of Music Therapy* 6(2), pp. 10-17.

Jones E. & Asen E. (2000) *Systemic Couple Therapy and Depression*. Karnac Books, London and New York.

Lee, C. (1995) 'The analysis of therapeutic improvisatory music.' In A. Gilroy and C.Lee (eds) *Art and Music :Therapy and Research*.

Lindsay, W. (1980) 'The training and generalization of conversation behaviours in psychiatric in-patients: a controlled study employing multiple measures across settings.' *British Journal of Social and Clinical Psychology. 19,* 85-98.

Mulhall D.J. (1978) *Personal Questionnaire Rapid Scaling Technique*. Nelson Pub. Co. Ltd., London.

Odell-Miller, H. (1991) 'The experience of one man with schizophrenia.' In K.

Bruscia (ed) *Case Studies in Music Therapy.* Pennsylvania: Barcelona Pub.

Odell-Miller, H. (1995a) 'Approaches to music therapy in psychiatry with specific emphasis upon a research project with the elderly mentally ill ' In A. Wigram et al. (eds) *The Art Science of Music Therapy: A Handbook.*Switzerland: Harwood Academic Publishers.

Odell-Miller, H. (1995b) 'Why provide music therapy in the community for adults with mental health problems?' *British Journal of Music Therapy 9, 1*, 4-10

Odell-Miller, H. (1999) Investigating the value of music therapy in psychiatry: Developing research tools arising from clinical perspectives. In: *Clinical Applications of Music Therapy in Psychiatry*, eds. Wigram T. and de Backer J., pub. Jessica Kingsley, London.

Odell-Miller, H. (2001) BSMT Publications, in press.

Onyett, S. (1998) 'Planning a music therapy topic guide and questionnaire design' Personal communication.

Pavlicevic, M. Trevarthern, C. (1989) 'A musical assessment of psychiatric states in adults' In *Psychopathology 22, 6,* 325-334

Payne, H. (1993) *One River Many Currents- Handbook of Inquiry in the Arts Therapies.* .London: Jessica Kingsley

Rogers, P. (Check date) (1995) 'Music therapy research in Europe: a context for the qualitative/quantitative debate'*British Journal of Music Therapy 9, 2* , 5-13.

Roth, A. and Fonagy, P. (1996) *What Works for Whom? A critical view of Psychotherapy Research*. New York: Guildford Press.

Shepherd, G. Murray, A. Muijen, M. (1994) *Relative Values-The differing Views of User, Family Carers & Professionals on Services for People with Schizophrenia in the Community*.London: The Sainsburys Centre for Mental Health Pub.

Shepherd, G. Hardy, P. Hill, R. (1996) *Perspectives on Manic Depression.* London: The Sainsburys Centre for Mental Health Pub.

Tang, W. Yao, X. Zheng, Z. (1994) 'Rehabilitative effect of music therapy for residual schizophrenia' *British Journal of Psychiatry* 165(Supplement 24) 38-44.

Wilkinson,N; Srikumer,S, Shaw K & Orell, M. (1998) Drama and Movement Therapy in Dementia: A Pilot Study. *The Arts in Psychotherapy* Vol 25 Non 3 pp 195-201

Wigram, T (1995) *The Art and Science of Music Therapy : A Handbook.*

West, R
Saperston, B
Switzerland:Harwood Academic Publishers

Zigmond, A. S & Snaith, R. F. (1983)
The Hospital Anxiety and Depression Scale. *Acta Psychiatric Scandanavia* 57, p. 361-370.

APPENDIX I

TREATMENT GROUP

INTERVIEW QUESTIONS

Which therapy did you have (music, art, dance-movement)?

Did you find the therapy helpful?

If helpful

What was it about the therapy that made it helpful? Therapist / Medium / Someone to talk to / etc.

What were the benefits of this compared to a talking therapy?

What was it about the medium? (Elaborate) What it allowed you to express / An interest in the medium

How much did you use music, art or movement in your sessions.

What do you think the therapy helped you with specifically? Relationships, self esteem, thinking through a problem, coping with life.

Did you get what you expected out of the therapy? Refer back to the reason for referral and ask them about that.

If not helpful?

What do you think it was about the therapy that prevented it from helping you?
Were the difficulties related to the medium.

What could have helped you either in the art, music, dance-movement therapy or some other therapy?
Would another form of therapy have been better?

What could have helped you at that time? e.g. nothing.

How much time during sessions did you use the medium?

Ensure that the patient understands that this interview is about the therapy but that it has nothing to do with their therapist, the information will not get back to them.