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A MIXED-METHODS EXPLORATORY STUDY

BY
HELEN LEITH

DISSERTATION SUBMITTED 2014

AALBORG UNIVERSITET

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AALBORG UNIVERSITY
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CV

Helen Leith was born in 1958. She studied bassoon and piano at the Musikhochschule Detmold, Germany. She later worked as youth worker with young German women in France and Great Britain. In 2005 she gained her Master in Music Therapy at Nordoff Robbins London. She has been working with women prisoners since 2008. She was project manager and delivering music therapist of a 'through-the-gate' music therapy project, working with female offenders on their pathway through prison and back in to the community. In 2010 she was awarded a Mobility Fellowship by Aalborg University for doctoral research, which is the topic of this book.

DECLARATION

I hereby declare that neither this thesis nor part of this thesis have previously been submitted for a higher degree to any other University or Institution in Denmark or abroad.

Helen Leith 8th September 2014

ENGLISH ABSTRACT

Women form a minority (5%) in the UK prison system, which is predominantly designed for men. A high number of women prisoners bring experiences of trauma and abuse with them into the system. The incidence of mental health problems is inordinately high compared to the general population. Whilst an increasing number of UK music therapists work in forensic psychiatry providing treatment for mentally disordered offenders, there is a dearth of music therapists working in UK prisons. There is correspondingly little research into music therapy and women prisoners.

This embedded QUAL(quan) mixed methods study investigates whether there is a change in the self-perception of women prisoners attending music therapy, and whether, if this is the case, they show an improved ability to engage with prison resettlement interventions. It also examines the impact of different treatment lengths on outcomes.

10 participants were recruited to the program and attended (bi-)weekly music therapy sessions of 45 minutes. They attended for a minimum of 8 sessions and a maximum of 52 weeks. Clinical interventions included songwriting, improvisation, singing of popular songs, computer technology based composition, rap, and therapeutic teaching. Sessions were held by a registered music therapist.

Data was collected concurrently in the form of semi-structured interviews, self-report measurements, staff observation questionnaires and prison logs on behavioural incidents, adjudications, and program attendance. The interviews of 6 participants were coded thematically and both within participant and between participant analyses conducted. Effect sizes were calculated from the self-report and staff observation questionnaires for all 10 participants. The data was triangulated in the form of exemplary case studies.

Findings showed that women prisoners attending music therapy experienced a change in self-perception. Engagement in music therapy translated into behavioural change outside the music therapy room. Participants showed an increase in self-confidence, self-esteem, self-efficacy, achievement motivation and a number of other areas relevant to successful resettlement. There was a reduction in the number of self-harm or behavioural incidences and attendance of other programs improved. Although short-term therapy was not contra-indicated significant gains were achieved if participants attended music therapy for 3 months or longer.

For severely disaffected prisoners music therapy provided an appealing and motivating intervention, which served as an entry point to other programs required

for resettlement. Women prisoners not only showed an enhanced ability to attend the programs required for their successful resettlement; music therapy created aspirations, which is of significance to downstream outcomes.

DANSK ABSTRAKT

Kvinder udgør en minoritet (5%) i Storbritanniens fængselsvæsnet , der overvejende er designet til mænd. Et stort antal af kvindelige indsatte tager traumer og oplevelser af overgreb med sig ind systemet. Forekomsten af psykiske problemer er overordentlig høj sammenlignet med befolkningen som helhed. Mens antallet af musikterapeuter, der arbejder i retspsykiatrien i Storbritannien er stigende, ses en mangel på musikterapeuter i de britiske fængsler. Der er tilsvarende meget lidt forskning i musikterapi med kvindelige indsatte.

Dette KVAL(kvant) mixed metode studie undersøger, om der sker en forandring i selvopfattelsen (self-perception) hos kvindelige indsatte, der deltager i musikterapi, og hvis dette er tilfældet, om disse kvinder viser forbedret evne til at engagere sig fængslets udslusningstiltag (resettlement interventions). Studiet undersøger også, om behandlingslængden har indflydelse på resultatet af terapien.

10 deltagere blev rekrutteret til undersøgelsen og modtog ugentlige musikterapisessioner á 45 min. De modtog som minimum 8 sessioner og maksimalt i 52 uger. De kliniske interventioner bestod af sangskrivning, improvisation, synge populære sange, kompositioner udført på computer, rap og terapeutisk læring. Sessionerne blev udført af en britisk registreret musikterapeut.

Data blev indsamlet sideløbende i form af semi-strukturerede interviews, selv-rapporteringsspørge-skemaer for indsatte, observationsspørgeskemaer for personale, fængslets opgørelser af adfærdsmæssige hændelser, adjudication og grad af deltagelse i fængslets tiltag for indsatte. Interview med 6 deltagere blev kodet tematisk, og der blev udført analyse for hver enkelt deltager og for gruppen som helhed. Effect size blev udregnet for alle 10 deltagere. Data blev trianguleret i form af tre eksemplificerende casestudier.

Undersøgelsesresultaterne viser, at kvindelige indsatte, der deltager i musikterapi, oplever en forandring i deres selvopfattelse. Engagement i musikterapien overføres til adfærd uden for musikterapirummet. Deltagerene viser øget selvtillid, selvværd, "self-efficacy" (findes ikke i dansk oversættelse), motivation for at opnå forandring, og en række andre områder, der er relevante for at opnå en succesfuld udslusning til samfundet. Der var en reduktion i tilfælde af selvskade,upassende adfærd samt en øget deltagelse i fængslets tiltag for indsatte. Selvom kortere behandling ikke var kontraindiceret viste undersøgelsen positive resultater, når deltagere deltog i musikterapi itre eller flere måneder.

For aldeles utilfredse indsatte udgjorde musikterapi en appellerende og motiverende intervention, der tjente som udgangspunkt for deltagelse i andre tiltag krævet for

udslusning. Kvindelige indsatte viste ikke alene øget evne til at deltage i nødvendige tiltag for en succesfuld udslusning; musikterapi skabte forhåbninger, der er nødvendige for efterfølgende positive resultater.

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No acknowledgments would be complete without mention of the late Tony Wigram who gave me the wherewithal with which to write this thesis. Without his wise and realistic assessment of the funding situation I would not have been in a position to complete.

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CHAPTER 1. SITUATING THE INQUIRY

This section will introduce the research study and outline personal and professional motivation. It will state the initial focus for the research, including, a description of the phenomenon, intervention and population targeted by this study.

There is compelling global evidence that many prisoners suffer from mental health problems (Fazel & Danesh, 2002; James & Glaze, 2006; van den Bergh, Gatherer, Fraser, & Moller, 2011). The incidence is disproportionally high amongst the female prison population. 78% female prisoners in the UK show some sign of psychological disturbance compared to 15% in the general adult female population (Plugge, Douglas, & Fitzpatrick, 2006). Despite evidence of a high level of need for therapeutic input (Corston, 2007) there is a dearth of music therapists working in UK prisons. This raises the question whether the lack of music therapy provision is due to funding restraints within the prison system, whether there is a failure to recognise the benefits of music therapy for this client group and the positive impact it could have on the successful resettlement of offenders, or whether music therapy is contra-indicated for this client group. These questions have acted as a catalyst, leading me in to doctoral research.

1.1. BACKGROUND INFORMATION

From September 2008 until October 2010 I was project music therapist for a Speedwell Trust 'through-the-gate' music therapy project Together through Transitions – in and beyond prison (hereafter TTT) targeting female (ex)offenders with emotional, psychological, mental health and/or substance misuse issues.

TTT offered music-therapeutic support to women who were struggling to engage with prison life and the resettlement process[1]. It aimed to work with them during their passage through prison, helping to support attitudinal change, and to encourage a readiness to engage with the resettlement pathways interventions [2] on offer within the prison.

[1] 'Resettlement' is the process of preparing prisoners for returning to the community after release.

[2] 'Resettlement pathway interventions' refers to the UK government's strategy for facilitating the resettlement of prisoners. It consists of seven 'pathways' or areas where intervention may be required (accommodation; education, training & employment; health; drugs & alcohol; finance, benefit & debt; children & families; attitudes, thinking & behaviour). It takes gender differences in to account by adding two further 'pathways' for women prisoners (support for

For those women released directly from prison into the Greater London area, TTT offered continued support, helping the women through the challenging transition from prison to outside life. Building on the capacity music has to touch upon both 'inner' and 'social' processes (Dickerson, 1982; Odell-Miller, 1995; Pickett, 1976) community music activities were use to help forge relationships between individuals and communities (S Wood, 2006; Stuart Wood, Verney, & Atkinson, 2004), thus promoting social inclusion.

To achieve these aims TTT operated in three phases, each operating at a different site:

- Phase 1: HMP Bronzefield - a local prison for female offenders
- Phase 2: women@thewell - a women's centre for women with substance misuse, domestic violence and mental health difficulties, many of whom have contact with the criminal justice system
- Phase 3: Morley College, North Lambeth - an adult education college

1.2. PERSONAL MOTIVATION

At HMP Bronzefield I worked predominantly with women who were failing to engage with the prison regime and resettlement process either because they were severely self-isolating or because of their challenging behaviour. Such women are difficult for service providers to engage due to the complexity of their emotional and psychological states.

The women I worked with as a music therapist typically had mental health problems such as mood/anxiety and traumatic stress disorders, depression, and anger management issues. Some had diagnosed mental illnesses such as schizophrenia or bi-polar disorder but were in a medically stabilised state. Others were not diagnosed but filled the diagnostic criteria for personality disorder (generally borderline) or Complex PTSD (American Psychiatric Association, 2000). In the course of my clinical work with these women I noticed how many started to gradually re-connect with prison interventions and prison life.

Session notes and recordings of sessions of work at HMP Bronzefield showed a growing ability on the part of these women to work reflectively with music and to

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women prisoners who have been abused, raped or who have experienced domestic violence; support for women prisoners who have been involved in prostitution) (HM Prison Service, 2006)

experience shared meaning making with the music therapist[3]. With some women there was a shift in their way of "being in music" (Pavlicevic, 1997 p.155) suggestive of an underlying change in self-concept. This, in turn, appeared to have a positive impact on their ability to engage positively with the prison system.

An unpublished qualitative and quantitative evaluation of the first 9 months of the project, conducted by the Nordoff Robbins Research Department (2009), confirmed this impression. Music therapy was shown to have a positive effect for these women and offered them much needed support through multiple transitions in the prison, including the transition from solitary in-cell education to participation in more conventional programs offered in the prison Education and Program Departments. This was corroborated in the evaluation of the second year of the project (Nordoff Robbins Research Department, 2010).

Following women 'through-the-gate' heightened my awareness of the complexity of the individual process. I learnt that the sense of identity of offenders is not only formed by the complex interaction between family/societal influences and an individual's life story; it is impacted on significantly by their offending history. The label (ex)offender can become the defining element of a person's sense of self-identity and make it difficult for them to identify with other more positive elements of their person. This was often particularly hard for women whose personal biographies were of trauma and abuse, as was the case with the majority of TTT participants. This confirmed a key concept of TTT, namely that reintegration needs to be supported not only at a practical but also at a psychological and emotional level if feelings of profound disempowerment, self-alienation and low self-esteem are to be overcome.

The observations made in clinical work with these women inspired me to investigate the possible links between music therapy, change in self-perception and improved engagement with prison interventions more closely, leading to my doctoral research on this subject.

1.3. THE SITUATIONAL CONTEXT

1.3.1. THE UK PRISON POPULATION AND MENTAL HEALTH PROVISION

Epidemiological research shows a high incidence of prisoners with mental health problems in UK prisons (2010; 2013). Surveys of the UK prison population have

[3] My thanks go to Prof. Mercedes Pavlicevic. These thoughts were first formulated in discussion of these phenomena with her as part of an evaluation of the project conducted by the Nordoff Robbins Research Department.

shown that up to 90% of prisoners (95% in the case of young offenders) have a diagnosis of mental illness, a drug and/or alcohol dependency related mental or behavioural disorder, or both (2010). Mental disorders are over-represented in women and other minority groups, with the prevalence of mental health disorders much higher than in the general population (Plugge et al., 2006). Changes in sentencing have led to more people being imprisoned at the custody threshold[4], and the number of prisoners with troubled psychiatric histories is rising (Liebling, 2006). Whilst the majority of prisoners with mental disorders do not suffer from a mental illness severe enough to require detention in hospital under the Mental Health Act (1983) statistics indicate a high level of need for therapeutic interventions in prisons (2013).

In recognition of the inordinately high quotient of women prisoners with mental health problems the UK government has repeatedly stated its commitment to improving mental health care for women (offenders) (2001, 2002; 2004; 2009). It outlines a vision of mental health provision which responds to individuals' diverse needs (2003) and recognizes that women value and want more access to complementary, creative and psychological therapies (2002). In spite of numerous reports and governmental papers, mental health provision equivalent to that offered to the general public remains a utopia for the majority of (women) prisoners.

1.3.2. WOMEN AND THE UK PRISON SYSTEM

Despite the recommendations of the Corston Report (2007) the specific needs of women continue to be neglected in a prison system, which is predominantly designed for men (Caulfield, 2010; National Offender Management Service, 2012; Smee, 2009; van den Bergh et al., 2011). These recommendations concern the implementation of gender equality in service delivery, visible leadership and a strategic approach (e.g. the establishment of a commission for women offenders, systematic safeguards to ensure good practice), the addition of two gender specific pathways to the established seven resettlement pathways (for an explanation of resettlement pathways see Footnote 2), prioritisation of the education, training and employment pathway, the creation of alternative sanctions to ensure a proportionate approach to sentencing, and, most importantly in the context of this study, the creation of structures ensuring a holistic, woman-centred approach, establishing an integrated approach to women's (mental) health and well-being.

Whilst there have been important developments aiming to address these issues, there is a significant gap between UK government policy-making and implementation.

[4] Custody threshold is the point at which an offence is considered serious enough to warrant a custodial sentence

The standardized Offender Assessment System (OASys), introduced by the UK government in 2002, and other research (Howard, Clark, & Garnham, 2006; National Offender Management Service, 2012; 2010) recognise that women's resettlement needs differ dramatically to men's in the areas of emotional well-being and relationships. A significant proportion of adult female offenders (65%) (National Offender Management Service, 2012) are assessed as having significant needs in these areas.

Two thirds of women prisoners are mothers (2008) and incarceration can have a disproportionate impact on the mental and emotional well-being of women who have caring responsibilities, particularly if they are imprisoned a long distance from home (Smee, 2009; van den Bergh et al., 2011; Van Voorhis, Wright, Salisbury, & Bauman, 2010). The self-perception that they have failed as mothers further exacerbates the situation. Women in prison are five times more likely to have a mental health problem than women in the general population (Prison Reform Trust, 2013). 53% of women prisoners report having experienced emotional, physical or sexual abuse as a child. Over 50% have been victims of domestic violence (2008; 2010; National Offender Management Service, 2012; 2013; Smee, 2009). In my own clinical work I see a high incidence of women manifesting symptoms of PTSD (complex). There is presumably a link between all of these factors and the inordinately high incidence of parasuicidal[5] behaviour to be found in women's prisons (2010).

Women form a tiny minority in the UK prison population (4.8%) (Prison Reform Trust, 2013). Statistics show high rates of histories of victimisation and trauma amongst women offenders. This often leads to depression, other internalized mood disorders and self-medicating behaviour through substance misuse (Blanchette & Brown, 2006; Bloom, Owen, Covington, & National Institute of Corrections (US), 2003; National Offender Management Service, 2012; Salisbury & Van Voorhis, 2009). Trauma, dysfunctional relationships and mental health concerns impact on a woman's ability to adjust to prison life (Van Voorhis et al., 2010). Such women often manifest self-isolating or challenging behaviour, making it difficult for the prison to engage them in Resettlement Pathways interventions. The Corston Report (2007) highlights the need for therapeutic interventions and environments if women are to rebuild their lives.

[5] Non-fatal self-injury including suicide attempts and self-mutilation

1.4. RESETTLEMENT PARADIGMS

1.4.1. 'RISK-NEEDS-RESPONSIVITY (RNR) MODEL

To date UK government policies have favoured interventions following certain 'evidence-based' principles (Miles & Clarke, 2006; Underdown & Ellis, 1998) with regard to the accreditation of resettlement programs. These principles have their source in the principles of the 'What Works' movement of the early 1990's, which can be understood in terms of a theoretical paradigm for the resettlement and rehabilitation of offenders. This movement, formalised in the Canadian 'Risk-Needs-Responsivity' (RNR) model, favours cognitive behavioural principles (Mair, 2000; D. Smith, 2004) and has been criticised for its implicit deficit aetiology (Tony Ward & Marshall, 2004). Whilst the assessment tool connected to the RNR model - Level of Service/Case Management Inventory: LS/R (Donald Andrews & Bonta, 1995) - was revised to allow for "areas of particular strength to be scored as protective factors" (Donald Andrews, Bonta, & Wormith, 2008 p.2), its primary focus remains risk management and relapse prevention.

Offender's "needs" are divided into:

- Primary level
  "Criminogenic" needs - i.e. 'dynamic risk factors' such as attitudes, criminal associates, skills deficits, substance abuse, family issues, or self-control problems, which are known to be linked to offending behaviour and which can change over time (Bonta & Andrews, 2007).

Criminogenic needs are targeted with the primary aim of reducing harm to the public.

- Secondary level
  "Noncriminogenic" needs such as low mood, relationship conflict, low self-esteem, personal distress, anxiety etc. that impact on the offender's welfare.

The Offender Assessment System (OASys) was introduced by the UK government in 2002 as the main assessment and resettlement tool for use in the community and in custody. Like its Canadian counterpart it gathers information on static factors such as offending history and current offence, and considers dynamic risk factors such as attitude, thinking, behaviour etc. Its primary focus is also on risk assessment and risk management with a view to protecting the public. It aims to guarantee a seamless sentence management (HM Prison Service, 2005).

The RNR model has been criticised for its position with regard to noncriminogenic needs. These appear to be considered of secondary interest and as discretionary treatment targets (T Ward, Mann, & Gannon, 2007). It is true that whilst the 'need' principle does not denounce services addressing noncriminogenic needs (Blanchette & Brown, 2006), it has tended to view them dismissively in the past. Music therapy and other non-cognitive-behavioural therapeutic approaches were seen at best as controversial and at worst as "correctional quackery" (Bonta, 2004). However in a more recent document (Donald Andrews, Bonta, & Wormith, 2011 p.746) the authors explicitly acknowledge that criminogenic needs cannot be dealt with in isolation and that noncriminogenic needs may require targeting in the first instance.

Attrition is highest in the group of high-risk offenders identified through the dynamic risk principles of the RNR model as needing to participate in correctional treatment programs (Olver, Stockdale, & Wormith, 2011; Wormith & Olver, 2002). Programs are needed which increase motivation and build on strengths in order to improve engagement with offence-focussed treatment programs (Donald Andrews et al., 2012). Thus targeting minor risk/need factors in the first instance may be necessary for motivational purposes (Donald Andrews et al., 2008). Furthermore, interventions targeting noncriminogenic needs could potentially impact indirectly on recidivism through their psychological and behavioural effects (Salisbury & Van Voorhis, 2009).

RNR and women offenders

The RNR principles are based primarily on Canadian and North American research and a meta-analysis of relatively small studies predominantly focused on young (male) offenders (McGuire, 2002). It is questionable whether findings from research conducted primarily with male offenders can be directly applied to women offenders, particularly with regard to the development and implementation of appropriate resettlement programs (Turner, 2010; Van Voorhis, 2012). Recent research (Donald Andrews et al., 2012; Rettinger & Andrews, 2010; Van Voorhis et al., 2010) shows that the gender-neutral dynamic risk factors of the RNR-model do have validity for both male and female offenders and are relevant to the prediction of reconviction. However, as Blanchette & Brown point out (2006), given that most offender risk assessment tools were originally developed using male samples and decline in predictive validity when applied to women offenders, it remains to be ascertained whether this is due to shrinkage[6] entailed by cross-validation procedures, or whether it represents an inability of male-based tools to predict female recidivism accurately.

[6] Shrinkage: the phenomenon that generally occurs when an equation derived from, say, a multiple regression, is applied to a new data set, in which the model predicts much less well than in the original sample. In particular the value of the multiple correlation coefficient becomes less, i.e. it 'shrinks'. (Everitt & Skrondal, 2002)

The presence of the same criminogenic needs in both male and female offenders does not necessarily mean that the distribution, the level of need, or the aetiology behind this need is the same (Caulfield, 2010). Gender considerations are more likely to be relevant to program development and delivery (Rettinger & Andrews, 2010) since programs which focus on male criminogenic needs fail to address factors which are unique or more relevant to female offending (Blanchette & Brown, 2006; Harper & Chitty, 2004; Holtfreter & Morash, 2003; Van Voorhis, 2012; Van Voorhis et al., 2010). Taking this into account the Level of Service/Case Management Inventory: LS-R was revised in the LS/CMI (Donald Andrews et al., 2008) to include gender-informed factors.

Nevertheless it remains to be noted that whilst the RNR model has been implemented enthusiastically in many Anglophone countries, its approach has been criticised for a failure to address the structural causes of crime. Independent evaluations have shown only a limited and short-term reduction in reconviction rates and the programs have suffered from low compliance rates (Healy, 2013). A longitudinal study in the UK found that accredited interventions in custody to reduce re-offending did not show statistically significant association with re-offending on release (Brunton-Smith & Hopkins, 2013). This raises questions concerning the effectiveness of resettlement programs introduced into UK prisons.

1.4.2. "GOOD LIVES" (GLM) MODEL

A second theoretical paradigm has emerged in theories that can be encapsulated under the "Good Lives Model" (GLM). GLM contends that managing risk alone is not sufficient to effect rehabilitation (Tony Ward & Brown, 2004; Tony Ward, Yates, & Willis, 2012). Rather, recidivism is more likely to be reduced if individuals are given the wherewithal to live fulfilling lives. Inspired by the tenets of positive psychology they suggest a positive, strength-based approach to assessment, with a twin focus on managing risk and promoting human goods at the same time. They propose a treatment plan, which takes in to account the individual's preferences, strengths, primary goods and relevant environments. Primary goods are defined by the American philosopher John Rawls as things that every rational man is presumed to want. (Rawls, 2009) These can be natural primary goods such as intelligence, imagination, health etc., or social primary goods such at civil rights, political rights, liberties, income and wealth etc. Such a treatment plan establishes what competencies and resources are required to achieve these goods. This involves identifying "the internal and external conditions necessary to implement the plan and designing a rehabilitation strategy to equip the individual with the required skills, resources and opportunities" (Tony Ward & Brown, 2004 p.248). Some noncriminogenic needs, they argue, such as anxiety, low self-esteem and psychological distress can impede the engagement of offenders in a therapeutic alliance. As negative mood states can hinder the processing of information and impair learning these need to be targeted if the learning of new

skills or competencies necessary for resettlement is to be facilitated (Tony Ward & Brown, 2004; Tony Ward, Melser, & Yates, 2007; Tony Ward & Stewart, 2003). Arguably some noncriminogenic needs could be necessary intervention targets in their own right and a necessary precursor to offence-focussed cognitive behavioural work (Blanchette & Brown, 2006; Ogloff & Davis, 2004; Tony Ward & Stewart, 2003). If gender-responsive needs were not found to be risk factors they might still, if left unaddressed, be "integral in creating an indirect recidivistic pathway… through other behavioural factors" (Salisbury & Van Voorhis, 2009 p.546).

Dialogue between the proponents of the RNR and GLM resettlement paradigms has served to clarify their understanding of the potential relevance of noncriminogenic factors to resettlement initiatives. The conceptual divide between the two approaches could be less significant than initially apparent. The RNR model now acknowledges that many preconditions require attention before addressing criminogenic needs. Thus interventions need to build on strengths to facilitate effective participation. "Addressing noncriminogenic needs may also facilitate offender motivation and create a more effective therapeutic environment for the offender" (Donald Andrews et al., 2011 p.746).

1.4.3. SUCCESSFUL RESETTLEMENT

An understanding of the desistance process is essential if resettlement programs are to result in positive downstream outcomes. Research shows that for the vast majority of offenders offending behaviour starts to decline after a peak in their teenage years (F McNeill, Farrall, Lightowler, & Maruna, 2012). For most offenders the normal maturation process will be sufficient to lead to a decline and eventual desistance from criminal behaviour. However, for a small number of persistent offenders the maturation factor will not suffice. Giordano and colleagues (Giordano, Cernkovich, & Rudolph, 2002) argue that for the desistance process to evolve successfully an offender must show a general openness to change, be exposed and respond to environmental 'hooks for change', be able to envisage a 'replacement self', and learn to view deviant behaviour in a different way. Maruna defines this 'replacement self 'as a coherent, pro-social identity (Maruna, 2001) and sees a link between high levels of self-efficacy and the development of such a new 'agentic'[7] identity.

Across the paradigms it is now generally recognised that, in order to be successful, resettlement interventions need to target emotional needs and effect change in

[7] 'agentic' defined as: 1) Social cognition theory perspective that views people as self-organizing, proactive, self-reflecting and self-regulating, not just as reactive organisms shaped by environmental forces or driven by inner impulses 2) The capacity for human beings to make choices in the world (Agentic Communications)

attitudes, feelings and relationships (Antonowicz & Ross, 1994; Bonta & Andrews, 2007; Fergus McNeill, 2009; F McNeill, 2009). Strengthening motivation is essential if offenders are to engage successfully with resettlement programs.

If resettlement is to result in desistance from crime and thereby reduce recidivism prisoners need activities that not only address their offending behaviour but that also engage them holistically and enhance their emotional well-being (Parkes & Bilby, 2010). To make this final connection between resettlement and desistance, programs need to facilitate subjective change in the person's sense of self and identity. The forging of an alternative agentic identity (F McNeill, 2009 p.5) is thought to be a major factor in enabling the offender to desist from crime.

CHAPTER 2. LITERATURE REVIEW

This section will give information concerning the search strategy used to identify literature for this review, the bibliographical resources used, the inclusion and exclusion criteria, as well as the results of the search. It will explore the potential interface between music therapy and resettlement, reviewing relevant music therapy literature in the light of current resettlement paradigms.

2.1. SEARCH STRATEGY

2.1.1. ELECTRONIC DATABASES

A literature search was conducted until October 2011. Relevant literature published after this date is discussed in the Discussion Chapter.

A search of the following electronic databases was conducted:

Aalborg University Research Database, Anglia Ruskin University Research Database, Academic Research Library, Academic Search Premier, CINAHL, Cochrane dk, DADS, EBSCOhost Research Database, ERIC, Google Scholar, Medline, Music Therapy World Archive, ProQuest, ProQuest dissertations, PsychArticles, PsychInfo, PubMed, RILM, SportDiscus, Springer

The following search terms were used:

1. "music therapy" + women + prison*, "music therapy" + women's prison, "music therapy" + prison*, "music therapy" + offenders, "music therapy" + inmates, "music therapy" + rehabilitation of offenders, "music therapy" + recidiv*, "music therapy" + forensic, "music therapy" + correctional, "music therapy" + special* hospitals, "music therapy" + Regional Secure Units, "music therapy" + criminally insane, "music therapy" + forensic psychiatry, "music therapy" + treatment in prisons, "music therapy" + criminal justice system, "music therapy" and delinqu*, music + prison*, music + criminal justice system
2. "music therapy" + self-perception, "music therapy" + self-concept, "music therapy" + identity, "music therapy" + self-actualisation, "music therapy" + self-identity, "music therapy" + self-belief, "music therapy" + self-consciousness, "music therapy" + self-efficacy, "music therapy" + self-esteem

A wider search was conducted of the above databases replacing "music therapy" with "creative therapies" and "arts therapies".

2.1.2. HANDSEARCH

A hand search was conducted of the following journals:

Music Therapy Journal 1968-2003, Music Therapy Perspectives, Music Therapy, British Journal of Music Therapy 1987-2011, Australian Journal of Music Therapy 1997-2011, Nordic Journal of Music Therapy 2001-2011, and Voices: a world forum for music therapy.
Although German and French studies were identified in the initial search they could not be examined for inclusion, as none were electronically accessible.

Edited books were also searched for relevant chapters.

2.1.3. REFERENCE SEARCH

References of all identified studies, included or excluded, were searched for further studies.

2.1.4. RESULTS

A total of 178 studies were found using the above search methods. The initial search identified

- 61 studies relating to music therapy and the criminal justice system (prison, forensic psychiatry & probation)
- 15 studies relating to music projects in prison
- 83 studies relating to music (therapy) and self-concept and its synonyms
- 19 studies relating to music (therapy) and self-esteem.

2.1.5. STUDY INCLUSION AND EXCLUSION CRITERIA

All available data-based studies relating to creative, receptive music therapy, Bonny Method of Guided Imagery and Music, and Musical Presentation published in peer reviewed journals in English were included. Masters theses, PhD dissertations and book chapters were also included where full texts were available.

Papers presented at conferences or symposiums were not included. Studies concerning vibroacustic therapy, or music education and prisoners were excluded.

2.2. PURPOSE

The purpose of this review is to give an overview of existing literature relevant to the research focus of this study. The areas that will be discussed are:

- Music therapy and the criminal justice system
  - Music therapy and the general prison population
  - Music therapy in specialist prison psychiatric units and forensic psychiatry
  - Music therapy and juvenile/young offenders and at-risk youths
  - Music therapy and offenders in the community
  - Music projects in prisons
- Music therapy and self-concept
- Music therapy and self-esteem

2.3. MUSIC THERAPY AND THE CRIMINAL JUSTICE SYSTEM

2.3.1. THE DEVELOPMENT OF MUSIC THERAPY IN CORRECTIONAL AND FORENSIC PSYCHIATRIC SERVICES

The history of forensic music therapy, as documented in the literature, is relatively short, with articles appearing from the late 1970's onwards However, the therapeutic use of music in forensic settings dates is recorded as early as the mid 1930's (Van de Wall & Liepmann, 1936), well before the establishment of music therapy as a registered profession. In the UK there was a rapid growth of the number of music therapist working with offenders with a mental disorder in Regional Secure Units in the 1990s (Sloboda & Bolton, 2002). This continued to grow in the new millennium.

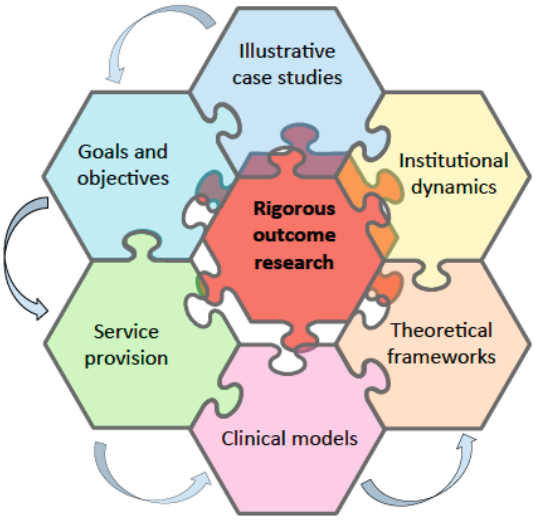
2.3.2. MAJOR THEMES OF FORENSIC MUSIC THERAPY LITERATURE

Most papers on forensic music therapy were concerned with the treatment of offenders with a mental disorder in specialist correctional or forensic[8] psychiatric units (n=21). These papers were primarily descriptive. They reported service provision (Fulford, 2002a; Reed, 2002; Romanowski, 2007; Wardle, 1979, 1980) and provided information on clinical aims. They presented models of work for specific sub-groups of forensic patients such as personality disorder (Compton

[8] Correctional psychiatry works with prisoners whom a court has found guilty and sentenced and who also have a psychiatric diagnosis. Forensic psychiatry refers to the treatment of patients with criminal records who have been found not guilty for reasons of insanity (Daveson & Edwards, 2001).

Dickinson, 2006), bi-polar disorder (Cohen, 1986), sex offenders (Skaggs, 1997; Watson, 2002), violent offenders (Cohen, 1987; Hakvoort, 2002; Nolan, 1983), dual diagnosis (Dijkstra & Hakvoort, 2004; Gallagher & Steele, 2002), and young offenders (Wyatt, 2002). They also offered supportive evidence of effectiveness through accounts of clinical work in the form of illustrative case studies (Boone, 1991; Cohen, 1987; Compton Dickinson, 2006; Dijkstra & Hakvoort, 2004; Glyn, 2002; Hakvoort, 2002; Huckel, 2009; Sloboda, 1997; Sloboda & Bolton, 2002). At the time of this literature review only a small number of empirical research papers were available. Publications in the intervening period have addressed this issue and papers published recently will be discussed in Chapter 6.

Figure 2-1 Themes of forensic music therapy literature



To allow a synthesis of the substantial collective knowledge of practitioners and quantifiable results of outcome research (Barkham & Mellor‐Clark, 2003) papers pertaining to both evidence-based practice and practice-based evidence will be construed as "occupying a space along a continuum" (p.323) and considered equally valid for the purposes of this literature review. It is hoped that this will deliver a review of the literature, which is both "rigorous but relevant" (p.1).

2.3.3. THEORETICAL FRAMEWORKS OF MUSIC THERAPY IN FORENSIC SETTINGS

The literature differentiated between music therapy with mentally ill offenders in correctional/forensic psychiatry and music therapy interventions with the general prison population. A study of the literature revealed four conceptual frameworks (Figure 2-2).

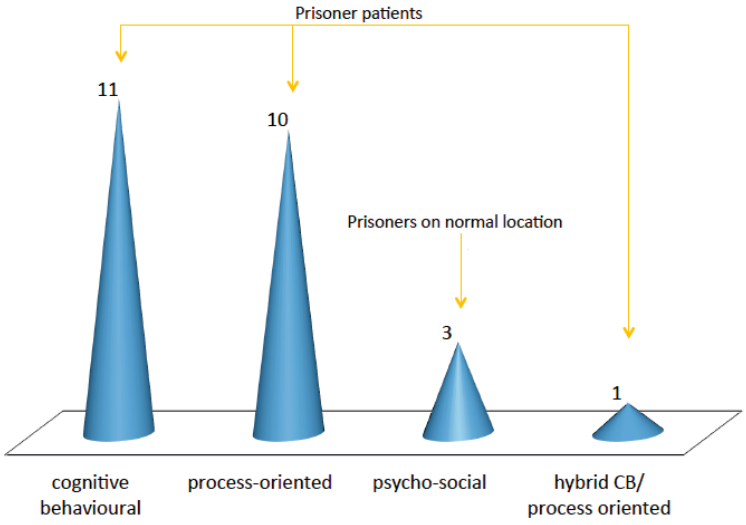
Music therapists working in correctional/forensic psychiatry situated their work primarily within cognitive behavioural or process-oriented psychodynamic paradigms (or in one case, a hybrid cognitive-behavioural/process oriented model).

These therapists reported a strong focus on structure and behavioural outcomes such as relaxation, release of tension, improved social interaction etc. (Fulford, 2002a; Gallagher & Steele, 2002; Hakvoort, 2002; Reed, 2002; Watson, 2002). Their targeted outcomes were either explicitly or implicitly linked to relevant dynamic risk factors (e.g. impulsivity, poor social relationships, lack of motivation, and poor use of leisure/recreation time) of the Risk-Needs-Responsivity theory underlying most Western resettlement interventions (Bonta & Andrews, 2007; Smeijsters, Kil, Kurstjens, Welten, & Willemars, 2011).

Others, working within a process-oriented psychodynamic paradigm focused on intra/interpersonal or organizational dynamics (Compton Dickinson, 2006; Glyn, 2002, 2009; Nolan, 1983; Roberts, 2001; Sloboda, 1997; Sloboda & Bolton, 2002). They considered music therapy to be a valuable medium for facilitating the psychotherapeutic process, given that in a forensic setting verbal self-disclosure can be detrimental for the individual, and strictly verbal therapy of limited value, particularly with clients who respond best to action-oriented forms of expression (Nolan, 1983).

Psychosocial approaches were used more with the general prison population and with offenders in the community. Here the focus was more on personal development using creative, resource-oriented methods. These could be considered to strengthen 'protective factors' (Smeijsters et al., 2011) such as self-esteem, the ability to self-soothe, to set goals, and to act autonomously. They could thus be situated within the second major resettlement paradigm, the Good Lives Model.

Figure 2-2 Theoretical frameworks in forensic music therapy



Whilst the choice to work within a specific theoretical paradigm could reflect the training background of the individual music therapist author, it could also be a response to the mental health needs of the clients and the nature of the various institutions. Correctional/forensic psychiatric units are focused on treating patients with a mental illness whereas prisons serve a corrective function. Nevertheless, as cognitive behavioural and psychodynamic frameworks were generally favoured with mentally ill offenders in correctional/forensic psychiatry, and creative, resource-oriented methods used more with the general prison population and offenders in the community, it is possible that these approaches emerged over time in response to the differing clinical needs of the two populations.

2.3.4. CLINICAL AIMS AND OBJECTIVES IN CORRECTIONAL FORENSIC MUSIC THERAPY

Early music therapeutic interventions in forensic facilities, as documented by Van de Wall & Liepmann (1936), were designed to facilitate emotional growth, promote pro-social attitudes and provide prisoners with an appropriate leisure activity. As music therapy developed as a profession and an increasing number of therapists gained experience with this client group a more clearly defined understanding of the outcomes of music therapy interventions emerged.

Music therapy in correctional and forensic psychiatry[9]

Music therapy in correctional/forensic psychiatry was seen to alleviate symptoms of mental illness (Codding, 2002). This is in line with findings from research in general psychiatry (Gold, Heldal, Dahle, & Wigram, 2005; Gold, Solli, Krüger, & Lie, 2009). Music therapy was seen to have the capacity to enhance functioning, reduce disabling effects of mental illness and decrease the number and length of depressive episodes.

Music therapy was also considered to provide valuable links to reality. The concrete medium of expression in the physicality of playing an instrument helped establish links between an internal (delusional) reality and the external reality of the music therapy session (Loth, 1994), thus addressing a pressing need for mentally ill forensic patients to find ties with reality (Thaut, 1987). The physical, mental and emotional control required to participate in improvisatory drumming, for example, appeared to foster awareness of negative emotions (Fulford, 2002b; Watson, 2002), opening up opportunities for work on anger management issues using a structured behavioural approach (Hakvoort, 2002)

[9] Use was not made of Codding's (2002) list of goals of music therapy in correctional and forensic settings as she failed to clearly allocate goals to a particular setting, making it thus impossible to establish commonalities and dissimilarities.

Music therapy proved a valuable tool for therapeutic work with individuals who have a tendency to concretize because of its action-oriented form of expression. Music's capacity to be both concrete and symbolic made it particularly suitable for addressing the common split between thought and action observed in many offenders (Loth, 1996; Nolan, 1983; Sloboda, 1997; Sloboda & Bolton, 2002).

Music therapy facilitated the reduction of stress and anxiety, allowed for the constructive release of emotions and targeted realistic, time-limited goals (Gallagher & Steele, 2002; Loth, 1996; Thaut, 1989). For mentally ill offenders with limited insight and verbal capacity it offered a non-verbal means of self-expression. It also opened a space in which a range of issues arising from the setting could be looked at, from reflecting on interpersonal behaviour, and acknowledging negative feelings, to gaining rudimentary insight into learnt patterns of behaviour through the therapist drawing attention to analogies between musical events and daily life (J. M. Cohen, 1987; Smeijsters et al., 2011). Given the restrictions inherent to this setting music therapy was considered to offer a unique space for forensic patients to explore their feelings constructively with a degree of confidentiality and to practice exercising choice in a supportive context (Loth, 1994, 1996).

Chambers (2008) regarded the development and maintenance of a self-identity that is personally acceptable to the individual as a "mega conflict" (p.356) for those living within the cultural constraints of institutional life such as forensic psychiatry. The use of pre-composed songs in music therapy was seen to contribute towards the resolution of this 'meta-conflict,' facilitating the creation of an alternative identity so that the individual was no longer solely defined by their label as mentally disordered offender.

Music therapy in custodial settings and with offenders in the community

At face value the aims and objectives of music therapy with the general prison population and offenders in the community were the same as those of correctional/forensic psychiatry. However, close analysis showed that the primary focus was less on addressing issues of relevance to surviving in the immediate 'here and now' but rather on creating competencies, which had the potential to impact positively on long-term downstream outcomes.

The understanding of 'connection with reality', for example, changed subtly in music therapy with the general prison population. Whilst creating a bridge between the internal and external reality of the offender, the internal reality was no longer the internal delusional reality of the mentally ill offender but the tangible reality of prison life. It created a bridge between subjective and objective thought processes (O'Grady, 2009), helped prisoners express and process the feelings aroused by the frustrating 'here and now' of prison life (Daveson & Edwards, 2001) and move

beyond the narrow constraints it imposed (O'Grady, 2009). It created bridges at multiple levels such as from privacy to public, from solitude to togetherness, from self-focus to a focus on others, and helped create a metaphorical "home" (O'Grady, 2009). It also helped create and nurture links between the concrete reality of life 'inside' prison and life 'outside', particularly when a resulting product (e.g. in the form of a performance) could be shared with family and friends. However, the reality of 'outside' was not merely related to present ties with family and friends but also with the often conflicted and painful reality of an individual's past before sentencing (Daveson & Edwards, 2001).

The capacity to make these links is associated with the ability to self-reflect. Thus insight not only comprised the ability to recognize and acknowledge negative feelings. It encompassed an enhanced capacity to self-reflect on personal coping mechanisms, behavioural problems, and the individual's index offence (Daveson & Edwards, 2001). Furthermore, reflection on interpersonal behaviour facilitated the development of social and communication skills (Skyllstad, 2009), which could potentially have a beneficial impact on relationships.

As well as allowing for a constructive release of emotions, music therapy encouraged prisoners to find healthy and appropriate ways of expressing and channelling emotions. The ability to discharge tension, stress, anger and frustration positively (Daveson & Edwards, 2001) is related to emotional regulation and is of great relevance for offenders with violent offences. For those whose offences are related to impulsivity and anger management issues the capacity to regulate emotions is of direct relevance to their ability to desist from further offending.

Music therapy could challenge a prisoner's sense of identity (O'Grady, 2009) and facilitate the search for alternative more positive self-concepts (Hoskyns, 1995). It offered a crucial experimental play space in which insight into learnt patterns of behaviour could be further developed and consolidated by exploring and experimenting with new ways of behaving and functioning (Hoskyns, 1995). Music therapy work in this creative 'play' space could have an impact on downstream outcomes if positive behaviours and attitudes discovered and nurtured in music therapy sessions were transferred from the therapy room to daily life both in prison and beyond. This, however, was not the focus of research.

Music therapy with the general prison population contributed towards the personal development of the individual, helping improve their self-image, self-respect, self-esteem, their sense of responsibility and personal strengths. It also gave them a positive interest with which to structure their leisure time, which is an area of criminogenic need identified by the RNR resettlement paradigm.

Music therapy and juvenile offenders and at-risk-youth

Music therapy goals with young offenders and youth-at-risk shared the aims and objectives of music therapy with the adult population in both prison settings and forensic psychiatry. Music therapy provided a relaxing and playful supplement to cognitive, behavioural programs (Smeijsters et al., 2011; Wyatt, 2002). It addressed immediate issues such as accessing and expressing feelings, managing volatile emotions, decreasing hostile behaviour. However, it also addressed longer term downstream outcomes by helping the young offenders develop inner resources (Skaggs, 1997), by challenging and stimulating thought (Wyatt, 2002) and by developing pro-social skills, and increasing self-esteem (Rio & Tenney, 2002).

Summary

Music therapy, as reviewed over all three intervention areas (prison, forensic psychiatry, juvenile offenders and at-risk-youth) is thus considered to contribute to development in the following areas:

- Interpersonal skills and relationships (social/communication skills, group cohesion, socially appropriate behaviour, trust, empathy, awareness of others, co-operation)
- Personal development (improved self-image, self-respect, self-esteem, sense of responsibility, personal interests and strengths)
- Sense of identity (challenge to existing self-concepts, development of positive self-concepts and a positive alternative identity)
- Emotional regulation and coping skills (exploration, healthy expression and appropriate channelling of emotions, positive discharge of tension, stress, anger and frustration)
- Alleviation of psychiatric symptoms (enhanced functions, reduction of disabling effects of mental illness, decrease in number and length of depressive episodes)
- Connection with reality in the here and now (either the immediate here and now of the music therapy session in forensic psychiatry, or the wider reality of life outside for the general prison population)
- Insight (decreased denial of negative feelings, insight into offending behaviour)
- Locus of control (sense of control through decision-making in music therapy sessions)

2.3.5. COMMUNITY MUSIC PROJECTS IN PRISONS

Community musicians and music therapists share the same musical medium and can have similar targets and aims. However, in contrast to community musicians, music therapists in the UK are registered health professionals who have absolved a validated training program. Their specialist training enables them to carry out risk assessments and risk management and work with vulnerable people in sensitive

settings. Specialist training at Master's level gives music therapists the ability to work at the acute end of the spectrum with very vulnerable people in sensitive environments. They are trained to understand the processes of musical communication and to use music as a medium and tool for initiating or enhancing interpersonal or social communication. Thanks to their extensive training they are able to work over a wide spectrum from intense one-to-one therapy, small groups, large groups through to facilitating music making in the community.

Historically, music therapists have worked with the most severely isolated or with challenging individuals, using music as a means to help a person get round those aspects of their pathology which are precluding access to social interaction. Not being performance-orientated therapist and client are free to focus on the individual's process as it evolves.

There is an increasing amount of research into music projects run by community musicians in UK prisons. Interestingly the research is methodologically more developed than the analogous music therapy literature. Only one paper (Roma, 2010) cited anecdotal evidence. Most evaluations followed qualitative methodologies.

The literature regarding music projects in UK prisons shared common themes with the music therapy literature, in particular with the literature concerning music therapy and the general prison population:

- Music functioned as a bridge between the internal and external reality of the individual participant
- Performances and audio-recordings strengthened links with the outside world and with family and significant friends
- Shared music-making contributed to personal development with particular reference to self-esteem and social skills
- Shared music-making helped in the development of positive, alternative self-concepts by allowing participants to be viewed differently by staff, peers and family

The benefits of music programs were principally seen in areas of personal development such as self-esteem and self-efficacy, expressed through a sense of achievement in the acquisition of new skills (De Viggiani, Macintosh, & Lang, 2010). Programs offered participants the opportunity to develop more positive self-concepts and to experience a creative self, distinct to the role of 'criminal' occupied within the institution (Dunphy, 1999). Social interaction benefitted from learnt skills such as enhanced listening and eye contact and also through the role modelling of programme facilitators (De Viggiani et al., 2010; Digard et al., 2007; Dunphy, 1999; Silber, 2005). All programmes were valued as non-judgmental spaces where the prisoners felt treated with respect and equality.

However the limited, short time frame of such projects left participants with little opportunity to consolidate their gains and many participants found the transition back to normal prison regime difficult to negotiate (Digard et al., 2007). Issues around continuity and follow-up were identified. Some authors considered that music programmes could create a state-of-readiness for (group) therapy or might even require adjuvant therapy to address issues raised during the projects (Digard et al., 2007; Dunphy, 1999).

Whilst there was a belief that some more vulnerable groups of the prison population might benefit from participating in music programmes there was a difficulty recruiting and retaining such individuals (Cox & Gelsthorpe, 2008; De Viggiani et al., 2010; Digard et al., 2007). Because of higher risk factors, prisons were generally reluctant to give security clearance for their participation in group programs due to concerns either for the individual's safety or for the safety of the group. This meant that participants were often recruited from the pool of prisoners who were trusted and already engaging well with the prison system. It was also recognized that programme facilitators sometimes lacked the necessary therapeutic training to meet the needs of more vulnerable prisoners (Dunphy, 1999).

The constraints of working within the prison system highlighted a need for staff education, as lack of support from prison officers could make the implementation of a project flounder (Cox & Gelsthorpe, 2008; Dunphy, 1999). Difficulties accessing prison data and ensuring follow-up made it difficult to establish possible correlations between the outcomes of the immediate project and behavioural change in everyday life (Cox & Gelsthorpe, 2008; De Viggiani et al., 2010; Dunphy, 1999).

As with research into music therapy in prisons, research into music projects suffered from small sample sizes, lack of control/comparison groups, and lack of follow-up interventions.

2.4. MUSIC THERAPY AND SELF-CONCEPT/SELF-ESTEEM AND RELATED SYNONYMS

83 studies were identified using the search terms "music therapy" + self-concept and related synonyms (identity/self-actualisation/self-identity/self-perception) using the search engines mentioned above (2.1.1). 19 papers were identified using the search terms "music therapy" + self-esteem. Of the combined total of these papers 20 were foreign language studies and were excluded from this review. A further 14 papers were unavailable.

A cursory review of the topic area showed that changes in self-concept and increased self-esteem were frequently cited goals and outcomes for music therapy. This was confirmed in a survey of clinicians' use of songwriting as a therapeutic tool, where the categories 'developing a sense of self' and 'developing awareness of

musical and cultural identity' ranked highly as clinical aims (Baker & Wigram, 2005).

In contrast to the literature concerning music therapy and the criminal justice system, music therapy and self-esteem was the focus of numerous research studies. This would seem to indicate the importance attached by researcher music therapists to generating empirical data in support of the anecdotal evidence of descriptive studies.

Papers investigating music therapy and self-concept covered music therapy with a wide range of client groups. However, a range of different synonyms was used interchangeably, apparently to describe the same phenomenon (e.g. self-concept, self-identity, self-perception, self-image, self-actualisation, self-knowledge). The lack of operational definitions made it difficult to establish whether the same phenomenon was indeed under investigation in all papers, and whether or what relationship the different terms had with each other.

An overview of the literature showed that identity can become a central issue for people affected by an adverse life event, chronic illness, or a life situation in which they experience themselves as labelled or stigmatized (e.g. offender, disabled etc.). As Chambers (2008) pointed out, the development and maintenance of an identity acceptable to the individual can become a "mega conflict" (p.356) for those living within the cultural constraints of institutional life such as forensic psychiatry. She considers that issues and inner conflicts inherent to the process of identity-construction can be expressed within music therapy through a range of metaphorical images contained in the words of well-known pre-composed songs. Thus the use of pre-composed songs in music therapy could contribute towards the resolution of this 'meta-conflict' by facilitating the creation of an alternative identity so that the individual is no longer solely defined by their label of e.g. 'mentally disordered offender'.

Common themes emerged in the literature concerning music therapy and self-concept. Music therapy was seen to offer a space where new alternative identities could be explored, performed and validated (Ahmadi, 2011; Aldridge, 1995; Aldridge, Schmid, Kaeder, Schmidt, & Ostermann, 2005; Chambers, 2008; Magee, 2002; McFerran, Baker, Patton, & Sawyer, 2006) at both an intra and interpersonal level. It could offer those who experienced themselves as deprived of purposeful roles and responsibilities a new sense of purpose (Bensimon & Gilboa, 2010) and achievement (Colwell, Davis, & Schroeder, 2005; E. R. Johnson, 1981; Magee & Davidson, 2004). Music therapy was seen as a unique treatment modality – active and perceptive simultaneously (G. Aldridge, 1996) - with a capacity to bypass verbal processing, directly access emotional components of self (Magee, 2002), to allow issues to emerge in a non-threatening way (Allen, 2010) and to embody

concepts of self (Magee, 1999). These themes are equally applicable to all client groups, offenders and other.

The literature pertaining to music therapy and self-esteem covered two client groups only: women victims of abuse and children/adolescents.

Music therapy and self-esteem in women victims of abuse

Self-esteem can be seen as one of the "principle casualties" (Curtis, 1996 p. 305) of women living in abusive relationships. Self-esteem and agency and their antonyms are closely interrelated (Ruud, 1997). A tacit knowledge of this could be reflected in the fact that music therapists often cite empowerment and increase in self-esteem as goals for interventions targeting vulnerable women. Group music therapy for women victims of abuse was seen to offer participants a relaxed atmosphere in which to experience peer support. Women were able to find a voice and tell their stories. This was experienced as validating and inspiring (Curtis, 1996; Whipple & Lindsey, 1999). As in Compton Dickinson's (2006) research into music therapy with personality-disordered offenders, the use of music helped ensure an egalitarian relationship between therapist and clients, thus avoiding the pitfall of replicating the power imbalance in previous abusive relationships.

Music therapy and self-concept of children and adolescents

One of the major developmental tasks of adolescence is the revision of self-conceptions and the formation of an adult identity. Adolescent self-esteem is challenged in the process (Laiho, 2004). Music is considered able to influence psychological functioning profoundly possibly explaining the focus of a body of empirical research on music therapy and self-esteem in adolescents.

A number of research project were conducted to establish whether music therapy increased the self-esteem of children/adolescent, such as hospitalized children (Henderson, 1983), adolescent refugees (C. M. H. Choi, 2007), conduct-disordered/'troubled' adolescents (A.-N. Choi, Lee, & Lee, 2010; Clendenon-Wallen, 1991; Haines, 1989; Kivland, 1986), adolescents with histories of sexual abuse(Clendenon-Wallen, 1991). None of these studies produced conclusive results. Generally there was no statistically significant increase in self-esteem, or results could not be attributed solely to music therapy because of confounding variables. Problems with measurement tools were also reported (self-survey too lengthy, questionnaire not validated for this age group etc.)

Music therapy and self-esteem

Only Maack & Nolan (1999) reported gains in self-esteem for clients attending GIM therapy. The heightening of self-esteem was one of the areas investigated in a survey sent to former GIM clients. 80% of clients entering GIM therapy for reasons of low self-esteem reported gains in this area. The authors felt that an increase in the *"n"* would have confirmed this finding significantly.

Summary

A review of music therapy and self-concept, and music therapy and self-esteem showed that these were not only frequently cited therapeutic goals in the descriptive clinical literature but also the focus of numerous research studies. This would seem to indicate the importance attached by researcher music therapists to generating empirical data in support of the anecdotal evidence of descriptive studies.

It is noteworthy that empirical research into music therapy and self-esteem focused primarily on women (with experience of abuse) and (at-risk) adolescents raising the question of whether this is indicative of a propensity within these groups towards low self-esteem and a belief that gains in this area would be beneficial.

However, much of the empirical research reported in the reviewed papers showed inconclusive results. Whether this was due to a lack of power, insufficiently sensitive measurement tools or mono-methodological study designs is unclear. Studies, which triangulated both effect and process data were more able to evidence and explain change in this domain.

What knowledge gap this research is designed to fill

The music therapy profession has accumulated a substantial, collective body of knowledge in the areas of music therapy and the criminal justice system and music therapy and self-concept/self-esteem. There are, however, no linking studies combining research into both areas simultaneously.

Whilst women prisoners are proportionately well researched in comparison to their male counterparts (taking in to consideration their minority status in the prison estate) there is still little research into this area. A mixed-methods study investigating music therapy and the self-perception of women prisoners would provide a welcome extension to the knowledge base in this field. A multi-methods study of music therapy and self-perception could also address the difficulties experienced by mono-methodological studies in this area, where findings have been disappointingly inconclusive.

At the time of this literature review (October 2011) there is no literature at all explicitly examining the interface between music therapy and resettlement. Given that little is understood conclusively about the gender-specific needs of women in the criminal justice system, music therapy research could offer an additional, novel lens through which to study the phenomenon.

This study aims to study the phenomenon of music therapy and the self-perception of women prisoners with respect to their resettlement needs, as outlined in the working hypotheses and research questions of the following chapter

CHAPTER 3. METHODOLOGY

This section will outline the working hypotheses and research questions and how they arose. The epistemology underlying the study design and the rationale for choosing an embedded (QUAL/quant) mixed methods approach (Creswell & Clark, 2007) will be discussed. This section will also explore the researcher's pre-understanding and bias and give information concerning data collection and data analysis. It will introduce the measurement tools used in this project and outline statistical deliberations. It will address ethical considerations and give information concerning research ethics approval.

3.1. HYPOTHESES AND RESEARCH QUESTIONS

The working hypotheses are based in the clinical experience of the researcher, who worked in this setting over a number of years:

1. Women prisoners attending music therapy experience a change in the way they see themselves and feel about themselves
2. Music therapy helps women prisoners feel more positive about themselves
3. This impacts favourably on their willingness and ability to engage with prison interventions.

Following the literature review the working hypotheses were further refined and were tested internationally at conferences, through seminar discussions at PhD courses with others in related fields and through discussions with PhD supervisors. They are:

1. Is there a process of change in the self-perception of women prisoners with non-psychotic mental health problems attending music therapy?
2. What is the nature of the experience of women prisoners with non-psychotic mental health problems attending music therapy, with particular reference to self-perception?
3. If there is a process of change in the self-perception of this population, how does this affect a prisoner's ability to engage in resettlement pathways interventions?
4. What is the effect of different treatment lengths on a prisoner's ability to engage in resettlement pathways interventions?

3.2. PRE-UNDERSTANDING AND BIAS

The primary focus of this study is qualitative and it takes the interaction between the researcher, participants and data into account. The researcher's own subjective perceptions are seen to hold potential for yielding rich, informed data (G Ansdell & Pavlicevic, 2001). As long as checks against the potential distortion of data through bias are built into the research method this interaction can be used as a research tool (Bruscia, 1995). This is achieved in part by the researcher reflecting on how the process and outcomes of the study are linked to his or her perspective.

My own values and beliefs, personal and professional perspectives will be examined in the following Epoché and in a RepGrid analysis. These have been undertaken with a view to explicating any possible biases with regard to particular aspects of this study (Bruscia, 2005).

3.2.1. EPOCHÉ

After training as a music therapist, I became aware of the plight of women in prison. I was struck by the high incidence of women with mental health problems in UK prisons, the limited availability of psychological therapies and the lack of music therapeutic provision. My assumption was that music therapy would be relevant and appealing to many of these women. They are sometimes reluctant to access verbal therapy because of a perception that they might be required to talk about their index offence or painful issues related to past experiences. Music therapy could conceivably be perceived as a less intimidating alternative to verbal therapy.

Personal life experience and the experience of women prisoners

My own extensive experience of life in the 'closed' institution of a religious community (from 1981-2008 I was a member of a Benedictine community of women) lead me to identify with women living in the, albeit very different, 'closed' institution of a prison establishment. In the community I was part of a minority age group (neither young nor old), which was largely disregarded by the leadership, and I experienced this as disempowering. This deepened my ability to relate to the situation of women prisoners, who are a minority in a prison system which is predominantly designed for men prisoners (Corston, 2006; Smee, 2009).

In clinical supervision of the 'through-the-gate' music therapy project Together Through Transitions – in and beyond prison (TTT) UK music therapist Sandra Brown, my supervisor at that time, drew my attention to the similarity of my personal situation (I was in the process of transitioning out of the community back into life as a lay person at that time) with the project focus of supporting women prisoners through multiple transitions on their trajectory through the criminal justice system.

It is possible that some or all of these parallel experiences bias me to assume that all women prisoners experience their situation as restricting and disempowering, and that this experience will make them desirous of change.

Personal life experience and worldviews

I came to training in music therapy as a mature student. After prolonged exposure within the community to a monolithic worldview based on the underlying tenet of a single, absolute 'Truth' I was confronted with worldviews which embraced the existence of multiple truths and realities. My own experience of Catholic dogmatism, with its tendency to 'black and white' interpretations of reality, is in stark contrast to the stance I adopt as a music therapist. In work with clients I encourage them to acknowledge and integrate the grey zones of their individual biographies. Over the course of time I experienced a growing dis-ease with worldviews, which fail to acknowledge the complexity of human existence and individual situations.

This experience leads me to feel uncomfortable with dogmatic tenets such as the incompatibility theory of the paradigm 'war' (Howe, 1988). To speak in terms of one paradigm precluding the other (Guba, 1987) just as surely as "belief in a round world precludes belief in a flat one" (p.31) is polarising. It rules out all consideration of an intermediate grey zone. Thus complex questions involving, for example, both rational and experiential components, such as why our human perception leads us to *experience* the world as flat whilst *knowing* that it is round (to continue with Gruba's allegory), are excluded from the debate. Including such questions would shift us out of the bi-dimensional into a multidimensional thinking space. To my mind this would do better justice to the complexity of the human experience. This conviction has undoubtedly influenced my decision to adopt a study design, which enables me to study complex phenomena and relationships and their interaction from multiple perspectives.

My decision to incorporate quantitative elements in my research design is influenced by the need of an evidence-base to support my work in prison. This is driven by the pragmatic requirement to demonstrate the effectiveness and relevance of music therapy for women prisoners to colleagues and managers at HMP Bronzefield and, in the long-term, to influence policy. It responds to the legitimate desire of the service commissioner to know what outcomes can be expected of the service provided.

My own personal experience of completing surveys and other 'quantitative' methods makes me aware of both their potential and their limitations. Whilst useful, they can be a blunt instrument, revealing little of a respondent's reasoning (Feilzer, 2010). My desire to gain as complete an understanding as possible of the phenomenon and its relation to resettlement has influenced my decision to approach this study from a mixed-methods perspective.

Personal stance as researcher and music therapist

My stance both as a researcher and music therapist can best be defined as humanistic. I trained in the Nordoff Robbins tradition[10]. My clinical work focuses on the evolving musical process between client and therapist, and the aesthetic experience of creating music. My clinical thinking is formed by psychoanalytically informed supervision with UK trained music therapists and psychoanalysts Sandra Brown and Ann Sloboda. My work with women prisoners is psycho-socially rather than medically oriented. It focuses on well-being and the development of inner resources of the individual rather than on pathological factors. As such it has much in common with Rolvsjord's (2010) resource-oriented music therapy. The conceptual framework underlying my music therapy practice is also informed by my experience of the "ripple effect" (Stuart Wood et al., 2004) of work done in individual music therapy sessions on the client's relationships within the prison with fellow inmates and staff and with the family and friends in the wider community outside.

With regards to clinical techniques my interventions are dictated by the needs of the individual client. Techniques used in my music therapy work with women prisoners include improvisation, songwriting, the singing of composed songs (predominantly popular music), therapeutic teaching and reflective music listening.

As a music therapist I hold beliefs, which influence my therapeutic approach. I believe that a client's way of "being in music" (Pavlicevic, 1997 p.155) may be indicative of their way of "being-in-the-world" (Aldridge, 1989 p.91). This applies not only to the pathological presentation of the individual but also to the expression of potential (Aldridge, 2002 p.17). In my clinical work with women prisoners I have often observed that positive changes in behaviour noticed by prison staff have been pre-dated by a corresponding change in the musical parameters within which a client has been functioning in music therapy. This observation has influenced the scope and focus of the research questions substantially.

Furthermore, my clinical experience leads me to believe that music therapy offers women prisoners an unparalleled opportunity to discover an alternative 'agentic' identity (Fergus McNeill, 2009). This 'agentic' identity is not stigmatised by their criminal past and can be explored, experimented with, and forged in music therapy. In Aldridge's understanding of life as a "performative" process (Aldridge, 2001 p.2), music therapy offers such women a stage on which to practice performing and owning this alternative un-stigmatised identity. It enables them to realise

[10] The Nordoff Robbins music therapy approach is based on the belief that everybody has a healthy innate musicality, regardless of impairment or life experience. This responsiveness to music can be used to facilitate personal growth and development, whereby the music is seen as the main agent of change.

themselves creatively (Aldridge, 2002) through the medium of music, allowing the self to be expressed in the breadth of its capacities through a creative act in relationship (Aldridge, 2001 p.2). The documentation of this process in the form of a song or a piece of improvised music renders it tangible and accessible at will and can help the individual keep hold of what they have achieved in music therapy. The creation of a new agentic narrative to replace the old life script is an important step in the process of desisting from crime (Fergus McNeill, 2006). Consequently I see potential for music therapy to be a powerful tool in the resettlement process.

Summary

In summary it could be said that

- My perception of women prisoners and their situation as a minority within a closed institution is coloured by my personal experience as a member of a religious community. This could bias me to assume that the women I work with will be desirous of change.
- My dis-ease with a monolithic worldview predisposes me towards research methods, which will allow me to contemplate the phenomenon under study from multiple perspectives.
- My clinical experience leads me to assume that music therapy offers a valuable platform for women prisoners to experiment with alternative ways of being.

3.2.2. REPERTORY GRID

The Repertory Grid (RepGrid) Technique (Kelly, 1955) was used to elicit some of the constructs underlying my understanding of music therapy and women prisoners. The interpretation of data produced through the RepGrid interview, which is presented below, aimed to explicate some of the implicit assumptions and expectations I bring to my clinical work and to the research project.

The RepGrid instrument

Based on Kelly's personal construct theory (Kelly, 1955) the Repertory Grid is an instrument designed to capture the dimensions and structure of personal meaning. Its aim is to describe the ways in which people give meaning to their experience in their own terms and to explore the relationships between implicit theories/personal meaning (A manual for the Repertory Grid, 2004). As such its focus is not on drawing out normative patterns. It concentrates rather on making idiosyncratic meanings explicit (Aldridge & Aldridge, 1996). Triadic elicitation is used to draw out constructs in which the user is asked in which way two elements are alike and differ from a third; and the feedback of element and construct matches prompts the elicitation of further constructs and elements to reduce the matches.

A repertory grid consists of

- A series of *elements* – here 10 TTT participants (labelled using codes to protect anonymity: NL, FA, RM, CS, BS, EN, RA, GA, MS, HC)
- A set of *personal constructs* used to compare and contrast these elements – in this case the following 10 bipolar constructs (in random order):
    - Able to express herself emotionally in music ←→ Not able to express herself emotionally in music
    - Able to self-regulate musically ←→ Not able to self-regulate musically
    - Able to self-articulate ←→ Not able to self-articulate
    - Able to listen ←→ Not able to listen
    - Self-aware ←→ Not self-aware
    - Honest with herself ←→ Not honest with herself
    - Takes responsibility for her offence ←→ Does not take responsibility for her offence
    - Outward looking ←→ Focused on self
    - Empowered ←→ Remains disempowered
    - Successfully integrated her criminal offence ←→ Still stigmatised by criminal offence
- A *rating system* that evaluates the elements based on the bipolar arrangement of each construct using a Likert-type scale of 1-7 (i.e. 1 = left pole -7 = right pole)

Personal experience of using the RepGrid

Using the RepGrid to elicit constructs underlying my work with women prisoners was helpful. Although the use of bipolar constructs polarised differences between 'elements' (participants) in a way which often did injustice to the individual clients by failing to take into account the subtleties of the individual therapeutic process, once the ratings were edited to more accurately reflect the individual client's process it proved a useful tool for identifying commonalities and thought constellations which form and inform my understanding of the role music therapy can play for these individuals with relation to resettlement.

PhD supervisor Niels Hannibal conducted the RepGrid interview using Rep IV software (Gains & Shaw, 2005). The following interpretation was completed by myself and represents my understanding and interpretation of the analysis produced by the software.

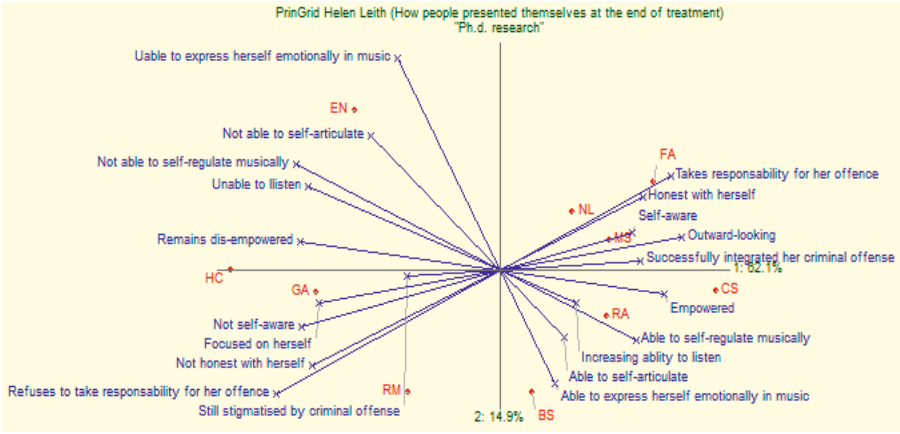
3.2.3. REPGRID DATA INTERPRETATION

Principal components analysis

The principal components algorithm combines the user's constructs into larger groups known as components. Results are displayed in a diagram with constructs represented as straight lines passing through the centre of the space. It gives a visual

representation of the relative interrelationships among all the constructs with respect to the construction as a whole (Abrams & Meadows, 2005).

Figure 3-1 RepGrid Principle components analysis



In Figure 3-1 the *horizontal axis* represents the construct that correlates the most with the remaining constructs (first component or factor) - here 'Successfully integrated her criminal offence ←→ Still stigmatised by criminal offence'. The *vertical axis* is the construct accounting for the next highest amount of variance but which does not correlate with the construct chosen as the horizontal axis (at a 5% significance level) – here 'able to express herself in music/not able to express herself in music'. The remaining constructs *(blue)* are then plotted on the graph by the software according to the coordinates taken from their correlations with the axis or constructs (Terapia Cognitiva). The *red initials* (e.g. RM) are the codes for TTT participants used as elements in this grid.

An analysis of the construct constellations showed two major concepts:

1. MUSIC THERAPY AND LOCUS OF CONTROL
   (left upper quadrant & right lower quadrant)

Constellation1 (left upper quadrant)

An examination of the attributes contained within this quadrant show that I relate difficulties with self-expression and affect regulation/impulse control, both in and outside of music, with feelings of disempowerment. The belief that life is controlled by external forces seems further compounded when the client has difficulty processing incoming information.

Constellation 2 (right lower quadrant)

The components of this quadrant show that I link improvements in the ability to listen, to express emotions creatively and to regulate emotions and impulses in music with feelings of empowerment, with the client more able to believe that her behaviour is guided by her personal decisions and efforts.

2. PERSONAL ATTRIBUTES AND RESETTLEMENT
   (right upper quadrant & left lower quadrant)

Constellation 3 (right upper quadrant)

The factors in this quadrant show that I assume that growth in aspects of reflexivity such as self-awareness and honesty and awareness of others allow the client to take responsibility for their criminal offence. I see this as crucial to the process of successfully integrating the criminal offence and freeing the individual from self-absorption.

Constellation 4 (left lower quadrant)

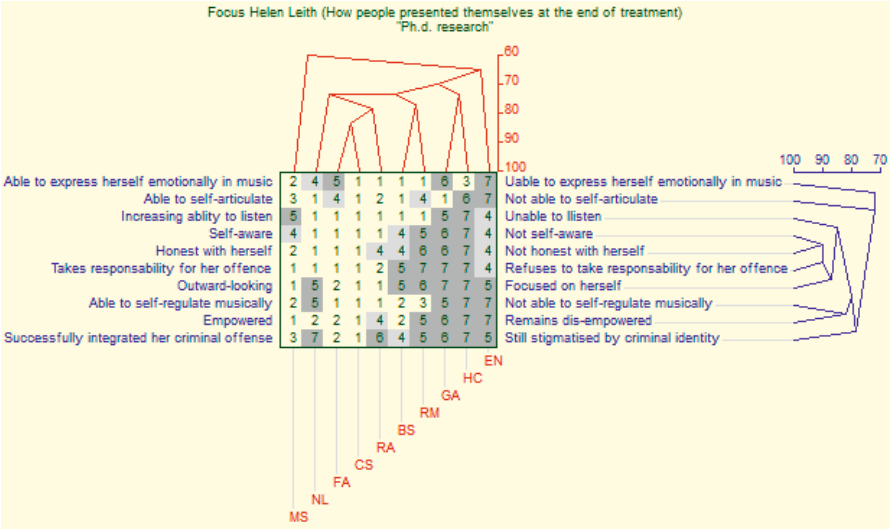
The concepts of this quadrant show that I relate an inordinate focus on self and a lack of self-awareness and honesty with an external locus of control. Here the individual believes that her behaviour is guided by fate or external circumstances and is unable to take responsibility for her offending behaviour. This means that they remain defined by their offence.

Focus algorithm analysis

In Focus both elements and constructs are clustered and then sorted according to proximity by the Focus algorithm. The elements (participants) are placed vertically on the bottom half of the table and they constitute the columns while the constructs are placed horizontally on the left side of the grid and constitute the rows. Tree diagrams above and to the right indicate the levels of matching (Abrams & Meadows, 2005).

The order of elements and constructs is organised so that the degree of adjacency corresponds with the degree of numerical similarity. Thus, for example, the construct rows *Self-aware ←→ Not self-aware, Honest with herself ←→ Not honest with herself* and *Takes responsibility for her offence ←→ Doesn't take responsibility for her offence* in Figure 3-2 match at around 90% and are placed directly next to each other.

Figure 3-2 RepGrid Focus algorithm analysis



An analysis of Figure 3-2 revealed the following assumed correlations:

1. Creative self-expression and an ability to self-articulate are correlated (and its inverse)
2. Growth in the ability to listen and to self-regulate musically is empowering (and its inverse)
3. Self-awareness, honesty with oneself and the ability to take responsibility for the offence are interrelated and also link in with an ability to be outward looking (and its inverse)
4. Successful integration of the criminal offence happens when the above criteria 2 & 3 have been met

From the information gained from the interpretation of both data analyses I extrapolate the following:

I see music therapy as contributing to the resettlement process of women prisoners in the areas of creative emotional self-expression, impulse control, reflexivity, self-awareness and self-agency. My assumption is that growth in the ability to self-reflect and to take responsibility for oneself and one's actions (inner locus of control) will influence the process of integrating the criminal offence. A revised perception of self, catalysed by this process, enables the individual to move on.

3.3. STUDY DESIGN

This research followed a flexible mixed methods study design (Robson, 2002) incorporating both qualitative and quantitative data.[11] The data collection of both data sets was concurrent. The primary focus of this study was on the qualitative data; the quantitative data played a supplementary role. The design could thus be termed an embedded QUAL(quan) mixed methods design following Creswell & Clark's (2007) categorisations.

The collection and subsequent integration of both data sets aimed to minimize personal bias, counterbalance the strengths and weaknesses inherent to individual methods (Denzin, 1989; Onwuegbuzie & Leech, 2005; Sieber, 1973), give a broader understanding of the topic by accessing "different domains of knowing" (Mathison, 1988 p.14) and draw together different facets of knowledge and experience (Bazeley, 2004).

3.3.1. WORKING DEFINITIONS OF 'CHANGE' AND 'SELF-PERCEPTION'

Change

For the purposes of this study 'change' was considered under the dual aspects of:

1. Process
   Change as a dynamic, fluid *process* implying a shift or transition from one state to another in the form of an alteration, modification or transformation of the original state (The American heritage dictionary of the English language, 2006; The Cassell Concise English Dictionary, 1989).
2. Result
   Change as the *result* of altering or modifying (ibid)

Self-perception

There would appear to be a lack of consensus with regard to an operational definition of 'self-perception'. Few Dictionaries of Psychology give a definition for this term. References to 'self-perception', if any, are generally in relation to Self-Perception Theory (Bem, 1973). (It is to be noted that this is neither the context nor the definition underlying the use of the term 'self-perception' in this research study.) In music therapy and psychology literature, the term self-perception would appear to be used interchangeably with a number of synonyms (e.g. self-concept,

[11] Following Feilzer (2010) I use capitalisation (i.e. Qualitative and Quantitative) when referring to the meta-level of paradigms and world-views, and lower case (qualitative and quantitative) to refer to the method level of data collection and analysis.

self-image, self-identity, self-schema etc.), often in the same sentence, without reference to a working definition.

For the purpose of this study 'self perception' was understood as:

> An internal representation of the self (Princeton University, 2008) which can be formed as an understanding, a sense, an impression, a feeling, a notion, a recognition, an apprehension (Collins English dictionary and thesaurus, 2000).

It was decided to opt for the term 'self-perception' as a more fluid and differentiated term than self-concept.

3.3.2. UNDERSTANDING THE CONCEPT OF 'CHANGE' IN RELATION TO THE OVERALL RESEARCH DESIGN

The aim of this study was to better understand the self-perception of women prisoners, to explore whether music therapy facilitated a change in self-perception, and, if so, whether this had an effect in terms of outcomes such as a reduction in behavioural incidents and an improved engagement with prison interventions. The dual understanding of 'change' as both *process* and *result* was important at both the meta-level and design level of this study.

Qualitative methods were used to investigate research questions 1 (Is there a process of change in the self-perception of women prisoners with non-psychotic mental health problems attending music therapy?) and 2 ([If there is a change in self-perception], what is the nature of the experience of women prisoners with non-psychotic mental health problems attending music therapy, with particular reference to self-perception?). These research questions explored the phenomenon of change in self-perception as a dynamic *process*.

Quantitative methods were used to investigate research questions 3 (If there is a process of change in the self-perception of this population, how does this affect a prisoner's ability to engage in resettlement pathways interventions?) and 4 (What is the effect of different treatment lengths on a prisoner's ability to engage in resettlement pathways interventions?). These aimed to establish the *effect* of the process of change in self-perception on the ability to engage with prison interventions and its relation to treatment length.

The relation of individual research questions to the overarching research design is presented below in Figure 3-3 (Bonde, 2011a)

3.4. RATIONAL FOR A MIXED-METHODS STUDY DESIGN

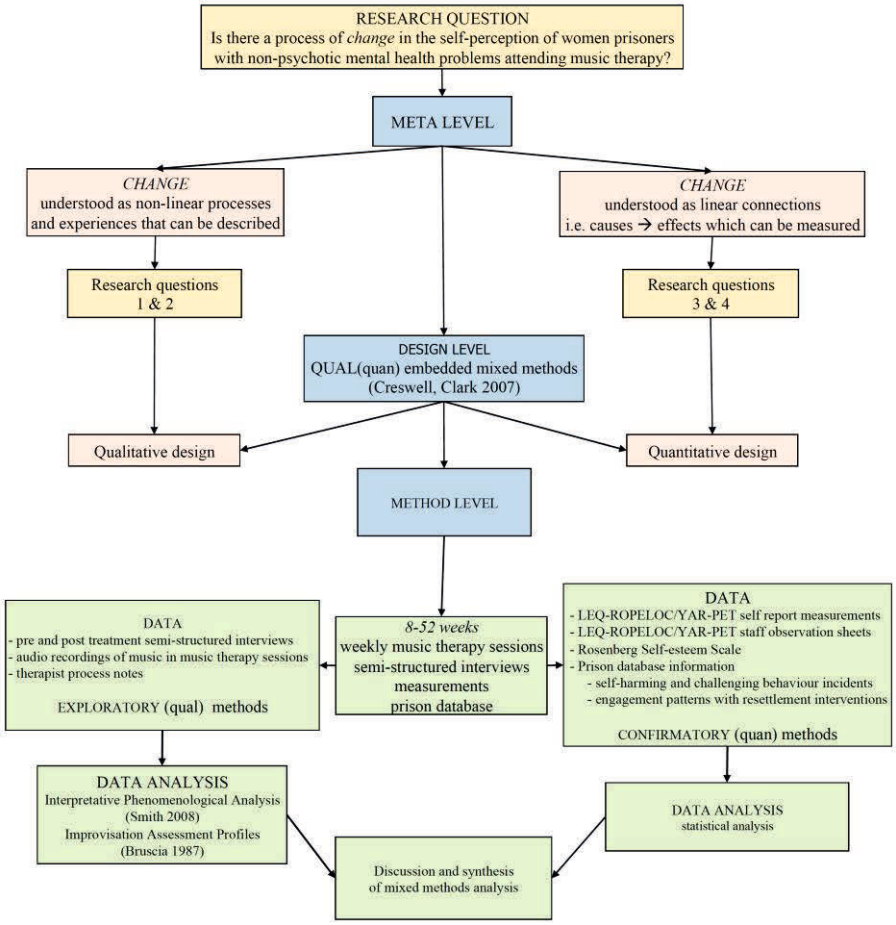
The polar divide between Qualitative and Quantitative research paradigms characterised by the "incompatibility thesis" (Howe, 1988) is increasingly questioned by researchers from both sides of the divide. The dichotomy between the two paradigms is more and more recognised as artificial (Newman & Benz, 1998; Reichardt & Cook, 1979)with researchers and methodologists acknowledging that all researchers, both constructivist and positivist, bring implicit theories and assumptions to their investigations. There is acknowledgment of effect of the researcher's knowledge, language, or historical situatedness (Ruud, 1995) as well as the inherent subjectivity of decisions made throughout the research process (Onwuegbuzie, 2002; Onwuegbuzie & Leech, 2005) on even the most positivist of research designs (Hanson, Creswell, Clark, Petska, & Creswell, 2005). There is also a realisation of a potential discrepancy between the meta level of paradigms and the method level of research designs. Proponents such as Reichardt & Cook (1979), Daft (1983), and Sieber (1973), and more recently Onwuegbuzie & Leech (2005), argue that quantitative methods are not necessarily positivist, neither are qualitative techniques necessarily hermeneutic.

There is a growing conviction that the two paradigms need not be mutually exclusive. Indeed both objective and subjective knowledge can be valued (Cherryholmes, 1992). This frees researchers from what Creswell terms the ''forced choice dichotomy between post-positivism and constructivism'' (Creswell & Clark, 2007 p.44).

A 'third' major research paradigm, namely mixed methods research (Creswell & Clark, 2007) or flexible study design (Robson, 2002) is increasingly finding recognition (R. B. Johnson & Onwuegbuzie, 2004; R. B. Johnson, Onwuegbuzie, & Turner, 2007). Proponents of this so-called third paradigm argue that there is an advantage in combining the representativeness and generalizability of quantitative findings with the in-depth, contextual nature of qualitative findings (Greene & Caracelli, 1997, 2003) and consider that the research questions rather than methodological, theoretical or paradigmatic considerations should be foremost when designing research (De Vaus, 2001; Tashakkori & Teddlie, 2003; Wigram, Pedersen, & Bonde, 2002)

Pragmatism sidesteps the philosophical debate concerning the nature of truth and reality and argues that there are both singular and multiple realities which are open to empirical inquiry (Feilzer, 2010). 'Reality' is understood as "existential" (Dewey, 1958 in Feiler 2010), relating to a world "with different elements or layers - some objective, some subjective, and some a mixture of the two" (Feilzer, 2010 p.8) - which is experiential in nature. Pragmatism prefers to focus on solving practical problems in the "real world" (Creswell & Clark, 2007; Robson, 2002).

Figure 3-3 Relation of research questions to the over-arching research design



This study positioned itself within the third paradigm for the following reasons:

- The primary focus of this study was change in the self-perception of women prisoners as a result of music therapy treatment. Self-perception is a multi-layered and complex phenomenon. There is a lack of a good operational definition of self-concept in quantitative literature and of good measurement tools (Prof. C.H. McKinney, personal communication, Spring PhD course April 2011). Researchers investigating change in self-concept or related areas have experienced difficulties (Markus & Kunda, 1986; Richards, Ellis, & Neill, 2002). This suggests that there might be a

methodological advantage in combining self-report questionnaires with semi-structured interviews (Bonde, 2011b). Thus elements such as participant understanding of self-perception and their experience of change, which would not be captured through self-report questionnaires, could be explored and elaborated on in discussion during the interviews.

- Furthermore, a potential link between change in change in self-perception and change in presentation and behaviour outside the therapy room could be explored through the combined analysis of semi-structured interviews, self-report measurements, and prison data on behavioural and engagement patterns.
- Service commissioners, including the prison system, increasingly demand evidence of meaningful outcomes of services provided. Including descriptive statistics in the study design aimed to facilitate communication with colleagues and service commissioners by providing numeric evidence in terms of outcomes (Odell-Miller et al., 2006); it was also anticipated that it would help the researcher to position her results within the 'what works' debate.

The following elements were seen as important influences in the choice of a mixed-methods design for this study:

3.4.1. CAUSALITY

It was anticipated that the use of a mixed methods approach would expand the concept of causality (defined as "cause established through demonstrating empirical regularities" (Robson, 2003 p. 475)) to include the concept of causality as the "identification of mechanisms, going beyond sheer association" (p.475). It allowed for the "complex network of events and processes in a situation" (p.475) to be taken into account when seeking causal attributions. This addresses a major deficiency of a reductionist understanding of causality. It allowed the researcher to include factors such as context, space, time, and complex structures such as human emotions, intentions and responses into her deliberations on causality. Including such factors has the potential to lead the discussion beyond the narrow constraints of mere empirical regularities (Bonde, 2011b), much in the same way as information from an aeroplane's "black box" (Robson, 2003 p. 475) expands findings of flight incident investigations to include not only empirical data in the form of debris but also human elements such as thought processes, actions and interactions which might have influenced the outcome.

3.4.2. TRIANGULATION

The triangulation of methods and data is commonly seen as a means for improving validity and eliminating bias (Denscombe, 2008; Mathison, 1988). However, as Mathison points out triangulation "rarely provides a clear path to a singular view"

(p.15). In this study triangulation between methods (qualitative and quantitative), sources of data (research participants, self-report questionnaires and staff observation questionnaire, measurement points, prison databases) and researchers (coding by two researchers, cross-checking of semi-structured interviews and peer review) searched for links with which to draw a more complete picture of the phenomenon than could otherwise be expected. By analysing the data individually, then comparatively before bringing together the knowledge produced by each data set it was possible to interpret the data from a multidimensional perspective. Thus, each data set could be informed, questioned and enhanced by the other (Feilzer, 2010).

Given the complexity of the phenomenon studied in this project it could not be taken for granted that findings would converge into a singular proposition. The advantage of the triangulation of methods and data in this study was thus seen in its potential to provide a rich and complex picture of the phenomenon and to enhance the discussion, as meaningful constructions and constructs could be sought to provide an explanation for inconsistencies or contradictions (Mathison, 1988).

3.4.3. CONTEXTUALIZATION

Most comprehensive self-concept theories acknowledge two apparently contradictory aspects of self – the stable or core self-concept, which is established early in life and which seeks consistency and resists change (Coopersmith, 1967; Greenwald, 1980; Marx & Winne, 1978; McCrae & Costa, 1982), and more malleable "self-conceptions" (Markus & Kunda, 1986 p.858) which are essentially social in nature and constructed in response to different experiences, events or situations (Markus & Kunda, 1986; Marsh, 1990). Such "working self-concepts" (Markus & Wurf, 1987 p.306) vary according to affective states and are constantly adjusted and calibrated in response to social situations and interactions. Markus & Kunda (1986) suggest that if situations repeatedly arise which activate self-conceptions that are at variance with core self-concepts, there is reason to think that these core concepts could eventually change too.

Thus contextualisation was an important factor in this study because of the close interplay between the internal representation of the individual research participant and the external context of the prison environment. It was anticipated that the use of both qualitative and quantitative methods might enhance our understanding of the impact a custodial sentence has on the sense of identity of women prisoners and the influence of music therapy on the complex interaction between self-perception and behaviour.

3.4.4. GIVING A VOICE TO RESEARCH PARTICIPANTS

Giving a voice to service users is an integral part of the UK Department of Health's "New Horizons" program (The Future Vision Coalition, 2009). In this the need for "a new relationship between mental health services and those who use them" (p26) is identified; service users, carers and communities are to be offered an active role in shaping the support available to them. In terms of research this requires ''evidence-based practice'' to take into account patients' needs, experiences, and evaluations of services (Gary Ansdell & Meehan, 2010).

Mixed methods research is well adapted to "convey the needs of individuals or groups of individuals who are marginalised or underrepresented" (Feilzer, 2010 p.226; Mertens, 2003; Punch, 2005). Women prisoners are an underrepresented minority in research into 'what works' in offender rehabilitation; most research conducted to date investigates the responses of male prisoners to prison resettlement programs (McGuire, 2002). It was important not only to increase our understanding of 'what works' for women using numeric data methods but also to give a voice to the women themselves. This project aimed to include women prisoners' narratives, perceptions and insights, through the analysis of semi-structured interviews.

3.5. STRATEGIES TO REDUCE BIAS

In addition to the elucidation of personal and professional researcher bias in the form of an Epoché and RepGrid analysis, and the inbuilt bias-reducing strategies inherent to mixed methods research (triangulation between methods, sources of data and researchers), this study included negative case sampling with regard to the selection of semi-structured interviews to be analysed. Member checking, where members are requested to check the accuracy of the representation of their thoughts, was not considered feasible or appropriate for this study as it was anticipated that most participants would have been released or transferred to another prison at the end of their participation in the study.

3.6. PROCEDURES FOR DATA COLLECTION AND DATA ANALYSIS

For an overview of the participant trajectory please se the research protocol flowchart (Figure 3-4)

This was a naturalistic study. For ethical reasons it was considered important not to impose constraints on the therapy in the form of a standardised treatment protocol.

The natural course and length of therapy followed individual need. 10 research participants attended weekly, or in some cases twice weekly one-to-one music therapy music therapy sessions of 45 minutes. For the purposes of this study music therapy lasted between 8 sessions and 12 months. If needed, the individual could continue to attend music therapy after completing the study.

3.6.1. RECRUITMENT

Potential research participants referred themselves to music therapy or were referred by key members of prison staff (ACCT Managers, Offender Managers, Healthcare staff, Personal Officers, Chaplains etc.). Recruitment was not linked to a specific diagnosis. All referrals with mental health related problems were considered.

3.6.2. INCLUSION CRITERIA

The following prisoners were eligible for inclusion in the study:

- Prisoners of all categories (remand, convicted, sentenced, lifers, Indeterminate Public Protection prisoners, Prolific and Priority Offenders, Restricted Status prisoners)
- Prisoners with mental health difficulties (e.g. anxiety/mood/traumatic stress, personality and bipolar disorders, schizophrenia, depression, parasuicidal behaviour, substance misuse), provided they were not experiencing an acute episode of psychosis
- Prisoners showing self-isolating or challenging behaviour, and prisoners with no access to other activities due to their Restricted Status, provided risk could be adequately assessed and safely managed

3.6.3. EXCLUSION CRITERIA

The following prisoners were excluded from the study:

- Prisoners suffering an acute psychotic episode, due to issues concerning informed consent and reliability of data. They were assessed for music therapy and offered a non-research place for music therapy if considered appropriate.
- Prisoners who posed a significant risk to the researcher/research assistant and where this risk could not be safely managed
- Foreign nationals who did not speak any English, due to lack of research resources to conduct interviews and measurements in foreign languages. However, those suffering from mental health problems or struggling to survive within the prison system were prioritized for a non-research place

for music therapy as it was recognized that their needs could not be met through other verbal interventions because of the lack of language skills.

3.6.4. RECRUITMENT PROCESS

The recruitment process included a meeting of approx. 45 minutes with the researcher who outlined the study and responded to questions. It was made clear at this stage that participation in the study was entirely voluntary and that research candidates/participants could withdraw at any stage without this impacting on their right to music therapy. Music therapy referrals who did not wish to participate in this study were assessed for music therapy and offered a non-research place if considered appropriate.

3.6.5. QUALITATIVE DATA

Aim: to capture the individual participant's experience and process in music therapy

Collection in the form of

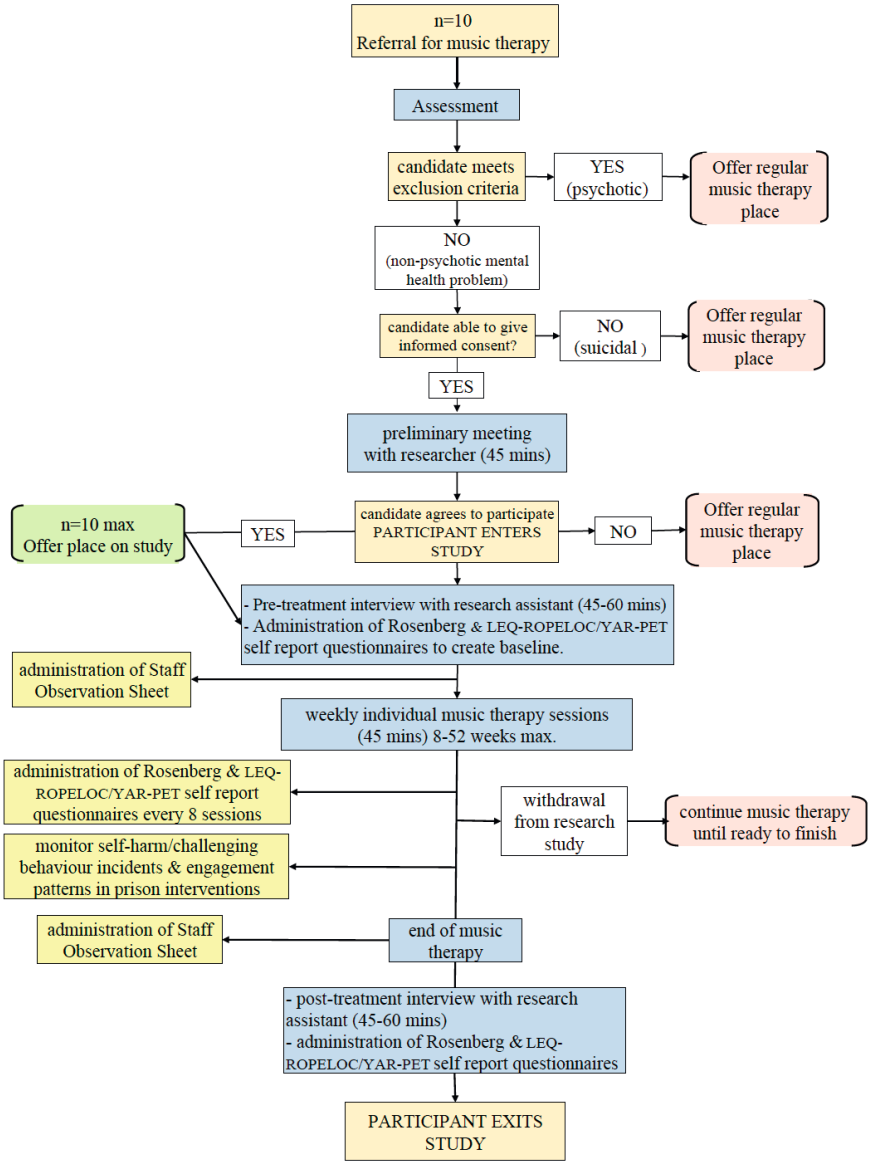
- Pre, 8 week, and post treatment semi-structured interviews
- Therapist notes
- Selected audio recordings of music created in music therapy sessions

3.6.6. QUANTITATIVE DATA

Aim: to measure for change in life-effectiveness and to establish outcomes with relation to behaviour and engagement patterns with resettlement programs

Data was collected through the administration of the self-report and staff observation questionnaires listed below. This data was linked to research questions 1 and 2 (Is there a process of change in the self-perception of women prisoners with non-psychotic mental health problems attending music therapy? If so, what is the nature of the experience of women prisoners with non-psychotic mental health problems attending music therapy, with particular reference to self-perception?) and to research question 4 (What is the effect of different treatment lengths on a prisoner's ability to engage in resettlement pathways interventions?)

Figure 3-4 Research protocol flowchart



- LEQ-ROPELOC/YAR-PET (adapted & amalgamated version) self-report questionnaire (Neill, 2007, 2009). (See Appendix 4 for a sample questionnaire)
  The LEQ-ROPELOC/YAR-PET self-report questionnaire is a user-friendly self-report instrument designed to measure change in key areas of 'life effectiveness' where moderate positive correlations with overall self-concept can be expected. The questionnaire was administered before treatment to establish a baseline, following the 4th and 8th sessions, and then every 8 music therapy sessions and at the end of music therapy.
- LEQ-ROPELOC/YAR-PET Staff Observation Questionnaire (corresponding to the participant self-report questionnaire) administered pre and post treatment. (See Appendix 5 for a sample questionnaire) Rosenberg Self-Esteem Questionnaire (1965) administered before treatment to establish a baseline, following the 4th and 8th sessions, and then every 8 music therapy sessions and at the end of music therapy. (See Appendix 6 for a sample questionnaire)

The following data was collected with relation to research question 3 (If there is a process of change in the self-perception of this population, how does this affect a prisoner's ability to engage in resettlement pathways interventions?):

- Parasuicidal incidents and adjudications (prison database) as proxy indicators of change
- Participant engagement patterns in prison resettlement pathways interventions (prison database) as proxy indicators of change

3.7. MEASUREMENTS

Researchers frequently experience difficulties when trying to measure the type of effects produced by experiential learning programs (Richards et al., 2002). Many 'off the shelf' psychological or clinical measurements are inadequate or inappropriate for this purpose. This can be due to the limited number of factors and scope of some psychological questionnaires (e.g. Rosenberg Self-esteem Scale), which allow a global assessment but are restricted in their ability to provide a detailed evaluation of the individual. Other assessment tools such as those testing self-concept (e.g. Self Description Questionnaire II) can raise issues of compliance, testing fatigue and practice effect due to the large number of items and factors included in these questionnaires. Furthermore, there are concerns with regard to the reliability and validity of other well respected and popular measurement tools such as the Tennessee Self Concept Scale (Marsh & Richards, 1988) and the Coopersmith Self Esteem Inventory (Ahmed, Valliant, & Swindle, 1985).

Reliance on a single measure can be considered to limit the interpretation of results (Kazdin, 1995). However, a battery of measurement tools can lead to overload and

testing fatigue without significantly improving findings. Two tools were selected for the purposes of this study:

3.7.1. ROSENBERG SELF-ESTEEM SCALE

The Rosenberg Self-Esteem Scale was used in another prison research project investigating music therapy and the emotional needs of Chinese prisoners (X.J Chen, Hannibal, Xu, & Gold, 2012). It was included in this study to enable a comparison of outcomes. However, the limited focus of Rosenberg Self-Esteem Scale on a single aspect of self-concept, namely self-esteem, made it ill-suited to be used as a single, primary measure.

3.7.2. LIFE EFFECTIVENESS QUESTIONNAIRE (LEQ)

Problems measuring change in self-concept

Discussions at the November 2010 Aalborg PhD course with Prof. Cathy McKinney and Prof. Raymond MacDonald first drew my attention to the difficulties to be anticipated when researching into change of self-concept. It is generally understood that core self-concepts are established early in life. They are considered to be stable and not amenable to change (Markus & Kunda, 1986; Markus & Wurf, 1987; Marsh, 1990). When researching into change in self-concept it was suggested measuring for change in areas of behaviour, which might be considered indicative of change at a higher self-conceptual level. The LEQ with its "items grounded in self-perceptions but expressed and interpreted in terms of behaviours" (Richards et al., 2002 p.2) seemed a viable tool for this study.

LEQs – outcome/behaviour instruments

The Life Effectiveness Questionnaire (LEQ) (Neill, Marsh, & Richards, 2003) aims to measure personal change. It has several versions, each targeting a different participant group, including the YAR-PET (Youth At Risk Program Evaluation Tool) (Neill, 2007) and the ROPELOC (Review of Personal Effectiveness and Locus of Control) (Richards et al., 2002). It was developed to measure multiple life effectiveness constructs, which are theoretically amenable to change. Outdoor education and other personal development or psychosocial programs typically target these constructs.

The LEQ authors acknowledge the central importance of self-concept in research investigating outcomes of experiential programs and raise the question whether self-concept is an outcome variable in itself or a mediating variable only to be seen through manifesting behaviours. They suggest that because self-concept is considered to be of primary importance self-concept measurement tools are often used as a surrogate for more appropriate "outcome or behaviour" instruments (Richards et al., 2002 p.2). This can result in frustration at non-significant results

because the tools chosen were not designed or sensitive enough to capture change in this area.

LEQ factors

The LEQ is defined as a "testing instrument with items grounded in self-perceptions but expressed and interpreted in terms of behaviours" (Richards et al., 2002 p.2). It covers the following areas:

- Personal abilities and beliefs
    - Self-Confidence, Self-Efficacy, Stress Management/Emotional Control, Open Thinking/Intellectual flexibility
- Social abilities
    - Social Effectiveness, Cooperative Teamwork, Leadership Ability
- Organisational skills
    - Time Management, Quality Seeking/Achievement Motivation, Coping with Change
- An 'Energy' scale
    - Active Initiative/Involvement
- Overall Life Effectiveness

The ROPELOC includes two additional items:

- Internal Locus of Control, External Locus of Control

The YAR-PET includes the following additional factors:

- Community Engagement, Communication Skills, Problem Solving, Goal Setting, Conflict Resolution. Respect and Personal Boundaries, Self-esteem

In addition all versions have an inbuilt Control Scale to determine whether changes reported in other scales are due to program effects or simply to retesting on the same instrument. The LEQ questionnaires can be used with a wide range of participants from youth at risk to corporate managers. It uses simple language. All items are rated on a Likert Scale from 1 (false/not like me at all) to 8 (true/very like me).

A corresponding Staff/Observer questionnaire allows program effects to be investigated from different perspectives.

3.7.3. PSYCHOMETRIC VALIDITY

The LEQ has good internal reliability with a Cronbach alpha of .79 - .93. Exploratory Factor Analysis (EFA) shows a strong and stable factorial structure for both males and females, adolescents and adults (Neill, 2008).

The Rosenberg Self-Esteem Scale has high reliability and validity with a reported Cronbach alpha of 0.88 (Blascovich & Tomaka, 1991).

3.8. LEQ YAR-PET/ROPELOC SELF-REPORT AND STAFF QUESTIONNAIRES

No single version of the LEQ was entirely suitable for the purposes of this study. The LEQ-g and LEQ-h versions lacked some of the items of the YAR-PET and only the ROPELOC included items measuring locus of control. Furthermore the language differed significantly between versions. Authorisation to design an adapted combined version of the LEQ appropriate for this study was requested and granted by the authors.

3.8.1. CONSULTATION AND PARTICIPANT INVOLVEMENT

Current and past TTT participants (n=7) and one member of prison staff were invited to evaluate the suitability of the LEQ with particular reference to the situation and needs of women prisoners. The prisoners represented a wide range of ethnic, socio-cultural, educational and professional backgrounds.

Both prisoners and staff gave valuable contributions thoughts concerning

- The relevance of individual items to resettlement pathways interventions and future desistance from crime
- Accessibility (literacy and comprehension issues, clarity of instructions)
- Data collection procedures (assistance for prisoners with little or no literacy skills, confidentiality, administration)

Their comprehensive feedback was then incorporated in the design of a single questionnaire consisting of a revised and combined version of the LEQ-ROPELOC/YAR-PET questionnaires and a corresponding Staff questionnaire.

3.9. MEASUREMENT POINTS

Many (women) prisoners with non-psychotic mental health problems are difficult for the prison to engage due to symptoms such as blunted affect, low motivation and poor social relationships. Interestingly these symptoms are similar to the

negative symptoms ascribed to schizophrenia (American Psychiatric Association, 2000). In Gold et al's (2009) study 'Dose-relationship in Music Therapy' music therapy was shown to be successful in helping to address these issues. A "steep increase of effect for the first sessions" in the area of negative symptoms was found, a moderate but continuing increase for later sessions (p.200) and a large effect for 42 sessions".

The findings from this meta-analysis informed considerations concerning the measurement points in this study. The LEQ-ROPELOC/YAR-PET and Rosenberg Self-Esteem self-report questionnaires were administered before treatment begin in order to establish a base line. Thus participants could act as their own controls. Measurement then followed at the fourth and eighth sessions, and then every eight sessions until the participant exited from the study. A final measurement when the participant exited the study completed the administration. Measurements points were defined according to session numbers rather than in terms of weeks in order to facilitate the incorporation of research participants attending short-term therapy twice a week. Data collected from participants who were transferred or released after starting the study but who had completed at least two measurements were included in the data analysis if a pre and post treatment interview had been conducted.

It was hoped that by placing the measurement points this way and by including flexible treatment lengths in the design of this study further insight could be gained concerning dose-relationship in music therapy.

3.10. STATISTICAL CONSIDERATIONS

3.10.1. SAMPLE SIZE

Taking into account the QUAL(quan) balance of this study it was decided that test power should not be the main focus of the study design and that the small sample size (n=10 max) was reasonable. Larger participant numbers would shift the focus away from a QUAL(quan) towards a QUAN(qual) study.

Collecting quantitative data in several waves of measurement at pre-specified time points was seen as a means to enhance the interest and relevance of this study. There were several reasons for this:

- If duration of therapy varied and measurements were collected pre/post treatment only, the amount of time passed would be a confounding variable. This problem could be addressed by defining certain time points a priori.

- In a descriptive analysis, two numbers alone (for pre and post) would not give very much insight. It would be more interesting to look at the shape of development over time.
- Test power could be increased, at least to some extent, by having several data points for the same outcome variable on the same participant (Gold, 2011). It was decided to measure early and often in equally spaced time intervals (more often early than later). Equally spaced intervals have the advantage of being simple and clear whereas unequally spaced intervals are a "compromise between feasibility and being able to model changes precisely" (quote from email correspondence with Prof Dr Gold).

3.10.2. RELIABILITY AND VALIDITY OF THE LEW-ROPELOC/YAR-PET SELF-REPORT QUESTIONNAIRE

The sum of many Likert-type items, as in this questionnaire, was considered good as they could be assumed to approximate a normal distribution. The only surprise would be if all scored close to the maximum ("ceiling effect") or minimum score ("floor effect"). However, this could be checked graphically and the use of a particular statistical technique decided on if this proved to be the case. The reliability indices looked good in view of the Cronbach alpha value of .79 - .93.

3.11. ETHICAL CONSIDERATIONS AND RESEARCH ETHICS APPROVAL

This research study complied with the UK Research Governance Framework for Health and Social Care (Department of Health, 2005). The proposal was first reviewed by the ethics expert of Anglia Ruskin University, Cambridge, UK. It was then reviewed independently by the National Research Ethics Service Committee East of England – Essex to ensure that it met ethical standards. This committee has particular competence with regard to research with prisoners. A favourable opinion was granted thus authorising the research study to begin. A copy of the final IRAS Research Ethics Application is attached to this dissertation in a separate electronic file. The approved Participant Information Sheet, Consent Form, the self-report, staff/observer and Rosenberg Self-Esteem questionnaires can be seen in Appendices A-E.

A substantial amendment was made towards the end of the data preparation period to allow feedback of LEQ-YAR-PET/ROPELOC scores to be given to individual participants who were still in prison and requested their results at the end of treatment.

3.11.1. INFORMED CONSENT

Prisoners are quite literally a 'captive audience'. The continuous pressure to comply with prison rules and regulations inherent to a custodial sentence can condition prisoners, making it difficult for them to decline an invitation to participate in a research project. As such, care was taken to ensure that potential research candidates were fully aware that they could access music therapy without participating in the research study should they prefer. The Participant Information Sheet, outlining the aims of the project, treatment and research procedures, and issues of consent and confidentiality, specifically gave assurance that neither participation nor non-participation would have a (negative) effect on an individual's offender management.

It was anticipated that potential research participants would be experiencing mental health problems. Particular attention was paid to the psychological state of the individual referral, especially those identified as suicidal or at risk of self-harming and who were being monitored by the Safer Custody team, to ascertain that they were capable of making an informed decision concerning participation in this study. All due care was taken to ensure that potential research candidates were capable of making an informed decision concerning participation.

Referrals were taken from prisoners living in normal location[12] on the house blocks or in the Separation and Care Unit rather than from patients living on the Healthcare Unit. Prisoners with a history of psychotic illness living in normal location or in Separation and Care are generally in a medically stabilized state. It was decided that should a participant become psychotic during the course of treatment they would be withdrawn from the study but could continue in music therapy if deemed appropriate. However, this issue did not arise as none of the research participants became psychotic whilst participating in the research project.

Care was taken to ensure that the Participant Information Sheet was written in an appropriate form to accommodate prisoners of all literacy levels. TTT participants were consulted in the process and their feedback gave valuable information concerning potential concerns and issues as well as accessibility. A designated person was nominated to assist prisoners with literacy problems and a procedure was put in place to gain verbal consent.

[12] 'Normal location' refers to the house blocks where basic and standard status prisoners reside as well as a separate house block reserved for enhanced status prisoners, as opposed to specialist units such as Healthcare Unit, and Separation and Care Unit where prisoners are held in solitary confinement.

3.11.2. APPROPRIATE USE AND PROTECTION OF PERSON IDENTIFIABLE INFORMATION

Access to participant personal data was on a need-to-know basis only. A code was allocated to participants and person-identifiable information was not requested on the self-report/staff observation questionnaires to ensure confidentiality. Person-identifiable information material was removed from interview transcripts; potentially identifiable speech from music therapy sessions was deleted from audio-recordings. Only the researcher, the research assistant, and those who witnessed participants' signatures of consent forms were aware of who was participating in the study. The researcher was the only person able to access personal data.

Movable data was coded, filed and stored in a locked facility. Electronic data was encrypted and stored securely on a password protected external hard disk, which was stored in a locked facility. If processed on a laptop computer data was encrypted, with access limited to the primary researcher.

Data was dealt with in compliance with the United Kingdom Data Protection Act 1998.

3.11.3. SERVICE USER INVOLVEMENT

As mentioned above (see above 3.3.4.) TTT participants representing a wide range of ethnic, socio-cultural, educational and professional backgrounds contributed towards the development of the Participant Information Sheet, Consent Form, and the design of the LEQ-ROPELOC/YAR-PET self-report questionnaire. They were major contributors with regard to the choice of life-effectiveness factors to be included in the questionnaire and deliberations concerning the relevance of these factors with regard to resettlement pathways interventions and future desistance from crime. They assessed literacy and comprehension issues and made valuable suggestions concerning the facilitated participation of candidates with limited literacy or language skills.

3.11.4. DIVERSITY

Participation in this research study was open to prisoners of all categories and backgrounds. Care was taken to ensure that minorities such as foreign nationals and Restricted Status prisoners could participate if they wished unless they had no English language skills whatsoever, or risk could not be adequately managed. In recognition of the severely restricted access these prisoners have to other interventions (either due to language problems or risk factors) these prisoners were prioritised for a regular music therapy place if they could not be offered a research place.

3.11.5. RISK MANAGEMENT

Comprehensive risk management strategies and procedures were put in to place to address identified risks and burdens both for research participants and researchers. These are outlined in A22/23 and A26 of the IRAS ethics application form.

3.11.6. POTENTIAL CONFLICT OF INTEREST

Because of the researcher's personal involvement at multiple levels and in multiple roles (project manager, treating music therapist, researcher, data analyst) due care was taken to preserve the integrity of the therapeutic process through the establishment of clear boundaries between the research and clinical setting. Thus two independent research assistants were appointed to conduct the semi-structured interviews to facilitate the maintenance of appropriate boundaries. An independent clinical supervisor, who was not involved in the research, assured clinical supervision of music therapy work to ensure that the dual role of therapist/researcher did not compromise the participant's therapy. PhD supervisors Prof. Helen Odell-Miller and Assoc., Prof, Niels Hannibal were also available for consultation if concerns arose concerning blurring of boundaries.

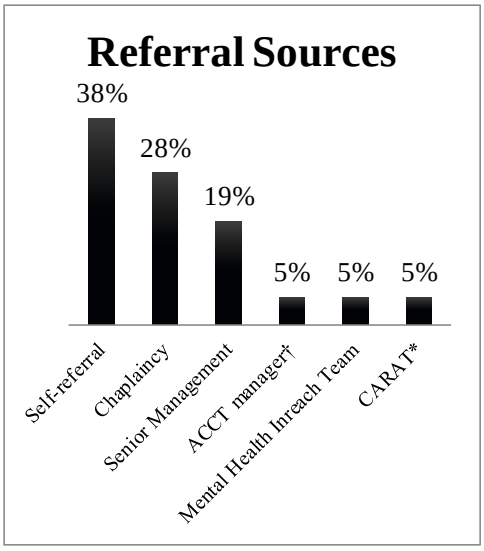
CHAPTER 4. METHOD

This section will give information concerning recruitment, issues encountered during data collection, and revisions to the study protocol. It will outline the data collection and data analysis procedures.

4.1. RECRUITMENT

Recruitment for this study was not linked to a specific diagnosis. All referrals with mental health related problems were considered if they met the inclusion criteria. The highest percentage of referrals came the prisoners themselves. Women often heard by word of mouth of the research program or approached the researcher when she was visiting the house blocks to ask who she was and what she did, and referred themselves to the program. The researcher assessed candidates for suitability for the research program and offered either a research or a non-research music therapy place as appropriate. In cases where there were concerns relating to suitability or risk management other professionals involved in the individual's management and the Security Department of the prison were consulted.

Figure 4-1 Referral sources



† Assessment, Care in Custody, and Teamwork (ACCT) for the management of prisoners at risk of harm to self, to others and from others (Safer Custody)

* Counselling, Assessment, Referral And Throughcare (CARAT) drug treatment service

Chaplaincy, because of their obligation to meet every prisoner attending the prison induction and because of their pastoral involvement in cases of serious illness or death of close relatives, was in a good position to identify women who were struggling within the system. This possibly explains the high number of referrals for bereavement. Senior management were acutely aware of women who were isolated because of their risk factor or women with particularly complex needs who were failing to engage with the system and referred them to the program.

The following table gives relevant background information on the research participants:

Table 4-1 Participant demographic information

ID	Duration	Referral reasons	Clinical method	Offence	Age	LEQ/ RSE*	Interview
A	12 mths	Isolation	Electronic composition	VATP†	30-39	8	PreT/8wk/ PostT
B	11 mths	Bereavement	Therapeutic teaching	VATP	50-59	8	PreT/8wk/ PostT
C	10 mths	Parasuicidal behaviour/ isolation	Song-writing	VATP	40-49	7	PreT/8wk
D	9 mths	Parasuicidal behaviour	Improvisation Song-writing	Drugs	30-39	5	PreT/8wk/ PostT
E	8 sess	Bereavement	Song-writing	Drugs	21-29	4	PreT/ PostT
F	6 mths	Parasuicidal behaviour/ isolation	Singing pop songs	VATP	18-20	5	PreT/8wk PostT
G	6 mths	Bereavement/ isolation	Song-writing	Drugs	40-49	5	PreT/8wk PostT
H	8 sess	Child adoption	Song-writing	Drugs	30-39	3	PreT/ PostT
I	8 sess	Relational problems	Rap	Burglary	18-20	3	PreT/ PostT
J	4.5 mths	Child adoption	Did not engage	Drugs	30-39	2	PreT/ PostT

Participants selected for interview analysis

* *Number of self-report questionnaires completed*
†*Violence Against The Person (VATP)*

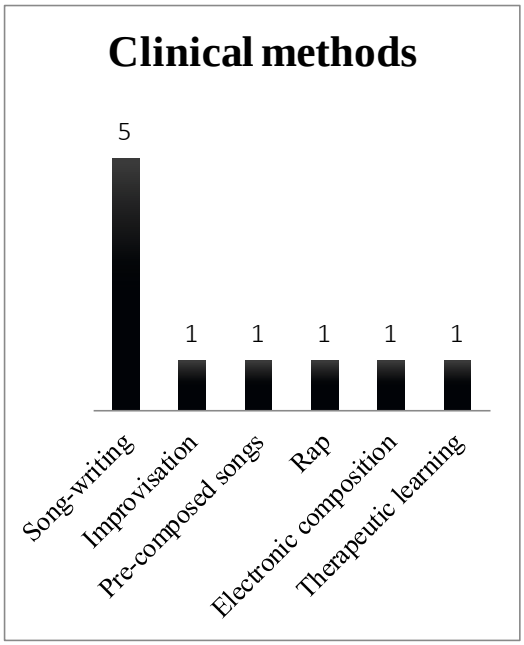
4.2. SESSION FORMAT

With the exception of Participant I (p.73) research clients attended weekly or bi-weekly individual music therapy sessions of 45mins length. They were encouraged to structure the sessions according to their needs. Many participants, but by no

means all, chose to start their sessions by telling the therapist how they were coping (or not) and what had been going on for them since the last session. There seemed to be a need to talk to someone they considered to be outside the prison system and consequently unprejudiced and non-judgemental. Once this had been done they were able to put things behind themselves for the moment and focus on the music making. Others were intent on loosing as little time as possible to anything other than music making. However, there was an overall trend of more talking in the early sessions and more focus on the music in later sessions.

4.3. CLINICAL METHODS

Figure 4-2 Clinical methods



A number of music therapy methods were used in music therapy sessions. The choice of content was entirely client-led and song writing was the method most frequently chosen (Figure 4-2)

4.3.1. SONG WRITING

In songwriting sessions participants contributed to the composition of the song in varying ways and to varying degrees. Participants C, D, E & G brought an initial text with them which was then refined and re-worked over a number of weeks, both in sessions with the music therapist and alone in the intervening days between sessions. Participant H wrote her text in sessions finding it developed best in spontaneous conjunction with the music. Most participants had at least an initial melodic snippet from which the melody could develop, with music therapist and participant jointly 'finding' the melody through a co-improvisational process. Participant G brought both lyrics and melody to the first session, leaving the development of an accompaniment to the music therapist. Participant C contributed texts only with the music therapist adding melody and harmony. However, the complex interaction between song lyrics and melody meant that the she was closely involved in the composition process, by indicating a preference for melodic forms, harmonies, and emotional qualities.

Two CDs were made at the end of therapy documenting the process of composition and the final product. Once clearance from the Security Department had been given, one copy was given to the participant to keep in her cell as a personal documentation of her achievements in music therapy. The other copy could be sent to a family member or the person to whom the song had been dedicated.

4.3.2. CO-IMPROVISATION

Participants seemed hesitant to engage in co-improvisational music therapy. Although the instrument kit had been carefully chosen with a range of easily accessible but attractive ethnic instruments, many participants had negative associations with early music making at primary school. They felt frightened of feeling embarrassed or doing something wrong and lacked the spontaneity to embark on the process without pre-conceptions.

Participant D was the only person who chose to improvise. She did this for the first 5 months of her music therapy and then changed to song writing for the last 4 months of therapy.

4.3.3. THERAPEUTIC LEARNING

For prisoners with long sentences finding a hobby with which to fill the long hours of isolation during lock-up at lunchtime and nighttime can be highly beneficial. Therapeutic learning was also useful if security required the presence of uniformed staff in music therapy sessions, as confidentiality could not be offered for deeper therapeutic work.

Participant B, who had a particularly long sentence, chose to learn to play the piano. She was authorized to have a keyboard in her cell and used the skills acquired in music therapy sessions to distract herself during lock-up. This opened up a long-term prospect of enjoyable, purposeful activity for periods of isolation.

4.3.4. COMPUTER TECHNOLOGY BASED COMPOSITION

Computer technology, notably the software program ‘Garageband’, offered participants who did not want to engage using conventional musical methods a way of composing their own music using the loops provided by the program. This was a useful tool for Participant A, who felt unable to make music in the presence of others, even that of the music therapist, but who enjoyed computer technology. She used the program to compose her own music. Participant G used the program to put loops behind the song she had composed and recorded with keyboard accompaniment.

4.3.5. RAP

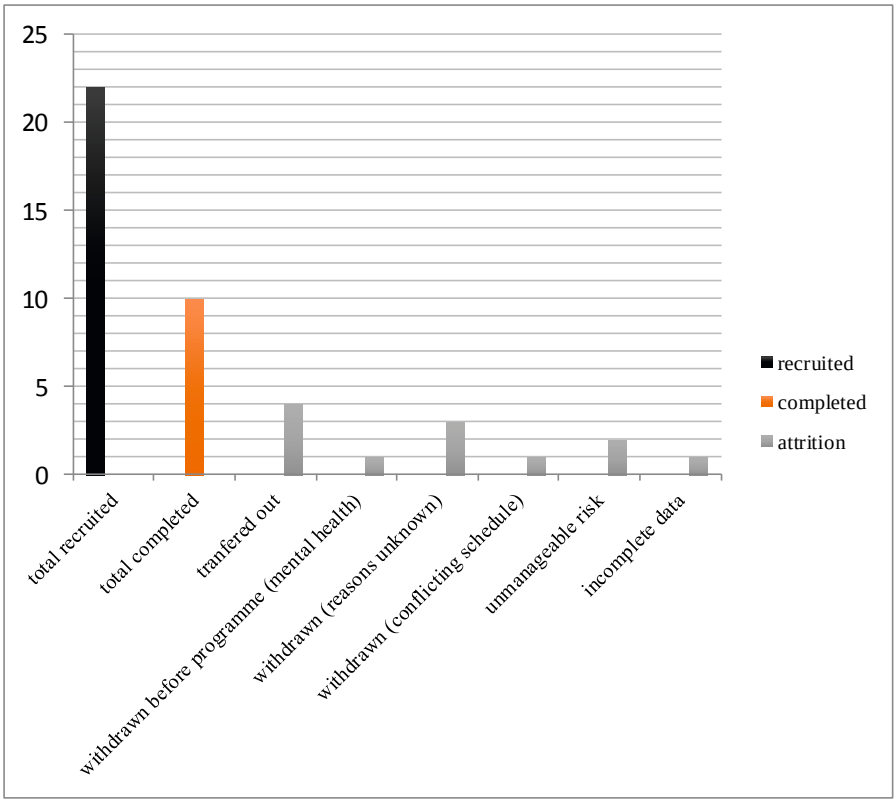
Participant I, a young offender involved in gang culture, chose rap as a culturally familiar form of improvisation. A fellow inmate provided the beat-box accompaniment and managed the amplification technology. The introduction of a prisoner who was not a research participant into the music therapy sessions changed the dynamics of the sessions significantly. As the music therapist had no experience of rap music the two clients took responsibility for managing their own music making, with the music therapist acting as observer and facilitator.

4.3.6. NON-ENGAGEMENT WITH MUSIC

Participant J was the only participant who did not engage with music at all as a therapeutic medium. Her attendance was irregular and she used the time to talk.

4.4. ISSUES ENCOUNTERED DURING DATA COLLECTION

Figure 4-3 Completion and attrition



In the original research protocol it was anticipated that up to 10 research participants would attend weekly one-to-one music therapy sessions of 45 minutes for a minimum of 8 weeks and a maximum of 12 months. Research participants were to participate in pre and post treatment semi-structured interviews and be measured at predetermined intervals (pre-treatment, week 4, week 8, every 8 weeks, and post-treatment) using the LEQ-ROPELOC/YAR-PET and the Rosenberg Self-Esteem self-report scales. The LEQ-ROPELOC/YAR-PET Staff observation questionnaire was to be completed pre and post-treatment by a member of staff who worked closely with the prisoner. The completion of a minimum of 2 measurements as well as participation in the pre and post-treatment interviews were mandatory for inclusion in the study.

22 participants were recruited to the program. 12 were unable to complete for the reasons outlined in Figure 4-3.

4.5. REVISION OF THE STUDY PROTOCOL

Because of the low retention rate a review was conducted five months into the data collection phase. The following issues were identified with regard to:

4.5.1. RETENTION AND ATTRITION

Issue

As a result of their complex needs and volatile behaviour some prisoners were liable to be shifted around the female prison estate so as to spread the burden of care evenly amongst establishments and give prison officers respite. Because of pressure on the prison it was not generally possible to have a hold put on prisoners. Prisoners could be transferred out without prior notice meaning that exit interviews could not be organised to complete data collection. Although considerable effort was invested to identify suitable candidates for the research project it proved difficult to assess accurately the likelihood of research participants being transferred out to other prison establishments whilst undergoing treatment.

Revision

In order to limit attrition to a minimum an interview was introduced at the third measurement point, generally at 8 weeks. Whenever possible a post-treatment interview was also conducted. Where participants were transferred out to other prisons and had completed at least 2 measurements the possibility of conducting the interview via inter-prison video link was explored. A renewed request for the prison to put holds on research participants was made and granted.

Issue

Remand prisoners taking part in the research could be released directly from court or sentenced prisoners on licence recall could be released conditionally. This could not always be anticipated and access to relevant information, which would have helped reliably assess the probability, was not always available.

Revision

The unexpected release of Remand prisoners could not be anticipated. However, if licence recall prisoners were re-released the possibility of the outside Offender Management Team facilitating an exit interview and post-treatment measurement was explored.

Issue

With regard to Restricted Status Prisoners the negotiated security conditions regulating access to the research participants could be changed without prior notice and violate the integrity of the therapeutic space to such an extent that one-to-one confidential music therapy was no longer possible.

Revision

The modality of therapeutic intervention (co-improvisational, song-writing, etc.) could be changed to therapeutic teaching to address issues of confidentiality. This could then revert back to the original intervention once security conditions were revised and lowered if the participant so wished.

4.5.2. PSYCHOMETRIC MEASUREMENTS

LEQ-ROPELOC/YAR-PET Self Report Questionnaire

Issue

Two factors included in the self-report measurements proved problematic for the Restricted Status Prisoner research participants (Leadership Ability, and Community Engagement) as these prisoners were held in isolation from the wider prison community with no opportunity to evaluate their capacity in these areas. They were also of very limited relevance to non-Restricted Status research participants.

Some research participants reported that it was difficult to answer the External Locus of Control items as their life was dictated by prison regime and rules and they were not in control of most day-to-day issues.

Revision

The irrelevant factors "Leadership Ability" and "Community Engagement" were removed from the LEQ-ROPELOC/YAR-PET Self Report Questionnaire. The discrete Internal and External Locus of Control factors were replaced by one single Internal Locus of Control factor.

Issue

The factors 'Stress Management/Emotional Control' and 'Overall Effectiveness' were mistakenly omitted in the questionnaire initially used with the first three research participants. 'Stress Management/Emotional Control' concerns the self-perceived capacity of the individual to self-regulate their emotions and reactions. It is highly relevant to the research because of a tendency to impulsivity observed in many offenders and the fact that it is targeted directly in many resettlement interventions.

There were also a number of factors with an incomplete number of items. 'Active Involvement', 'Self Confidence', 'Social Effectiveness', 'Time Efficiency', and 'Goal Setting' only had one item out of three. 'Open Thinking', 'Conflict Resolution', 'Achievement Motivation', 'Creative Self Expression' and 'Healthy Risk Taking' had two items instead of three.

Revision

In order to rectify this the LEQ-ROPELOC/YAR-PET Self Report Questionnaire was amended to include the factors 'Stress Management/Emotional Control' and 'Overall Effectiveness'. The missing items were inserted for the incomplete factors mentioned above.

Staff Observation Questionnaire

Issue

The corresponding LEQ-ROPELOC/YAR-PET Staff Observation Sheet was completed pre and post-treatment by a member of staff working with the research participant on a regular basis. During the initial 5 months it became clear that in the majority of cases the same member of staff would not be able to complete both questionnaires. Regular operational staff might be reallocated to other work areas within the prison and lose regular contact with the prisoner, and other key workers such as Offender Managers might leave their position at the prison.

Revision

With regard to the Staff Observation Questionnaire it was considered that, whilst it was desirable that one single member of staff complete both pre and post treatment questionnaires, this was not realistic because of frequent changes of workplace or high staff turnover. As this problem is encountered in other mental health settings the decision was taken to accept pre and post treatment questionnaires completed by different members of staff, providing these were closely involved in the prisoner's management.

Treatment frequency

Issue

With one pilot research participant treatment frequency varied as a result of an increase in vulnerability. In response to clinical need the researcher-therapist changed the session intervals from once a week to twice a week until the individual was in a more stable state. This raised questions with regard to measurement points.

In her non-research based music therapy work the music therapist worked with two women who had not been included in the research project because of the short duration of their custodial sentences (less than 10 weeks). These women attended twice weekly music therapy sessions because of clinical need. Both of these women would have been suitable candidates in all respects but were not considered due to the short sentence.

Revision

It was decided to broaden the protocol regarding treatment frequency and to consider the intervention over a period of time in which frequency and length could be adjusted according to clinical need. Thus prisoners with a short sentence attending short-term twice-weekly music therapy, as well as vulnerable prisoners with varied treatment frequency could be included in the program. This could yield interesting data concerning treatment frequency and length and help assess outcomes of short-term music therapy.

To facilitate comparison between research participants, measurement points followed session numbers rather than weeks. Thus measurements took place pre and post treatment, following the 4^{th} and 8^{th} session and then every 8 sessions until the research participant and therapist agreed the ending of the therapy.

4.6. DATA COLLECTION

4.6.1. QUALITATIVE DATA

Semi-structured interviews

Research data was generated in a series of semi-structured interviews with a view to capturing the individual participant's experience and process in music therapy, their relationship to music, and their engagement or non-engagement in prison interventions. The choice of semi-structured interviews allowed the research assistants to be guided by the interview schedule rather than constrained by it (J. Smith & Osborn, 2003). It enabled them to probe interesting areas that emerged in conversation.

A research assistant was engaged to conduct the semi-structured interviews on behalf of the researcher. This helped maintain the therapeutic boundaries, as the primary researcher was also the project music therapist. It also intended to allow the participants as much freedom as possible to make negative statements, which they might not have felt otherwise able to do if interviewed by the researcher/therapist. A second assistant was engaged when the primary research assistant went on extended leave. This was to ensure that new participants could continue to be recruited during her absence. Participants were interviewed by the same research assistant for all of their interviews (PreT, 8wks and PostT) to facilitate the building of trust and to allow for follow-up questions relating to previous interviews.

A total of 23 semi-structured interviews were collected from 10 participants. Participants in short-term therapy lasting 8 weeks (E, H, I) were interviewed pre and post treatment. Participants in long-term therapy (A, B, D, F, G, J) were interviewed pre-treatment, at 8 weeks, and post-treatment. It was not possible to conduct a post-treatment interview with one long-term therapy participant (C) as she had been transferred to another prison establishment where there was no inter-prison video link available. However, it was possible to retain her for the research study as she had completed two interviews (PreT and 8wks).

Interview structure

The interview schedule was designed to cover the following topics (see Appendix 1 for the interview schedule approved by the ethics committee) linked to the research questions as discussed below:

1. Music in everyday life (role, musical preferences, previous musical experience)
2. Self-description (strengths, difficulties, areas of desired change)

3. Engagement in resettlement programs (employment, program attendance)
4. Music therapy (expectations, fears, outcomes)

Questions relating to music in every-day life (1.) functioned as warm-up questions. They enabled the interviewer to set the interviewee at ease and establish a relationship with her. It also gave valuable insight into the individual research participant's relationship with music and their use of it in everyday life.

Questions relating to the self-perception of the interviewee (2.) helped establish how research participants defined themselves and whether there was a change in their self-perception over the period of treatment. They were designed to generate data with relation to Research Question 1: Is there a process of change in the self-perception of women prisoners with non-psychotic mental health problems attending music therapy?

Questions relating to engagement in prison programs and employment (3.) elucidated participants' attitudes and preferences with regard to prison interventions and collected information on their engagement or non-engagement patterns. The data generated through these questions responded to Research Question 3: If there is a process of change in the self-perception of this population, how does this affect a prisoner's ability to engage in resettlement pathways interventions?

Questions relating to expectations, fears and outcomes of music therapy (4.) were designed to capture the participants' perception and experience of music therapy and their music therapeutic process. They were aimed to elicit information on the individual's process in music therapy and thus generate data with relation to Research Question 2: [If there is a change in self-perception], what is the nature of the experience of women prisoners with non-psychotic mental health problems attending music therapy, with particular reference to self-perception?

The same areas were covered in the pre-treatment, 8 weeks, and post-treatment interviews. The length of interviews varied from 16-52 minutes.

Selection criteria

Due to time constrictions relating to the health condition of the primary researcher it was not feasible to conduct a close analysis of the interviews of all 10 participants. The interviews of Participants C, D, E, F, G and J were selected for data analysis. These represented different treatment lengths – 9-11months (C & D), 6 months (F & G), 4½ months (J), and 8 sessions (E) - and reflected proportionately the engagement of participants with varying music therapy techniques such as song writing (C, D, E, G), song performance (F), and co-improvisation (D). Participant I was not chosen for analysis as the introduction of a fellow inmate in her music

therapy rap sessions would have complicated a potential comparison of outcomes of clinical interventions. Songwriting, song performance and improvisation also reflected the general practice of music therapy with prisoners in this particular prison.

The selected interviews provided four case samples of participants who engaged well with the music-therapeutic process (Participants C, D, F & G). One further case (Participant J) was selected because she had not engaged with the therapeutic process. Her attendance was poor and she consistently declined to engage with the music. One further participant (E) was chosen as she represented inconstancies or contradictions with regard to the LEQ-ROPELOC/YAR-PET self-report questionnaire. Whilst most participants registered positive change in the majority of factors, participant E's results showed an improvement in only 5 of the 24 factors. Her post treatment scores went down in 8 factors and showed no change for the remaining 11.

It was considered that selecting interviews representing differing degrees of engagement and outcomes could help counteract selection bias. Common processes might be illuminated by juxtaposition (Barbour, 2001), enabling ''the exception to prove the rule" (Barbour, 1999 quoted in Barbour 2001). It could also provide a rich and complex picture of the phenomenon and enhance the discussion as explanations were sought for the inconsistencies or contradictions (Mathison, 1988). Furthermore it would help establish similarities and differences between research participants and could potentially give insight into optimal timing of therapy, treatment length and criteria with which to identify suitable candidates for music therapy.

Data preparation

The interview audio recordings were transcribed by an independent transcription service provided by Anglia Ruskin University, Cambridge, UK. All interviews were transcribed verbatim. Any names or identifying details, which could lead back to the individual participant, were eliminated from the text to protect participant anonymity. The researcher then compared the transcripts to the audio recordings, completed missing words and corrected erroneous transcriptions. Paragraph numbering was inserted to facilitate the tracing of text units back to their original context. For the interview transcripts see the electronic appendeces.

Guarding against researcher bias and over-representation of the data

The primary researcher was also the music therapist for the research participants. As such she not only had knowledge of the prison and client group but also insight into the life situation and therapeutic process of the research participants. In order to guard against unreflected-on bias an independent music therapist researcher was

engaged to collaborate on the analysis of the semi-structured interviews. Both primary researcher and independent music therapist researcher worked as a team. They both undertook the thematic coding of all of the interviews.

The independent music therapist researcher had no knowledge of the prison setting, client group, research participants, or their therapeutic process. She did not listen to the audio recordings of interviews. Her analysis focused exclusively on the written transcripts. Prior to coding she was given references to relevant handbooks and articles on thematic analysis, and brief instructions from the primary researcher. She was also given a table with which to collate information.

The independent music therapist researcher entered codes and data illustration chronologically with interview 1 codes grouped together followed by interview 2 codes etc. Her coding was descriptive (Figure 4-4.)

Figure 4-4 Exemplar coding table - independent researcher

Participant G	**Self-perception** ***(Independent researcher)***	
Code	ID	**Data Illustration**
I am an easy-going person, I mix well with people, I don't judge people before I get to know them	G/1/97	I think I'm an easy-going person; I tend to mix really well with people. I never judge a book by its cover; do you know what I mean? I get to know someone and then I'm just a friendly sort of person.
I am helpful and compassionate	G/1/99	I'm that sort of person but I'm very helpful, very loyal, I'd help anyone out and listen to their problems to see if I could help them out. Like this morning, I did one inmate and she was sitting there crying and I was trying to console her; do you know what I mean? I'm a bit like that.

The primary researcher grouped codes and data illustrations according to themes rather than chronologically. She used some brief descriptive terms or in vitro coding (Figure 4-5). The difference in the coding procedure was not intentional.

Figure 4-5 Exemplar coding table - primary researcher

Participant G	**Self-perception** ***(Primary researcher)***	
Code	ID	**Data illustration**
Easy going	G/1/97	I think I'm an easy going person
	G/2/27	I get on with everyone
Sociable	G/1/97	I tend to mix really well with people
	G/3/306	Confident, bubbly, er, I think I mix quite well with people. I'm a people person
Non-judgmental	G/1/97	I never judge a book by its cover. I get to know someone and then I'm just a friendly sort of person

The coding tables of both researchers were then merged in order to establish commonalities, discrepancies, and contradictions (Figure 4-6). Data illustrations that had been selected by both researchers were highlighted in green to visualise the extent to which their analysis coincided or diverged. The PhD supervisors each crosschecked the codes and categories for one participant.

These measures were undertaken to guard against researcher-bias and over-representation of the data, as member checking to ascertain the accuracy of representation of participants' thoughts was not considered viable for this study. They could also strengthen the reliability and validity of the analysis as disagreements and discussion could help refine coding frames (Barbour, 2001). Alternative interpretations offered could challenge existing ones, alerting the researcher to all potentially competing explanations.

Figure 4-6 Exemplar merged coding table

Category	Sub-category	Code	Participant Interview Paragraph PreT 8 wks PostT	Researcher 1 = HL 2 = OM	Data illustration
Empathy and awareness of others	Non-judgmental	Non-judgmental	G/1/97	1	I never judge a book by its cover. Do you know what I mean? I get to know someone
		I don't judge people before I get to know them		2	I never judge a book by its cover. Do you know what I mean? I get to know someone
	Helpful & compassionate	helpful	G/1/99	1	I'm very helpful... I'd help anyone out and listen to their problems to see if I could help them out. Like this morning, I did, one inmate, she was sitting there crying and I was trying to console her. Do you know what I mean? I'm a bit like that
		I am helpful and compassionate		2	I'm very helpful... I'd help anyone out and listen to their problems to see if I could help them out. Like this morning, I did, one inmate, she was sitting there crying and I was trying to console her. Do you know what I mean? I'm a bit like that
		I look after my siblings	G/1/409	1	I can connect with them because I look after them. (brother and sister)
			G/1/559	1	I never give up. Like when my brother was on the streets I used to go on the streets looking for him. Obviously, I couldn't... sometimes I could bring him back to my flat, other times he didn't want to know but I'd go and take him food of a night and feed the homeless as well; do you know what I mean? I couldn't feed him without the others. I'd go and buy a big bargain bucket of chicken or something but made a point of knowing he was eating or something you know?
		I care deeply about people in need		2	I never give up. Like when my brother was on the streets I used to go on the streets looking for him. Obviously, I couldn't... sometimes I could bring him back to my flat, other times he didn't want to know but I'd go and take him food of a night and feed the

Focus of the thematic coding

The specific focus of the thematic coding was

- Positive and negative self-perceptions
- Use and meaning of music in everyday life and in music therapy

Figure 4-7 'Long Table' analysis – supervision in situ

Within participant analysis

Both researchers collated two tables for each participant, one for self-perceptions and one for music. Relevant factor scores from the LEQ-ROPELOC/YAR-PET self-report questionnaire were noted in a fourth column in order to facilitate a later triangulation of data.

The codes of both researchers were discussed in the team. The primary researcher then collated the codes for each participant and ordered these according to a series of preliminary categories and sub-categories. The collated tables were then sent to the independent researcher to be checked for accurate presentation of her data and feedback. The table was then revised to reflect her feedback.

Between participant analysis

Data illustrations were extracted from the individual participant's coding charts and reviewed in search of overarching categories common to some or all participants. Existing codes and categories were excluded to allow a fresh analysis of the data. The data illustrations were glued together in two large separate charts (music and self-perception) following the low-tech 'long table approach' (Figure 4-7).

If data illustrations were equally valid for more than one coding option they were added by hand to the second option. This helped draw attention to potential links between codes. Data illustrations concerning music were divided into statements regarding the use of music in everyday life and the use of music in music therapy sessions. With regard to the self-perception chart, data illustrations which belonged to the same category and which seemed indicative of change in the way individuals talked about themselves were grouped according to interview (PreT, 8wks or PostT).

4.6.2. QUANTITATIVE DATA

LEQ-ROPELOC/YAR-PET self-report questionnaire

The scores from the individual measurements were programed into a pre-formatted Excel spread sheet, which calculated the average factor scores.

Imputation

The incomplete LEQ-ROPELOC/YAR-PET Self-Report Questionnaire sheet mentioned in 4.5.2 was used for measurements 1 & 2 with Participants B & C, and for measurements 1-3 with Participant A. Participants A, B & C represented 33% of the research sample. Rather than exclude such a large portion of the sample from the analysis, it was decided to proceed using imputation, particularly as the missing data could be regarded as "missing at random" and thus considered reasonably safe to impute. Pre-treatment scores were not available to replace the missing factors using a 'last value carried forward' strategy (Allison, 2001). Thus the values of the first measurement point of the amended questionnaire were taken instead (measurement point 4 for Participant A, and Measurement Point 3 for Participants B&C). It was considered prudent to take a conservative approach even though it could lead to an underestimation of the true treatment effect.

Between participant analysis

It was decided to do a standardised means effect calculation to help explore the quantitative data in more depth. Measurements had been taken pre-treatment, during treatment and post-treatment. Whilst results could not be generalised to a larger population, they could provide an important complement to the qualitative interview analysis as indicators of change. Because of the small sample size (n=10) it was considered unlikely that normality tests would show non-normality and so it was assumed that the research sample reflected a normal distribution of the UK female prison population. Cohen's *d* was chosen, as this is more commonly used and easier to interpret.

To calculate the effect sizes the pre and post-treatment scores of each participant were collated in a single table. The calculated group Means and Standard

Deviations (M1 & SD1 = Pre-treatment, M2 & SD2 = Post-treatment) were then used to make *d*-like effect size estimations using a tool provided by http://www.uccs.edu/lbecker/index.html (Becker, 1999).

LEQ-ROPELOC/YAR-PET staff observation questionnaire

Pre and post-treatment Staff Observation Questionnaires (SOQ) were collected for 8 participants. Of these only 2 were completed by the same member of staff pre and post-treatment. Scores from the SOQ were entered in to an Excel spread sheet, the average factor scores calculated, these were then collated together with pre and post-treatment self-report scores to facilitate a comparison and *d*-like estimations were calculated in the same manner as above.

Rosenberg Self-Esteem Scale

Scores for the Rosenberg Self-esteem Scale were entered in to an Excel table and calculated as follows:

Items 1,2,4,6 & 7

Strongly agree = 3
Agree = 2
Disagree = 1
Strongly disagree = 0

Items 3,5,8,9 & 10 (reversed in valence)

Strongly agree = 0
Agree = 1
Disagree = 2
Strongly disagree = 3

The scale ranges from 0-30. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem (Rosenberg Self-esteem calculator).

Effect size estimations were made in the manner outlined above.

Data collection of parasuicidal incidents and adjudications

Logs of parasuicidal incidents were collated using the daily report issued by the prison and emailed to the primary researcher. Adjudication reports were also emailed on a daily basis. The prison collated this information in to a prison database. There were considerable discrepancies between the emailed reports and the prison database. It was decided that the researcher log, which was collated from prison emails reflected the number of incidents more accurately than the prison database and these logs were used for analysis.

Engagement patterns with prison interventions

The prison employment database showed when participants had registered for a prison intervention. However it was not possible to see from the database whether participants had indeed attended and completed the programs. Data concerning attendance was completed from information gained in the semi-structured interviews.

Data storage

The data was stored in compliance with the United Kingdom Data Protection Act 1998 following procedures outlined in the application approved by the National Research Ethics Service Committee East of England – Essex, to be found under 3.11.2.

CHAPTER 5. RESULTS

5.1. QUALITATIVE DATA

The data of 6 participants were selected for thematic analysis.
This section will present the results of the analysis of the semi-structured interviews conducted with participants C, D, E, F, G, & J.

In this study 'self-perception' is understood as an internal representation of the self (Princeton University, 2008) which can be formed as an understanding, a sense, an impression, a feeling, a notion, a recognition, an apprehension (Collins English dictionary and thesaurus, 2000).

The questions relating to topic 2 of the interview schedule aimed to elicit information on the self-perception of the research participants. It was interesting to note that most participants struggled to describe themselves and mostly limited themselves to very general attributes such as friendly, caring, and helpful. Moreover, they could express conflicting views of themselves, not only within a single interview but also within a single sentence or paragraph:

> G/1/98[13] "I tend to mix really well with people. I don't ever go out. When I'm in here, I'm always in my cell."[14]

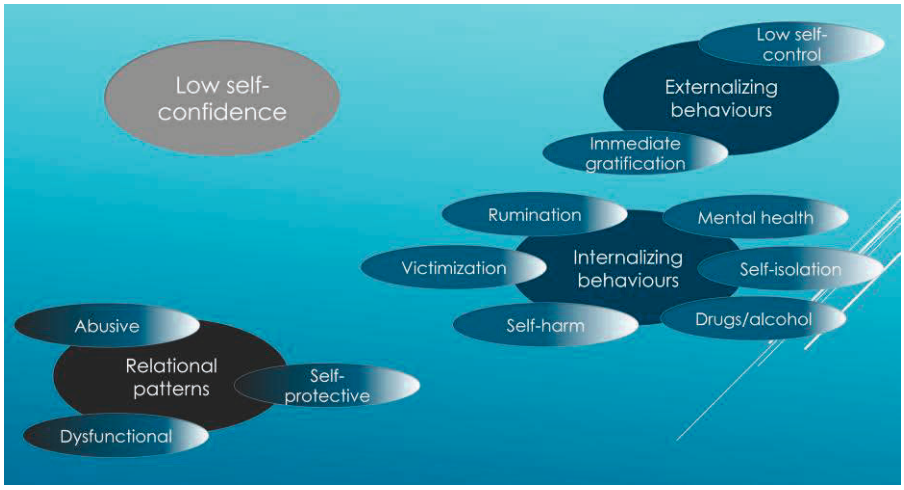
To get an in-depth understanding of how participants experienced and perceived themselves inferences had to be made from how they spoke about themselves in other parts of the interview(s).

A number of categories and themes emerged from the data analysis:

[13] UPPERCASE LETTER = participant ID (C, D, E, F, G, or J), 1 = interview number (1 (whole identifier in blue) = pre-treatment, 2 (green) = 8 weeks, 3 (red) = post-treatment), 97 = paragraph number.

[14] Quotes from the semi-structure interviews are representative rather than exhaustive and are given for illustrative purposes.

Figure 5-1 Self-perception categories and sub-categories



5.1.1. RELATIONAL PATTERNS

Participants C, D, E, G & J all spoke of dysfunctional relationships. Participant F did not speak about her family or past; however, deep scar tissue resulting from prolific self-mutilation and self-medication with drugs could be interpreted as indicators of relational difficulties.

Participants E & G had close relationships with mothers who were alcohol dependent:

> G/1/346 "My life was revolved around my mum. My relationships split up because I was more involved with my mum than with the relationship."

Both of these participants had cared for their mothers in the end stages of their lives and were struggling to come to terms with feelings of intense loss and abandonment following their deaths:

> E/1/74 "I done it [overdosed on the outside] because… I really didn't want to be here. I really just wanted to be with my mum."

Family relationships were often at the extreme ends of the spectrum, either all-consuming or ruptured:

> E/1/42 "My brother was my life and I didn't want anyone to have anything better than him and, you know, so I'd go out and rob and stuff."

> C/1/121 "[I feel] sadness because I'm not in contact with them [children and grandchildren]. I mean, one of them lives with me but we don't communicate when we are together. One lives near [NAME OF TOWN] and one, I'm not sure where he is living, but, um, yeah, we tend not to be in contact with each other."

Participants D and E spoke of domestic abuse in their childhood:

> E/1/38 "I couldn't concentrate at school when my mum was being beaten up by her boyfriend and that. So when I used to be at school I wasn't really concentrating on the work and stuff because my mum would be… my mind-set would be on 'oh, am I going to be picked up today from school', or, you know, 'is my mum going to be alright and that?' So I couldn't concentrate at school."

The experience of abuse led to maladaptive coping strategies. Participant D resorted to self-directed harm to cope with feelings of anger:

> D/1/120 "Instead of taking that out and being confident and taking that out on people that are hurting her, she [Participant D speaking of herself in the third person] re-directs it because she doesn't want to be like her dad. She doesn't want to be like her dad's family, who abused people, violated people, manipulated people, do you know what I mean? She doesn't want to follow in the tracks of her father. So… when she does get frustrated she does get angry. Instead of… being confidant and that, she runs away and takes it out on herself."

Participant J responded to difficulties within the family with challenging behaviour to draw attention to her distress:

> J/1/94 "I think a lot of it was because I wanted my mum to react and she never did. A lot of my behaviour was for a reaction and I never got the reaction that I wanted."

The feeling of anger continued to reverberate in her life.

> J/2/82 "A lot of my feelings is anger towards my mum for not being there when I needed her. It's really hard. I hate life. I fucking hate it."

Relationships were often fragile and were undependable:

> C/2/168 "I've told my mum what we're doing and she wants a CD. But that all depends because we are likely to fall out fairly soon through something else that is going on."

Early experiences of dysfunctional relationships impacted on later relationships. Participants D & E, who had experience of domestic abuse, engaged in abusive relationships in their adulthood:

> E/1/42 "so we got kicked out of there for domestic violence and then we was on the streets… friends of mine said… one morning they said listen you've got until the end of the day to get out of [NAME OF LOCATION], leave her alone and that then I ended up going with him because I was scared."

Participant J felt that the roots of her own dysfunctional relationship with her mother were intergenerational and that this continued in the present generation and defined her relationship with her own children:

> J/2/94 "My mum's kind of like my role model really, but she's not a loving person, which I find really difficult to accept. It's just the way she is. She didn't have a lot of maternal stuff thrown into her, so how could she be maternal to me, which therefore means how could I be maternal to my own children? It kind of makes sense. It all makes sense in my head."

Dysfunctional experiences had multiple and complex effects on a participant's life and relationships:

> J/1/70 "Yeah, I just don't feel very confident anymore and I think that's just because I've been in a relationship for 17-years and it's just been really chaotic I guess and I've lost a lot of contact with my family. You know, my dad I'm really close with but I'm not what he wants me to be because he feels that I've failed him because I've given up all my children. It was my own choice but… because I knew I wasn't ready to give up drugs and my relationship, I chose to give the children away. I think my dad feels quite angry about that… He has called me a 'brooding machine' for social services."

Such experiences encouraged participants to be defensive and over-protective for fear of being hurt. This made trust and close relationships with others difficult:

> D/1/114-116 "I have to keep reminding myself when I come out of the door, I have to pull myself back. When you come to this jail you have to make sure you've got your priorities right, your brick wall up, do you know what I mean? … You've also got to change your personality,

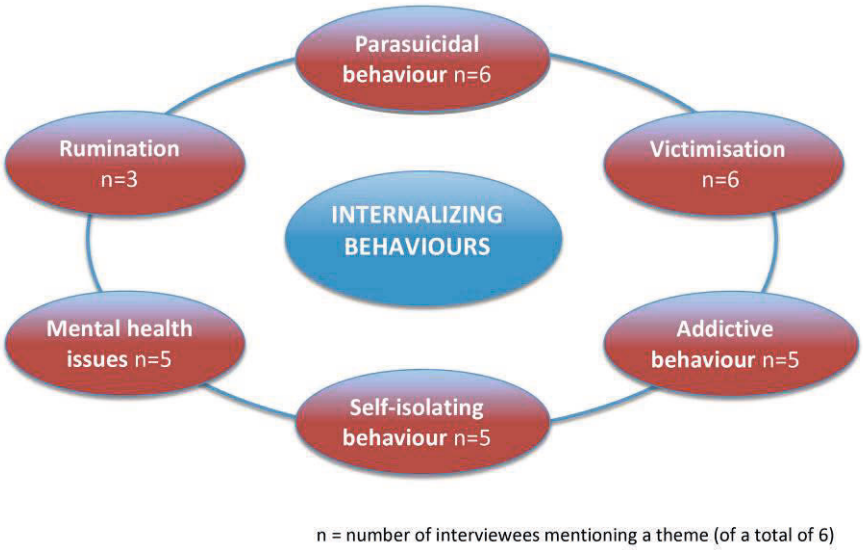
> you've got to change the way you talk, you walk, the way you that… because that's what they expect. It's what they're used to. And more than that, it's about protecting myself."
>
> D/1/132 "It's about me not being scared of showing who I am, but then also being able to control it so I don't get hurt."
>
> G/2/217 "Only someone in like authority or someone who's confidential I could trust… It's been a long time for me to come out with things; do you know what I mean? So, you know you tell people certain things or within five minutes you tell them not to say anything and they… do you know what I mean? No trust."

Participants developed maladaptive behaviours to help them survive in dysfunctional families. These can be categorized as 'internalizing' and 'externalizing' behaviours.

5.1.2. INTERNALIZING BEHAVIOURS

Internalizing behaviours are characterised primarily by processes within the self where the experience of problematic emotions and energy are directed inwards (Matsumoto, 2009).

Figure 5-2 Pre-treatment internalizing behaviours



Participants C, D, E, F, G, & J mentioned six core areas of internalizing behaviours in their pre-treatment interviews. These behaviours rarely functioned in isolation but interacted with each other in a self-perpetuating vicious circle. Such behaviours were entrenched and participants were aware that they had come to depend on them and used them as, albeit self-destructive, coping strategies:

> C/1/131 "I've got to find different ways of sort of coping [with emotions which turn inward] because normally I would harm myself…it gets into a vicious circle"

Parasuicidal behaviour

Pre-treatment

The National Institute for Clinical Excellence (NICE) defines self-harm as "self-poisoning or self-injury, irrespective of the apparent purpose of the act" (NICE, 2004). It can also be understood in a wider sense to include the misuse of alcohol and/or drugs, and eating disorders (NHS, 2013). The prison system does not give a definition of self-harm in its guidelines on the management of prisoners at risk of harm to self (HM Prison Service, 2012). However, the term 'self-harm' is used within the prison system to refer to acts of prisoners who inflict harm to themselves by cutting, burning, punching themselves, or by tying a ligature around their throat. In common parlance it does not include over-dosage. This is possibly because over-dosing is a relatively rare occurrence as the administration of medication is an intensely scrutinised and supervised practice. For the purpose of this study the term 'parasuicidal behaviour' has generally been preferred to 'self-harm' as it refers to all non-fatal self-injury including suicide attempts and self-mutilation. However, in the following section both terms are used interchangeably. The use of 'self-harm' reflects the preferred terminology used by the interviewees and the research setting.

Participants C, D, E, F, & J reported that they habitually resorted to self-harming behaviours to cope with complex, painful feelings raised by long-term abuse and had done this over a long period of time:

> D/1/146 "It's been so many years of self-harming, being constantly hurt, that I actually swore I would be dead by twenty-five. And when twenty-five didn't happen I said, well by the time I'm thirty I don't want to be around."

> F/2/61 "I've been self-harming since I was 8."

Participant G was the only exception. She had extended periods when she was free of parasuicidal behaviour and only self-harmed in response to negative life events:

> G/2/241 "I started to self-destruct again. I felt deep in myself that it was because I lost my mum".

For Participants C, D, E, F, & J parasuicidal incidents included both suicide attempts and self-mutilation, often on a prolific scale. The term 'self-harm' was often used in combination with the possessive pronoun and women referred to themselves 'self-harmers':

> C/1/133 "Being a self-harmer, I mean, you don't want to die."

This revealed the degree to which they were invested in this particular aspect of themselves.

Self-harm, however, was not limited to self-mutilation. Some women also understood their drug use or risky behaviour as self-harm:

> J/2/66 "I have done some things, like I've harmed myself, put myself in some predicaments as well, some situations. Sometimes I scare myself, but I just think I can cope with it; I'll be okay. Strange, strange how the mind works."

Post-treatment

In their mid-term or post-treatment interviews Participants D, E, & F reported that they no longer self-harmed:

> D/2/86 "I've got to admit one thing as well, with doing music therapy I haven't self-harmed for ages. I've thought about it on a number of occasions. I have thought about it. I've got so angry on my wing and that; the first thing I would have normally done was get a razor blade but I haven't. So, I've been five, six moths so far I haven't self-harmed."

Participant C's self-harm had reduced.

Participants D, E & F saw this in relation to their engagement in music therapy:

> E/2/22 "It [music therapy] stopped me self-harming."

> F/2/26-30 "I wouldn't say it's all because of music therapy but it has helped *a lot*. It has made me realise that I don't have to do that. I can take it out by writing music and stuff. If I'm pissed off, I'll write a really angry song. If I'm like feeling down, I'll write like a sad song or if I'm happy I'll just write a happy song… It's a different coping mechanism. Instead of picking up a blade and slicing myself, I pick up a pen and write a song."

Table 5-1 Pre and post-treatment parasuicidal behaviour

ID	Pre-treatment	Post-treatment
C	Prolific and enduring self-harming behaviour since early adulthood	Reduced self-mutilation incidents, no suicide attempts
D	Prolific and enduring self-harming behaviour since adolescence	5-6 months free of self-mutilation. No suicide attempts
E	Prolific and enduring self-harming behaviour since adolescence	Stopped self-harming
F	Prolific self-mutilation since 8 years	Stopped self-mutilating
G	Periodic self-harm in response to negative life events	No self-harm in response to negative life events occurring during music therapy
J	Enduring self-harming behaviour since early teens	No change

Addictive behaviours

Pre-treatment

Another self-destructive behaviour was the use of chemical substances and/or alcohol to self-medicate. Participants C, D, E, F, & J defined themselves as "users" and used drugs and/or alcohol in addition to self-mutilation to cope with their continual distressing and intense feelings:

> D/1/62 "I think I used drugs to block out the fact that I felt different".
>
> E/1/182 "I used drugs to suppress feelings about my mum."
>
> J/2/36 "I find it so hard to deal with all those emotions, which is why I've suppressed it for so long with drugs."

In addition to this Participants C & J reported having problems with eating. They had no formal diagnosis of an eating disorder but saw their food consumption as another aspect of their addictive nature:

> J/2/185 "I mean, I've really got the problem of addiction. I keep eating, eating, eating. It's got to the stage where three people have said to me are you pregnant? Oh my God, how could I possible be? So I've clearly

> got a problem with addiction. I can't eat when I'm outside. I won't eat when I'm outside. And now I'm in here I don't know how to stop eating."

Post-treatment

With regard to chemical substance misuse Participant D had already recognised the link between her substance misuse and her inner pain before she started music therapy:

> D/1/132 "It's not about the drugs, it's about me, it's about what's inside me."

She used her prison sentence to detox and identify the emotions leading to her drug use. She intended to stay clean and hoped that this insight would help her avoid relapse after her release:

> D/3/54 "It's about thinking about the consequences of acting on those feelings [vulnerability, excitement]. So I know how I'm going to feel now when I get out. I'm going to be all enthusiastic, happy. I'm going to think, oh just one, it isn't going to hurt, do you know what I mean. And it's at that kind of level. So, it's about knowing that those, I'll have those feelings and saying right, I'm not going to use, I don't want to use, and what can I do to prevent me from using when I've got those feelings?"

Participant C, who was an alcoholic, was engaging well with the Relapse Prevention Program team. She had completed their intensive group program successfully and continued to work with them on a one-to-one basis. She attended weekly Alcoholics Anonymous meetings in addition. She was also working on her addictive consumption of high sugar content drinks and foods.

Participant F, who reported substance-misuse-related-offending as a life style was motivated to contemplate alternatives:

> F/2/63 "Hopefully when I get out of here I'm going to go back to college and stuff like that; but I never did that before and we just go out, come in and doing drugs and whatever. I feel I want to do something with my life now."

Table 5-2 Pre and post-treatment addictive behaviour

ID	Pre-treatment	Post-treatment
C	Alcohol dependence, not engaging with programs	Working with Alcohol Relapse Prevention Team and Alcoholics Anonymous
	Addictive eating behaviours, not engaging with programs	Working one-to-one with cognitive behavioural program
D	Chemical substance misuse, engaging with CARAT team	Detoxed. Setting up post release community support. Intending to stay clean.
E	Chemical substance misuse, in contact with CARAT team	No change
F	Chemical substance misuse, engagement with CARAT team unknown	Detoxing. Intending to stay clean
G	No substance dependency	N/A
J	Chemical substance misuse, known to CARAT team, engaging with Narcotics Anonymous	No change
	Addictive eating behaviours	No change

Victimisation, vulnerability to exploitation, locus of control

Pre-treatment

Participants D, E, G, & J made statements indicative of a victim mentality:

> J/1/88 "I'm easily bullied, intimidated, and people… I think I must give off that vibe, because people do use my kindness for a weakness, definitely."

> G/1/244 "I knew what was going on throughout my life, and there was nothing I could do about it, apart from just tolerate it."

Much of the victimisation was on the relational levels of domestic, sexual, or emotional abuse:

> E/1/42 "I met a partner, who used to beat me up and beat me up and beat me up."

> E/1/143 "I went through it bad but he sent me to do things all the time. Because he raped me and stuff as well, you know, what I mean?

> D/3/14 "I found people were manipulating me because of me being a people pleaser, and they knew they could manipulate me, intimidate me and get what they wanted."

Participants D, F, G, & J reported feeling judged or misunderstood:

> G/1/254 "So they [siblings] look at me as a bad person in so many ways that I've been to prison."

> D/2/104 "No one's given me a chance. No one's listening to me. Everyone's judging me at the moment, criticising me and not criticising me for good either".

This could result in defensiveness and mistrust:

> D/1/108 "If you let yourself be normal, behaving how you want to be, eventually you're going to get hurt; do you know what I mean? And you'll be used, trampled on, or abused; do you know what I mean? So, you have to limit yourself; do you know what I mean?"

> D/2/106 "They say that they are here to help and then the next thing they do is just stab you in the back. So, who do you trust? Who do you talk to?"

Participants D & J expressed deep-seated feelings of being different to others and outcast from their peers and families. They tried desperately to fit in:

> J/1/124 "I found it really hard to fit in… I tried too hard sometimes… I always felt different, you know?... It's just kind of stuck with me and made me really unconfident – made me who I am today."

> D/3/130 "I was not comfortable. I needed to be class clown or a bully to fit in. And that's all I ever did was trying to fit in."

An overwhelming desire to fit in and be loved left participants vulnerable to abuse at a sexual, emotional, and/or material level:

> J/1/90 "I've always tried to fit in. Even at school I never really fitted in with the in-crowd. And then I got involved with older men, thinking it

> would, you know, give me some sort of identity, some sort of, you know, status, which was, obviously it didn't."

> E/1/52 "If I had £10 and somebody needed £10, I'd give it to them, do you know, and then I feel like you give them an inch and they take a mile, you know?"

This vulnerability was exacerbated by a tendency to passivity:

> D/2/6 "I just tend to follow, which is pretty much similar in my lifestyle, which, I mean if anybody, if they suggested something I'd just go along with it."

Post-treatment

Participants who had previously been easily intimidated and victimised reported standing up for themselves:

> D/3/16 "I said, I'm not allowing this to happen no more, do you know what I mean? I'm watching myself and other ladies being manipulated because they know they can manipulate, do you know what I mean? And I stood up for myself and I went to the officers. They didn't hear me, so I went to someone who I knew would listen to me, which was [NAME] and between us we both made the steps of challenging these people but having to do it in a non-aggressive way, do you know what I mean?"

At a deep-seated level Participant D, for example, became aware of her victim identity and the need to address it:

> D/3/176 "I just needed to stop relying on guilt and all the other sad emotions, or better still, stop being a victim - cos I always had to be a victim, to feel a victim - and own it, own it."

There was a sense of pride and achievement in those who had learnt stand up for themselves:

> G/2/243 "It's made me a much better person to think that I'm not going to do this [comply to others] no more."

Participants D, E and F all found that music therapy offered them a space in which to experience being in control:

> E/2/24 "Yeah. Yeah, [music therapy makes me feel] more in control of the matter."

F/2/44 "When I first started doing this [music therapy] I said 'I don't mind. I'll do whatever' but now I come in and I'll like choose a song and she will start playing it and I will sing."

D/2/6 & 16 "At first, I thought of, like, I knew that she was going to be more in control because I didn't have the confidence to take control and continue the music. I think she let me take control just to see where we went with it; but then I felt there was a couple of times when I did actually take control. Then the last few sessions if she took control back I was able to just carry on playing by following her; do you know what I mean? Like following her lead. And sometimes I was able to take that control back and try again; do you know what I mean? The last session we did when I actually took control and was able to keep it going."

G/3/483 "Any benefits? [From release of emotions]. I can control it more now."

Table 5-3 Pre and post-treatment victimisation and locus of control

ID	Pre-treatment	Post-treatment
C	Vulnerable to abusive relationships	Extricating herself from abusive relationships
D	Bullied	Self-assertive
	External locus of control	Strengthened internal locus of control
E	Vulnerable to exploitation	No change
E	External locus of control	Strengthened internal locus of control
F	External locus of control	Strengthened internal locus of control
G	Compliant	Self-assertive
	External locus of control	Strengthened internal locus of control
J	Bullied	No change
	External locus of control	No change

Rumination

Pre-treatment

Participants C, D & F reported suffering from pervasive negative thought patterns:

> D/2/56 "When I get angry I can't just switch off, I just, like I said, I overthink, I just think and think and think about how hungry I am and how pissed off everything's making me."

Post-treatment

Participants C & F found song-writing an effective way of ordering thoughts by getting them out of their heads and on to paper:

> C/2/12-14 "The songs that I'm writing are about the ways that I felt over the recent period and that. So I'm writing sort of, it's done in like poem form as to the way I felt inside at that particular time. It's just getting it out and letting other people know how I've felt and why I've been as I have."

> C/2/44 "[Getting it down on paper] makes me sort of feel, well things aren't as bad as I might think they are."

> F/3/96 "I have the logic now to be able to try and iron out my faults as I think of a song."

Self-isolating behaviour

Pre-treatment

The interviewees found it difficult to join in general prison life and activities and reacted to this by isolating themselves. Participants D & J were the only participants in the study to engage in out-of-cell-work when they enrolled for the program and although Participant D worked outside her cell she did not feel safe enough to move off the house block without an escorting member of staff. Although J worked in the kitchens she shunned others both at work and on the house block:

> J/1/116-118 "I isolate, I do isolate… because I find that people are either laughing about me or trying to get things out of me. So it's just easier to be on my own."

All other participants were doing so-called 'in-cell' work as they reported lacking the self-confidence to mix with other prisoners and engage with prison programs:

> F/2/32 "Before, when you saw me last, I was unemployed and staying in my cell every day because I didn't have the confidence to come out."

Post-treatment

Participants C, F & G reported that they were now engaging in out-of-cell activities and mixing with other prisoners more:

> C/2/74-76 "I'm doing that course in the gym to get a qualification. I'm doing Health & Social Care and I'm doing Higher Literacy."
>
> F/3/148 "Before, when I first started music therapy and stuff like that, I done what's called in-cell work, where you don't come off the house block and you just stay in your cell the whole time, because I didn't have the confidence to mix in big groups and stuff like that but now I go to work like a normal prisoner, whatever normal is."
>
> G/3/311 "Normally I'd just sit and observe, whereas now I interact a bit more. I'm a quiet person that just sits. I used to sit on my own quite a lot in a cell but I don't do that now. I interact a bit more; do you know what I mean? I go into other people's cells whereas I would never go into someone else's cell."

Participant D, who had already been in prison employment when she started music therapy, now reported feeling more confident about moving around the prison independently:

> D/2/44 "Because before I was really scared to come off the wing, apart from when I used to come over for therapy and [NAME] used to come and get me because I wouldn't come through on my own, but like the last week or so I've been coming off the wing on my own and going over to Visits[15] or coming over here; I didn't even think about it. Normally I get quite panicky."

Table 5-4 Pre and post-treatment self-isolating behaviours

ID	Pre-treatment	Post-treatment
C	In-cell work	Engaging with Gym, Education and Programs
D	Working on house block but needs escort to move around the prison	Working off the house block and moving independently
E	Unemployed	No change

[15] Separate area of the prison where prisoners can receive visits from their legal team, or from family and friends.

F	In-cell work	Engaging with Education and Programs
G	No security clearance for work. Stays in cell and doesn't mix with other prisoners	Attending Gym and mixing with other prisoners
J	Employed in Kitchen, doesn't mix with other prisoners	Employed in Kitchen, doesn't mix with other prisoners

Mental health

Pre-treatment

Mental health problems in the form of mood and anxiety disorders or trauma related stress, were also a defining element of the reality of Participants C, D, E, F, & J's existence:

> J/1/158 "I think more than anything, it's more and more depression that plays a bigger part on my offending"

> J/2/84 "I wouldn't say I feel suicidal but I just feel like my life is shit and I try and I try and I never seem to get it right… I'm fed up. I'm tired of it."

Post-treatment

Participants C & D, who had reported being feeling depressed, now said that they were feeling happier:

> C/2/200 "I feel quite positive. I feel quite positive most of the time now."

> D/3/4 "I actually feel a lot calmer, a lot happier, more integrated, not so paranoid, which I had been but I've definitely calmed down on the wing."

Participants E & F remarked that friends had noted that they seemed happier:

> E/2/50-52 A few of my friends have said… I seem more happier. When I come back from music therapy I'm more happier sort of thing."

> F/3/52-54 "Everyone says that I seem a lot more happier all the time… because I'm back in my cell. I'm writing music and stuff like that as well. So that's right, I'm doing music every single day. It's good."

5.1.3. EXTERNALIZING BEHAVIOURS

Externalizing behaviours are characterised primarily by actions which direct problematic emotions and energy towards the external world such as acting-out, anti-social behaviour, hostility, and aggression (Matsumoto, 2009). Low self-control, which can be seen a major issue underlying externalizing behaviours and defined as "the tendency to pursue short-term, immediate gratification whilst ignoring longer term consequences" (Blanchette & Brown, 2006 p.18), is of particular relevance to offenders. It is the focus of the following analysis.

Pre-treatment

All six interviewees selected for data analysis, experienced difficulties regulating emotions and reactions in stressful situations. With family, peers and fellow inmates this could lead to angry, aggressive behaviour:

> C/2/186 "Even when I was a kid at home, I would… my brothers used to take the piss out of me and my step dad used to take the piss out of me and I just used to get up, storm out of the room, slam the door, bang my way up the stairs, slam my bedroom door, put my music on loud. And [NAME] used to like come up and say what's the matter? And I'd say; nothing and I would just have the hump and then about an hour later I'd go back downstairs and if they said something wrong again I would go up."

> D/1/22 "I got very aggressive at [NAME OF SCHOOL]; do you know what I mean? Lashed out quite a bit."

> D/1/90 "I ended up getting in to trouble so much that for a good few years I became an alcoholic, I'm going to turn out really nasty; do you know what I mean? I became very threatening; do you know what I mean?"

Whilst tense situations with fellow inmates were likely to be dealt with by open aggression, contentious situations with prison staff were sometimes responded to more indirectly with confrontational behaviour:

> C/1/101 "[How do I show anger with officers?] I'll argue. I'll look for confrontation. Um, in the prison, say, I've done graffiti on my walls about officers which isn't very nice and I've sent letters to the officers that aren't very nice and stuff, so…and um, lots of… on the house block I was turning my music up a bit loud."

Post-treatment

Participants C, E, F, & G reported an increased ability to regulate their reactions in stressful situations:

> C/2/110 "Before, I would fly off the handle and start storming off and shouting and banging the doors and stuff like that. I've only done that once or twice in about 3 weeks now. I just tend to bite my tongue a bit and think you know, when I want to get enhanced I can't afford to get a [negative] IEP[16]. I want to do this and I want to do that, so I can't afford to not do certain things or I can't afford to muck up, so…"

> E/2/42 "Yeah, that was to do with my mum… that… my mum but I did walk away from her out on exercise when she wanted to fight, I walked away from that, whereas before I would have been [2 WORDS NOT CLEAR] (3.15), I would have just gone bang, bang, bang but I didn't, I just came in and walked away…whereas before I wouldn't have done… and that makes me feel good, yeah."

Participants F & G saw their enhanced ability to cope with stressful situations in direct connection with their music therapy:

> F/2/73 "It's just… you can put so much emotion into when you're singing. Instead of getting like angry, shouting and punching and something and punching a wall or whatever, just sing. I mean I feel like a totally different person now…"

> G/3/383 "… and I have to work with them every single day and do you know? I've not been… ever said one single word to them and I would love to… I just know; what's the point? Whereas before, I would have just gone off the rails at them, flipping right gone into them. They've made accusations, the prison have believed it; what can I do? (I[17]) Do you feel that, that changed is a result of [music therapy]? (G) Yeah, definitely… (I) How has that helped? Has it I mean, [ONE WORD NOT CLEAR] (35.26)? (G) I think doing this music has chilled me up quite a lot you know. Chilled me out, calmed me down quite a bit."

Participant F saw this as a new coping mechanism:

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[16] Incentives and Earned Privileges Scheme. IEPS define a prisoner's regime level (Basic, Entry, Standard, and Enhanced), and linked privileges. Three positive IEPS lead to an enhancement of prison status and related privileges. Three negative IEPS lead to a reduction of regime status and associated privileges.

[17] (I) = Interviewer

> F/3/141 "I'm not as stressed out all the time and I've learnt a different… that's a good word… I've learnt a different coping mechanism on how to deal with my stresses and my emotions and my behaviours."

Participants were aware of a change in their way of thinking and increased ability to reflect and think of longer-term consequences:

> C/2/114 "I've never thought about long term things before. I mean, obviously I've got to work towards getting out and stuff like that but I'm not think… I'm not thinking that sort of term wise at the moment because I've got another court case coming up but I know that sooner or later when my court case is over I've got to think… well, I've got to work towards so and so because I'll be getting out in a certain time and stuff like that. So I know I'm going to have targets to reach before I get out."

> D/3/224 "I can't force anything or rush it because then I will trip over my own feet and that's when it all goes wrong. So, I'm going to make sure when I go out the first week, probation, set up all my appointments, but I want to do a slow, gradual build up so I can get used because I've been here for a while now, so I'm pretty institutionalised anyway from before. So I want to build things up and make programs build up; do you know what I mean? So that they are set into a routine like a slow build up routine and then get into a stable where I can do a full seven day thing."

5.1.4. SELF-CONFIDENCE

All six participants described themselves as lacking in self-confidence in their pre-treatment interviews.

> F/1/42 "I come across as quite cocky, outward-going, bubbly, but it's all a front. Underneath I'm really like insecure and stuff."

Participants C & F also mentioned having low self-esteem. In their mid-term and post-treatment interviews Participants C, D, E, F, & G reported feeling much more confidant:

> C/2/62 "Just knowing that I can do certain stuff [song-writing in music therapy] is a boost to my confidence. Knowing that I can get across how I am feeling and stuff boosts my confidence because if I am having a shit day, I'll write something shit, which might not be for confidence at the time but when I look back on it and think well, it wasn't really that bad, then it will raise my confidence again and think oh well, it wasn't really that bad. So I get a boost in confidence."

> C/2/180 "Yeah, more confidence, more self-esteem. I'm surprised at what I've done so far. I'm hoping to do quite a lot more."

> F/2/61 "I never thought I'd like feel confident enough to like come out of my cell and like go to education and now I just feel totally different. It's weird. It's good though."

This increase in self-confidence was manifested in various activities within the prison. Participants C, D, & G each reported doing things, which they would not have had the confidence to do before:

> C/2/70 "It makes me feel good [when staff respond positively to changes in behaviour] because I think… *I* didn't think I would change as much as I have in the few weeks that I have. I didn't think it was possible but because I'm aiming towards enhancement[18] and stuff like that, it's making me feel quite confident that I *can* do it."

> D/2/38 "I'm now working over in Visits. I wouldn't have done that before, I wouldn't have had the confidence to say; yes, I want to do that. I would have just not bothered. I would have stayed with the wing cleaning and stayed on that wing but I've actually said; yep, I'll do that; do you know what I mean? I've actually stepped out slightly, even if it's not much, I've still stepped outside of my comfort zone, which is on the wing and I'm cleaning Visits. But yeah, it has helped a little bit and I'm alright."

> G/3/375 "But I never… if I hadn't done this[19], I would have never sat in that room with a woman that I've never seen in my whole life, pick a book up and just like start reading it while she's sitting in front of you; do you know what I mean? But I didn't feel no way, I just went in there, picked a book, sat there… and I just did it because I'd been doing this."

5.1.5. SELF-EFFICACY

Participants also made statements indicative of an increase in self-efficacy. Perceived self-efficacy is defined as "an individual's subjective perception of his or her capability for performance in a given setting or ability to attain desired results,

[18] Enhanced regime status (highest status related to residence on a separate house block in the prison concerned) with associated privileges

[19] Participant G is referring to a program offered at the prison, where prisoners are recorded reading a children's book. This audio recording is then sent to the prisoner's children and helps keep contact with children during the sentence period.

proposed by Albert Bandura as a primary determinant of emotional and motivational states and behavioural change." (Matsumoto, 2009).

This growth in perceived self-efficacy was relevant to individual participants' pathway through the custodial sentence:

> C/2/70 "It makes me feel good [when staff respond positively to changes in behaviour] because I think… *I* didn't think I would change as much as I have in the few weeks that I have. I didn't think it was possible but because I'm aiming towards enhancement and stuff like that, it's making me feel quite confident that I *can* do it."

Significantly, it was also of relevance to downstream outcomes for the individual post-release:

> D/3/68 "You're secure and that's all I ever want when I get out; do you know what I mean? That's what I need and as long as I've got Probation, DIAS and Cranston[20], it will be okay, I know I'll be okay. I've done it before and I can do it again…"

> F/3/108 "I've come so far now and I've learnt so much so I don't think I'd ever go back to how I used to be. Everyone's going to have like their bad days when things happen to them, but I'm a stronger person now, so I know I'll overcome it."

5.1.6. CREATIVE SELF-EXPRESSION AND MUSICALITY

Pre-treatment

Some participants such as Participant J enjoyed creative activities:

> J/1/198 "I enjoy art as a way of creating stuff, creating things that I express myself."

Others were more reticent and insecure:

> C/1/391 "I think I'm tone deaf. So God knows what the music will sound like."

> G/2/296 "I was a little bit embarrassed because I'm not a singer or I ain't got a voice."

[20] Probation refers to mandatory post-release Offender Supervision. DIAS and Cranston are third sector external agencies.

> G/3/201-203 "The first few sessions that came on I couldn't… I just thought I didn't… I *know* I can't write the music, I know I haven't got the mind to sit there and put things down, and I *definitely* know that I won't be able to sing in front of her."

Participant F was the only participant to define herself in terms of her creativity and musicality:

> F/1/42 "I would describe myself as a creative person."

> F/1/48 "Everyone like back on the wing or at home and stuff like that know about my music… I'm always singing… walking around the wing or walking outside… anything, I'm always singing so they all know that I love music and I'm crazy about it."

> F/1/36 "Everything just revolves around music because if I didn't have music then I'd be rubbish. Seriously."

Post-treatment

Following music therapy participants who had initially been uncertain about engaging with the music were surprised and pleased at their musical ability:

> C/2/2 "I've been told that I'm not tone deaf. I'm quite enjoying it because I'm writing my own little things now as well. One of the songs that we've recorded, so it's going pretty well. I'm really enjoying the music."

> G/3/18 "Never in a million years thought I'd ever put… make a song, my own words, and write it all rhyming and me singing it. And now I know I can do it."

They identified themselves with songwriters and musicians:

> C/2/178 "I know the songs where groups have done like Everybody Hurts and stuff like that, which is quite a powerful song. So I didn't realise that I would do something on that sort of thing, putting powerful words into like songs or whatever."

> G/3/56 "Making the music with her has been absolutely amazing. I've loved every minute of it, and I've loved doing it all, putting the music together. And I was putting all the words, and I love just walking round like a film start or a musician, do you know what I mean? I was just like singing along and making it up as I go along."

5.1.7. MUSIC IN EVERYDAY LIFE

Questions relating to topic 1 of the interview schedule aimed to elicit information on the role music played in everyday life of the interviewees. For all participants music played an important role in their everyday life:

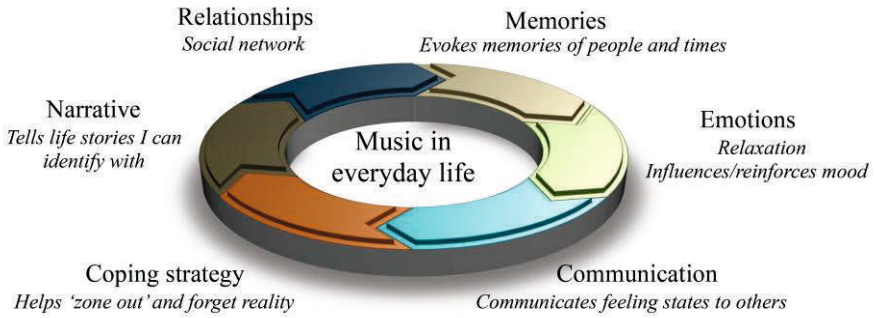
> F/1/98 "You'll be surprised, music is a big part in most people's lives because we all… if you walk onto our wing and that you'll hear sort of music playing and stuff like that."

They listened to music regularly and had favourite genres and artistes:

> F/1/20 "As soon as I wake up in the morning, I'll put the music channels on when I'm getting ready and then that's on all day until like the Soaps come on and then I'll put the Soaps on and soon as the Soaps are finished, it's back to the music and I leave the TV playing as well, sometimes at night as well like on Mellow-Magic where it's all relaxed and calm and I sit there on my bed listening to all the oldies."

An analysis of the data showed six different functions of music in everyday life.

Figure 5-3 Functions of music in everyday life



Relationships

Music served in the creation and maintenance of social networks. It was a social activity and bonded relationships:

> D/1/38 "I found a group of friends through the music and they became my friends."

> F/1/110 "I love meeting up with people that are musically talented and if they're not musically talented, just the fact you can sit there and share your music with them."

Memories

It was not just linked to a specific time. It could evoke both current and past relationships:

> G/1/70 "It reminds me of certain eras and certain people and you know someone… like, for instance, my pad mate, there's a certain song that she likes and every time I hear that it reminds me of her."

Certain genres were associated with childhood and family and called up a mixture of emotions:

> G/1/22 "Yeah, it was my childhood obviously as well because my mum listened to that country music when we was growing up and so it was a mixture of both sad and happy, do you know what I mean?"

Music could recall painful life events and help participants reconnect with how they had felt at the time:

> J/1/22 "If I'm sad I'll listen to things like Maverick Sabre, David Grey, Cold Play because a lot of the songs have meaning because you know they were released around certain things i.e. my granddad's death… there's a song… oh God, there's one song that relates to when I gave my daughter away, so that makes me feel a little bit sad but… I was sort of, you know, those sort of help me to tune with myself and how I felt at that time."

It could also help participants put past events into perspective:

> J/1/23-28 "(I) So when you're feeling down and you do put on a song that has important kind of memories for you what does it do to your mood? (J) It's still kind of uplifting because at the end of the day I then realise and get into my head that these things have happened for a reason, so yeah… (I) It kind of helps you look at the bigger picture or…? (J) Yeah, definitely, gets things into perspective."

The feelings that specific music pieces evoked, however, could be so strong that they were unbearable. Then the music needed to be switched off or blocked out:

> G/1/10-18 "You know, you hear a song and it will always remind you of someone. Do you know what I mean? Like, for instance, last, yesterday I was sitting in my cell and I heard people next door playing Jim Reeves… and I had to turn the telly off because it just reminded me of my Mum… and it was like really sad memories… because the last thing I did when she had dementia, I used to play this music to her all the

> time. So it just reminded me of me sitting there day to day with her playing the music and showing her photos… just before she died."

Emotional regulation

Listening to music helped participants relax:

> F/3/88 "I use music to calm me, do you know what I mean? Like make me feel calmer and relax."

> C/1/16 "Relaxing music as well because music… I used to listen to when I was going to sleep, if I was having trouble sleeping, I'd put on… just… um, music that was… probably like soundtracks to… like adverts like bank adverts and… all that, and it was sort of soothing soft music that I'd fall asleep to."

Music as was chosen to express mood states and could address interviewees at a personal level:

> J/1/6 "I have different genres of music for different moods that I'm in…depending if… usually if I'm in an up-beat mood and then I'll listen to things like Anya, Enigma if I just want to chill-out."

> C/1/20 "Um… I do associate some music with the way that I'm feeling [LAUGHTER] I'm reading… more so when I'm sort of down, I'll read into music and think… that's aimed at me [LAUGHTER] and I'll see some layers, intervals the words that are singing into the way that I'm feeling type thing."

Music not only expressed moods. Listening to it had to be carefully monitored for certain participants as it had the capacity to influence moods for the worse:

> C/2/130 "You've got to be careful of Magic though because it's… if you're feeling slightly low it can make you feel even worse… some of the music it's sometimes quite depressing."

Communication

Music not only expressed or influenced moods. It could also be used to communicate mood states to other people. The sound and quality of music emanating from a prisoner's cell could give other people on the house block a notion of how they were feeling and what sort of mood they were in:

> C/1/92 "If I'm, if you were outside my room and I suddenly had loud music on, you'd think… well, there's something not quite right there because she must be angry or something because if I'm angry then I tend to put my music on quite loud [LAUGHTER]."

Playing music in the background helped with day-to-day activities:

> G/1/6 "I find it helps me to carry on with day to day things like when I'm writing or something I can listen to music."

Coping strategy

Because music had so many emotional qualities it could be used as a coping strategy to help participants escape the harsh reality of prison life:

> D/1/16 "But if I want to zone-out or escape things, I tend to sort of shut the door and just like listen to music; do you know what I mean? And I can just take myself off in my head; do you know what I mean?"

At a more profound level it could allow a person to create an alternative idyllic world in which their person and lifestyle could be re-written:

> D/2/52 "So it helps me to forget where I am. Helps me just to go out of the box and be someone I'm not; do you know what I mean? I go to the stage where I'm not able… just fixate on this new me, I'm a different person and I've got a different lifestyle, different background and it's a fallacy world; do you know what I mean? And listening to music I can just sit there and go off into this world."

Narratives

Listening to music also helped participants feel connected with the life of performing artistes. They could identify with personal narratives, which often had much in common with their own life histories:

> G/1/467 "Years ago I used to be quite into Lisa Stansfield and I think she sings quite you know, like how she… relationship where she's in and she got beaten and he treated her like… Yeah where her husband was in love with her and then he just treated her like a housewife all the time and used to beat her and tell her she looked a mess; do you know what I mean? Sorted herself out; do you know what I mean? Things like that, I find interesting."

5.1.8. MUSIC IN MUSIC THERAPY

Music as a medium in music therapy shared the five functions that music played in the everyday life of the participants. However, close analysis of the data revealed several functions specific to music therapy (Figure 5-4 Functions of music in music therapy).

Communication

As with music in everyday life, music in music therapy was used to communicate feeling states to other people:

> C/2/24 "Because if you walk around with a smile on your face some people think oh she's okay but if you can write down how you feel and sort of put music to it, it makes them think, you know, well, she's not okay or she is okay but it helps them to sort of understand where you are actually at. You might be putting a big front on to make it, everything seems okay but it might not be but I get that across in my music."

However, music in music therapy could also be used to communicate things, which had not been spoken about previously:

> G/3/178 "(I) Do you find it easier to express yourself through music or through talking? (G) Um… I think you say more through music… (I) In what way? (G) I don't know because obviously when I'm thinking things and I write it down, I wouldn't probably come out with certain things. Like, I wouldn't tell you certain things whereas I probably put it into music. (I) Okay. (G) Do you know what I mean? Confidentiality and things like that I'd never spoke about or anything and I probably wouldn't put it into words… And then see if people can read between the lines. Do you get what I mean? (I) Yeah. So you're communicating… (G) Through the song… (I) In a way that you wouldn't verbally? (G) Yeah."

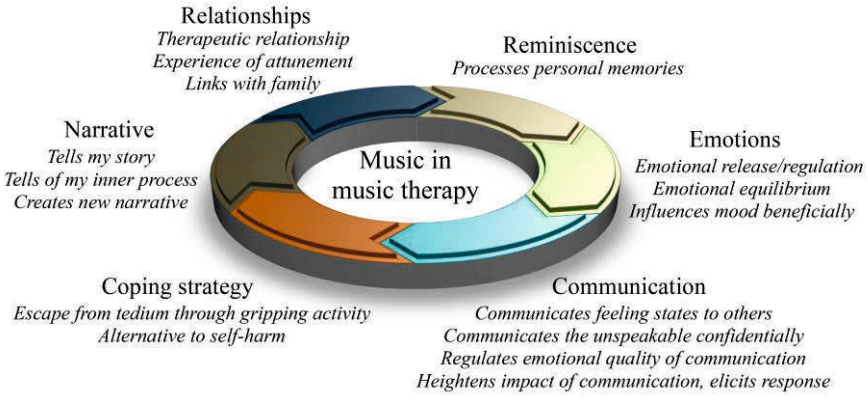


Figure 5-4 Functions of music in music therapy

Music could hold meaning for the recipient, which would not be apparent to the casual listener. This was important for Participant G as it enabled her to speak about things that had been hitherto unspeakable:

> G/1/238 "To say the things I never said to her and like. I could put it in music but not in the way that people would note, do you know what I mean? I: So if it's personal enough she would understand that it's for her? G: Yeah."

> G/1/242 "And obviously my sisters and brothers would understand it as well but although their lifestyle was not as bad as mine, I sort of got the brunt of it all and I don't know why but I just did but they knew; do you know what I mean? So, they'd understand it but other people probably wouldn't and I'd want it to be like that; do you know what I mean? It will be showing them how I knew what was going on throughout my life and there was nothing I could do about it."

Although the content might be painful and hard for the recipient, communicating it through music could regulate the emotional quality of the communication and convey suffering in a way that was kind, calm and non-aggressive:

> G/1/288 "Because I've suffered for years and like and they haven't… And I want them to realise how much I have suffered without them realising it if you know what I mean?... And I'm doing it in a kind way by putting it in music… so it's not aggressive… I'm not doing it in an aggressive way. I'm doing it in a calm way, I think. That's why I'm doing it in music… Whereas I was to write it all down, I could be really aggressive… But doing it that way, I find it will be different."

This did not mean, however, that the message lost in intensity. Indeed putting a message to music would grab the recipients' attention in a way that a letter would not:

> G/1/310 "(G) Rather than get a letter and read it and think here she goes again and throw it in the bin. They'd have that all the time; do you know what I mean? (I) So they'd…? (G) Listen."

It could also heighten the impact of the communication:

> G/1/284 "I'd rather them hear it in music that hear it in a letter, do you know what I mean? So it hits them hard."

Relationships

Whereas music in everyday life could help create and maintain social networks music in music therapy allowed participants to experience a good and trusting relationship as they built up a therapeutic alliance with the therapist:

> F/2/111 "It's my highlight of my week coming here and like I can have a really shit day at prison and then look on the pod and see that I've got music therapy it just makes me feel; ahhh, it's music therapy. See it does help… and it's good to like because [THERAPIST NAME] doesn't judge you about… she doesn't ask why you were there, she doesn't care. She just wants to get down straight away and that's good, it's nice you can just have a proper conversation with her without thinking oh God she wants to know what I'm in here for blah, blah, blah. Yeah, that's really good."

Songwriting required cooperative collaboration, with participant and therapist each contributing to the process:

> C/2/18 "So [THERAPIST NAME] sort of does the background music and we do wording together or I try to do it on my own when the songs are done but I couldn't get the pitch right but over time I'll probably get the pitch right on that as well."

Making music together also gave an experience of attunement:

> D/2/4 "We found that when we changed to different chords and different instruments, we found that we were playing automatically similar type of things, we read each other really well."

It was also crucial in creating and maintaining links with family as participants were allowed to send family members CDs of their work:

> F/2/95 "I want to make up a CD or something…Like my mum's never heard me sing ever… ever. So I want her to hear me. I want to make a CD and send it to her or something."

> G/3/101 "I just can't wait to let my children hear it. To think that I've sat here and done something. (I) How do you think they'll respond to it? (G) I think they'll be shocked. (I) What will they be shocked about? (G) Like I've actually sat down and wrote something and actually… they, they know I can't sing, so to hear me sing is going to be like; oh my God! (I) Once you've shown them that you can, yeah… (G) Can do something if I really put my mind to it. … So I'm quite… intrigued to see what… I'd love to see their faces when they were playing it but I'm

> not going to do that am I? I won't be able to see it but… I'm sure she will tell me, my daughter."

Songs on the CD written with specific family members in mind could help the recipients gain understanding of the interviewee's life history and inner process:

> G/3/111 "I'd *love, love, love* to do a song CD for my sisters. (I) Yeah, because that was something that you were talking about the first time? What would you say in the song? What sort of thing do you address? (G) Just basically I'm not such a bad person, although I've been in trouble and that. Deep down, I'm really not a bad person I just mix with the wrong people at the wrong time and; do you know what I mean?"

> G/3/83 "I did a song for my children… Really my family but mainly my children… And it's called like I'd Never Thought I'd Be Back… And just says that how I've come here and I'm wasting all my years, I was selfish and not thinking and it's so sad to see their tears and stuff like that; do you know what I mean? And I put it all in and it sounds really good."

Reminiscence

Certain songs or genres of music in everyday life had the capacity to evoke memories of people and past events. In music therapy, rather than listening to other people's compositions, participants could work their own memories in to a personalised song. This process was more akin to reminiscence and had the potential to help participant process past relationships and events meaningfully:

> G/1/178 "[I] think I can make something. You know, like memories… something I can listen to and know I done it myself rather than listen to other tunes that remind me of people. Something I've made myself, do you know what I mean?"

Narratives

Songs in everyday life were considered bearers of life stories:

> G/1/415-417 "I just think you can put a lot in music, can't you?... You can tell your life story in music can't you? I think most of the artists nowadays anyway sing a lot about their lives don't they, boyfriends and stuff and all that don't they?... It's like Amy Winehouse like got Go Rehab and stuff; do you know what I mean?... They all sort of… it's all really about their personal life or their friends like or their boyfriends or their relationships isn't it?"

Rather than sharing vicariously in another person's life by listening to an artiste's song, song writing in music therapy gave participants the opportunity to create their

own narrative. Songs could tell the story of the often painful, reality of a participant's everyday life:

> D/3/76 "I sat in a meeting one day, it was a health care meeting for drug users and an idea just came to me; do you know what I mean? Kept saying over and over; drugs, drugs, drugs; do you know what I mean? Drugs, the main point. Drugs, you need to help and sort people and then I got the first paragraph of my song from that and then from what the girls were saying that escalated within a week into a full song and I then done 'Here in This Room', which was around 'Here in This Room', which is really a lonely song. The drugs one is about me being right at my lowest point, people looking at us like thugs, treating us like scum when you're on drugs they don't want to know you and then like I was struggling and I needed help; do you know what I mean? So, that's that one and then I done 'Here in This Room' over the last year when I was down. I was like really lonely, depressed; do you know what I mean? I didn't trust nobody; I didn't know which way to turn or anything like that. So it's pretty depressing."

Songs could not only paint a picture of the lived experience of life, they could also convey inner processes:

> F/3/70-78 "I'd like to write a song with [THERAPIST NAME]… (I) What would the song be about? (F) I think it would be called Confidence and then yeah… (I) Would it be your story? (F) Yeah like the sessions, all those sessions. I mean, from when I started music therapy to now, I'd write all about that in a song. I'd start off about maybe how I used to be a self-harmer and stuff like that and start like about my moods and how they used to be shit and then - am I allowed to swear? – sorry!… how they used to be really bad and then how I started doing music therapy and how I started getting more confidence and then singing in front of people and stuff."

> C/2/52 "Well, take the song that I done, it was about an experience that I had here so it started off quite angry and as if I was out on a limb type thing but as the song progressed then I came to my senses and I'm no longer the fool that I was and stuff like that."

Songs could span past, present and future and provide a new life script:

> D/3/238 "I think I'll keep going on with that the music therapy because it was brilliant, it was brilliant doing that and seeing the growth of it; do you know what I mean? Seeing the happy song, which was the freedom one, which is my new start, my new life, my new beginning and it, yeah."

> G/2/126 "I'd love to make an album to think that everything I'd sung about would be my life and how I'm feeling and I hope it turns out eventually in the end and the suffering; do you know what I mean? I'd like to do something like that."

Emotional regulation

Music in music therapy helped regulate emotional states. In common with receptive music listening, active music making could help calm and relax the individual participant. However, active music making in music therapy had further functions that were not shared with receptive music listening. It could help release stress and channel emotions constructively:

> F/2/79 "It's a weird feeling. It's hard to explain. I can be really, really angry and then I'll sing and it's like I've just like took a calm pill, like a chill pill. I'm fine, it's really weird."

> F/2/73 "It's just… you can put so much emotion into when you're singing. Instead of getting like angry, shouting and punching and something and punching a wall or whatever, just sing. I mean I feel like a totally different person now."

This was not just during the music therapy session. It could help a participant become more calm and more in control of their emotions in general:

> G/3/389 "I think doing this music has chilled me up quite a lot you know. Chilled me out, calmed me down quite a bit."

> G/3/480 "(I) Okay and do you think there's any benefit from feeling the bad or…? (G) What do you mean? Any benefits? I can control it more now."

It could also create emotional equilibrium and help the individual find "that balance between happy and sad" (C/1/381).

Music in music therapy was connected to moods and emotions. Whilst listening to music in everyday life influenced and reinforced moods, this was often to the negative. In contrast, music in music therapy was seen to have a beneficial impact on moods:

> F/2/76 "(I) When you're feeling emotional and you use it to sing… how does it make you feel? (F) Better…"

Music in music therapy was used for emotional self-expression:

> F/3/92 "I use music now to express my feelings and stuff like that. And I gather all my emotions, stuff like that, and put them into my music."

More significantly, it could also help participants process their feelings and emotions and put them in to context:

> C/2/12 "…because the songs that I'm writing are about the ways that I felt over the recent periods and that. So, I'm writing sort of… it's done in like poem form but I'm doing it as to the way that I felt inside at that particular time."

> G/3/475 "I didn't think it [music therapy] was for me either because I didn't think it was for me in the beginning. But it does make you express your feelings and your emotions and you put it all down into context and you make something out of it and it makes you feel you can."

Coping strategy

Music therapy also helped participants cope with prison life:

> F/2/110 "(I) Has the music helped you cope with prison life better in any way? (F) It's the highlight of my week coming here and like I can have a really shit day at prison and then look on the pod and see that I've got music therapy. It just makes me feel 'ahhh, it's music therapy'. See it does help."

In a similar way to receptive music listening, music making in music therapy could transport the individual outside the mental confines of the prison walls. However, this was not an escape into a fantasy world. It was an escape through gripping activity:

> G/3/147 "Once that door's shut, it's just like you're in… you don't even think you're in prison in here and we're doing all this and putting on beats together and all that, it's wicked, I love it. I'm just gutted that it's finished."

> G/3/309 "I tell loads of people in here. I just say; do you know what, it's the best feeling, it really does make you completely switch off when you come in here. When you know you're doing something; do you know what I mean? Like this."

Music in music therapy also offered participants an alternative coping strategy to parasuicidal behaviour and helped reduce or stop self-harm:

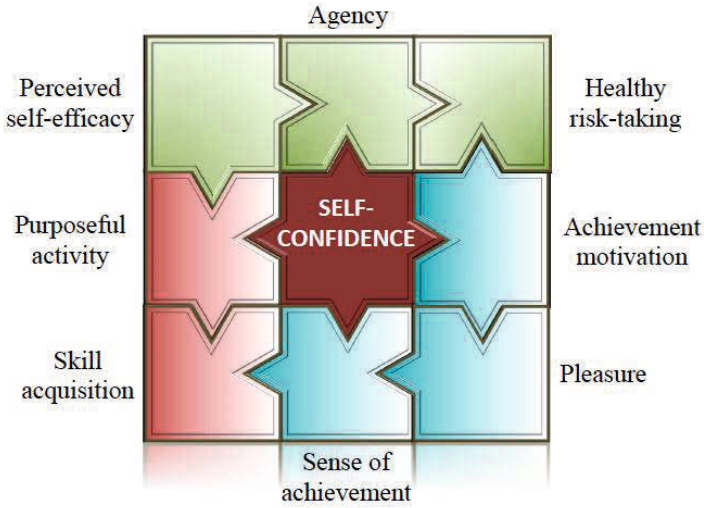
> F/2/26-30 "I wouldn't say it's all because of music therapy but it has helped *a lot*. It has made me realise that I don't have to do that. I can

> take it out by writing music and stuff. If I'm pissed off, I'll write a really angry song. If I'm like feeling down, I'll write like a sad song or if I'm happy I'll just write a happy song… It's a different coping mechanism. Instead of picking up a blade and slicing myself, I pick up a pen and write a song."

Self-confidence

A cluster of themes emerged around self-confidence and self-esteem, which were not evident in the data on music in everyday life. There was a complex and dynamic interplay between the individual elements.

Figure 5-5 Self-confidence and related outcomes



All participants reported having low self-confidence in their pre-treatment interviews. Participants C and F also mentioned low self-esteem. With the exception of Participant J all reported a growth in self-confidence in their post-treatment interviews and linked this to the attendance of music therapy:

> F/3/40 "[I feel] much more confident. I wouldn't have done it [sung for the Koestler Awards] if it weren't like music therapy and [THERAPIST NAME]. I never used to sing in front of every, anybody; now I sing in front of everyone."

> G/3/169 "[The music] made me more confident and more upfront, if you know what I mean."

> D/2/2 "Music therapy? Yeah, it's been good when I've been able to do it, it has been good. I've come out feeling really good, do you know what I mean. I feel confident like I said."

> C/2/180 "Yeah, more confidence, more self-esteem. I'm surprised at what I've done so far. I'm hoping to do quite a lot more."

> E/2/54 "Now I've become a bit more confident than I was before, I wouldn't have done that and I wouldn't have got up and sung… I even got up and sung."

Perceived self-efficacy

The sense of mastery created in music therapy not only increased participants' self-confidence. It also mediated a growth in perceived self-efficacy as defined above (p. 106):

> F/2/210-212 "If you were watching through my first few sessions, I'd walk all round the room and I'd stand in the corner so no one could hear me, but now I know personally that I'd come in a room and maybe a couple of weeks, maybe even months or whatever, I'll be sat here at the keyboard singing and [THERAPIST NAME] will be sitting in the corner… I know I can get there. I've just got to put my mind to it and just do it."

Growth in perceived self-efficacy would appear to be linked to positive experiences of achievement in music therapy, which were often completely unexpected:

> G/3/18 "Never in a million years thought I'd ever put… make a song, my own words and write it all rhyming and me singing it and now I know I can do it… Whereas I never, not in a million years would have thought because you literally write thoughts down don't you? And then you put it all into text and then you just like put it… make out of texts you've done you can put it into a song and that's exactly what I did."

Where this experience was missing, as with Participant J, there was also a frustrating lack of growth in perceived self-efficacy:

> J/2/173 "Even in the NA [Narcotics Anonymous] they say you'll find the power but it's only if I know what my fucking power is."

Agency and healthy risk-taking

Music therapy offered a participant a space in which they could experience being in control. For women who had a strong external locus of control, which was continually reinforced by the prison regime, this was an important experience. Participants could take control of the content of the sessions:

> F/2/44 "When I first started doing this I said I don't mind, I'll do anything whatever but now I come in and I'll like chose a song and she will start playing and I'll sing."

Participants could also experiment with taking control of the music:

> D/2/6 "At first I thought of like I knew that she was going to be more in control because I didn't have the confidence to take control and continue the music; do you know what I mean? So, every time she played and changed the course… the music, I just tend to follow, which is pretty much similar in my lifestyle, which I mean if anybody, if they suggested something I'd just go along with it. I think she let me take control just to see where we went with it but then I felt there was a couple of times when I did actually take control."

They could also afford to take a chance and step out of their comfort zone:

> D/3/112 "It was like when I started doing the songs with [THERAPIST NAME] it was like… I've took one chance doing it. It either f's up or it doesn't; do you know what I mean? Then I thought hmmm… then I was like; no, I can't, I can't, so she took over for a little bit and I was like: do you know what?..."

Purposeful activity and sense of achievement

Linked to the experience of mastery in music therapy was that of a sense of achievement. Often participants felt that they had done something constructive for the first time in their lives and were understandably proud of their achievement, which they could then share with their family in the final product of an audio CD:

> G/3/359 "Yeah, it makes you happy, doesn't it, when you know you've done something constructive like especially making a song. I'm going to be buzzing when I see this in a disc, actually in a disk and know that I've done it."

> G/3/361 "I'm going to be literally buzzing; do you know what I mean? I'm going to be buzzing knowing that my kids have got it. To think that I've actually done something with my life, do you know what I mean? And put it on a CD."

Enjoyment

Music therapy gave participants something to look forward to in the course of the week:

> G/3/339 "I just was adamant that I weren't going to stick to it. I said to myself I weren't going to stick to it because I didn't feel that I could do

> it. Now it's mad, I look forward to like the days when I know I've got it. I think; yeah, I've got music therapy for two hours; do you know what I mean? I look forward to doing it; I love coming here and just doing it."

and gave pleasure for the duration of the session:

> G/3/56 "Making the music with her has been absolutely amazing, I've loved every minute of it and I've loved doing all… putting all the music together and I was putting all the words and I love just walking round like a film star or a musician; do you know what I mean? Like singing and just got into it. I just loved it, I loved every minute of it."

However, music therapy not only gave pleasure in the session itself, it also gave participants something to do in the long hours of lock-up when they were confined to their cell:

> F/3/54 "I'm back in my cell, I'm writing music and stuff like that as well now. So, that's right. I'm doing music every single day. It's good."

Skill acquisition

Participants not only felt proud of their achievements in music therapy they also felt they gained in knowledge and skills:

> F/3/12 "I've got a wider knowledge of music. I've sung stuff that I thought I'd never sing before like different Genre's and stuff like that."

> F/2/48 "(F) I wanted to be more confident in my singing. I wanted to understand how to write and read music better and play music better and like work on my breathing and stuff like that. (I) So you feel that those expectations were met? (F) Yeah."

> G/3/436 "Now when I listen to music because I've made a song myself, I think that when I listen to like her album, I think yeah, it gives me ideas of what; do you know what I mean? … And it gives me to sort of follow the rhythm as well. I think; oh yeah, like if I write things down whereas if I just took you back to my cell, I've got a book here and I've been writing like little texts I just like write them down, like I could never do with doing that and like when I listen to her music, I think like I'll try and put these words and try and sing it; do you know what I mean?"

Achievement motivation and aspirations

This sense of achievement was instrumental in creating aspirations for their future. This could either be in the setting of goals for the immediate future in prison:

> C/2/52 "Take the song that I done, it was about an experience that I had here so it started off quite angry and as if I was out on a limb type thing but as the song progressed then I came to my senses and I'm no longer the fool that I was and stuff like that and now the song ends where I am now obeying prison rules and enhancement is my goal type of thing. So, it's given me… I'm writing things that I'm working towards as well."

> D/3/70 "If I don't get my tag, I would say like maybe help the girls pass Kleaning Akadamy[21] perhaps have someone who will go with them to support them on their first day of work, show them what they need to do and; do you know what I mean? So, I reckon and I've got a chance of resitting, doing a mentor and really looking at how I can help and support people; do you know what I mean?"

However, it could also be relevant to long-term aspirations for a professional future:

> F/3/56 "I already went to college and got an 'A' level in music. So I want to go to university one day and be a music teacher for disabled children. That's what I would like to do."

> G/2/239 "I've always wanted to help the homeless people and people on drugs and stuff like that but obviously because I had a criminal record myself, I didn't think it was possible but when I spoke to Probation outside they said I could do it. So I'd like to do something like that, yeah."

Reflexivity

Song writing in music therapy was also used by some participants as a reflexive tool:

> C/2/172 "We were talking basically because I had quite a few issues that I needed to resolve. Now I'm still resolving those issues but I'm using… beginning to use music to resolve them as well, which I didn't think you could really do. I didn't see the connection between the music and the different issues and how you could sort of do it. That's what we're doing now."

It helped externalise and thoughts and feelings:

> C/2/40 "I'm writing about how I feel again, which I done the last time I was okay. So I'm getting it down on paper and out of my head… I don't know… I don't know… just getting it out of my head and down."

[21] A vocational training program in cleaning offered within the prison

> E/2/7 "(I) And so were your sessions… how much was music and how much was talk? (E) Well the music was about my mum… (I) … right… (E) …so it was always about my mum. (I) So was you writing lyrics or were you… (E) I was writing poems and then we made it into a song. (I) Fantastic and what do you think it is about writing the poems and making it into the song that's helped you? (E) Writing things down."

> G/3/14 "Expressing my feelings, like you know like when you sit there and think of things. I'd rather write it down now and put it into another song…"

Writing song lyrics could help put things into context and process feelings and emotions:

> G/3/475 "I didn't think it was for me either because I didn't think it was for me in the beginning but it does make you express your feelings and your emotions and you put it all down into context and you make something out of it and it makes you feel you can… it makes you quite sad as well; do you know what I mean? (I) A good sad or a bad sad? (G) Both. (I) Right. (G) Both. Obviously like sometimes I've sat here and I've thought about my mum and stuff and there's a sad sad and then I think about my kids and there's some good sad not really. So yeah, it works both ways."

Music making could also help think things through before acting:

> D/2/22 "I ended up trying them out first [instruments] and thinking about it before I actually did it. I actually took the steps using them but thinking out where she did them first; do you know what I mean?"

Therapeutic process

An increase in capacity to self-reflect also meant that some participants were aware of a change in themselves, although it might be difficult to articulate in precise terms:

> G/3/393 "So it has, I believe it [music therapy] has done something. I honestly do think it's done something – maybe without even realizing, but it has."

> F/2/73 "I mean, I feel like a totally different person now."

> C/2/66 "This time round I have changed. And staff are noticing it."

5.2. QUANTITATIVE DATA

The quantatitive data of all 10 research participants was analysed.
This section will present the results of the

- statistical analysis of the LEQ-ROPELOC/YAR-PET and Rosenberg Self-esteem self-report questionnaires and
- analysis of available prison data on parasuicidal incidents, adjudications, and engagement in prison programs

Quantitative methods were used to investigate Research Question 3:

- If there is a process of change in the self-perception of this population, how does this affect a prisoner's ability to engage in resettlement pathways interventions?

and Research Question 4:

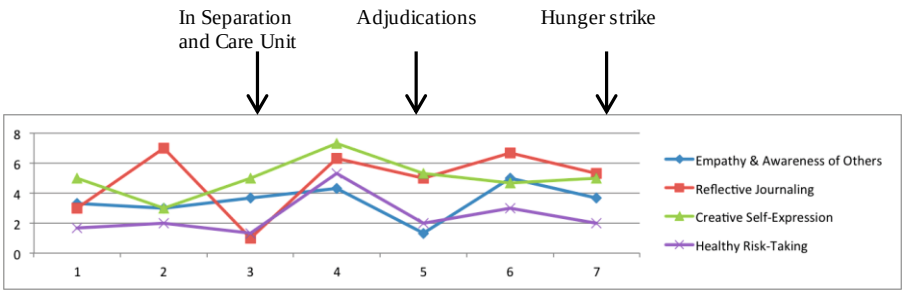
- What is the effect of different treatment lengths on a prisoner's ability to engage in resettlement pathways interventions?

Analysis of this data aimed to measure change, establish the effect of change in self-perception on a participant's ability to engage with prison interventions, and the relationship between change and dosage.

5.2.1. LEQ-ROPELOC/YAR-PET SELF-REPORT QUESTIONNAIRE

Charts were plotted for each individual research participant. These charts visualised changes in the self-perception of research participants and made the complex interaction between negative life events and self-perception apparent (Figure 5-6). This will be further explored in the individual case studies (5.3.1/5.3.2/5.3.3).

Figure 5-6 Participant C LEQ-ROPELOC/YAR-PET analysis exemplar



Because of the varying treatment durations, 2 to 8 measurement points per individual participant were available for analysis (Table 4-1). A Cohen's *d* type effect size analysis showed small to large effects for all factors of the questionnaire.

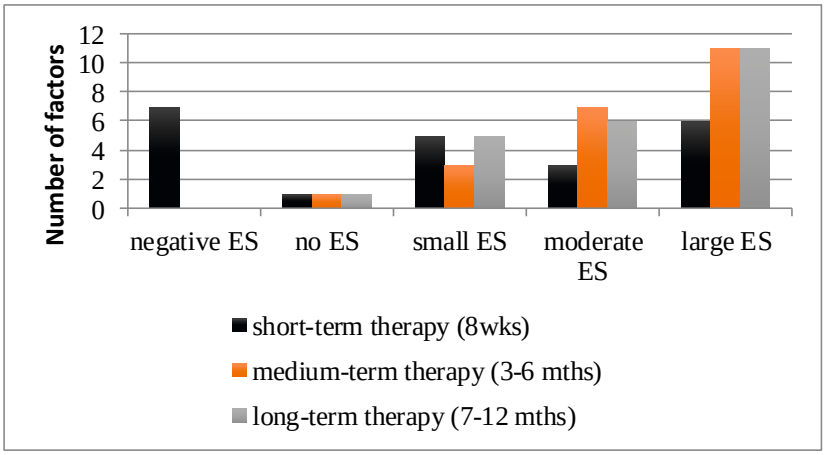
This analysis was further broken down to investigate the effect of short-term (8 weeks), medium-term (3-6 months), and long-term (7-12 months) therapy (Table 5-6)

Table 5-5 LEQ-ROPELOC/YAR-PET self-report questionnaire Cohen's d

Factor	Cohen's *d*	Factor	Cohen's *d*
Respect and personal boundaries	*d* = .21	Stress management	*d* = .80
Self-awareness	*d* = .24	Problem solving	*d* = .86
Empathy and awareness of others	*d* = .29	Achievement motivation	*d* = .89
Conflict resolution	*d* = .43	Open thinking	*d* = 1.03
Healthy risk-taking	*d* = .44	Goal setting	*d* = 1.13
Social effectiveness	*d* = .44	Self-esteem	*d* = 1.23
Active involvement	*d* = .60	Time efficiency	*d* = 1.24
Group work	*d* = .60	Overall effectiveness	*d* = 1.28
Self-efficacy	*d* = .61	Reflexivity	*d* = 1.54
Locus of control	*d* = .63	Self-confidence	*d* = 1.87
Coping with change	*d* = .72		
Communication skills	*d* = .77		
Creative self-expression	*d* = .78		

Red = small effect **Blue = moderate effect** **Green = large effect**

Table 5-6 Effect sizes of short, medium and long-term therapy



5.2.2. LEQ-ROPELOC/YAR-PET STAFF QUESTIONNAIRES

The Cohen's *d* effect size calculations for the Staff Observation questionnaires differed from the results of the self-report questionnaires (Table 5-7).

Staff found no effect for the factors 'Creative self-expression', 'Group work', and 'Respect and personal boundaries'.

Table 5-7 LEQ-ROPELOC/YAR-PET staff observation questionnaire Cohen's d

Factor	Cohen's *d*	Factor	Cohen's *d*
Creative self-expression	*d* = .00	Self-efficacy	*d* = .54
Group work	*d* = .10	Overall effectiveness	*d* = .54
Respect and personal boundaries	*d* = .16	Stress management	*d* = .65
Communication skills	*d* = .23	Locus of control	*d* = .67
Conflict resolution	*d* = .24	Empathy and awareness of others	*d* = .79
Open thinking	*d* = .28	Goal setting	*d* = .90
Social effectiveness	*d* = .42	Self-awareness	*d* = .91
Time efficiency	*d* = .45	Self-esteem	*d* = .95
Coping with change	*d* = .46	Achievement motivation	*d* = .96
Healthy risk-taking	*d* = .47	Reflexivity	*d* = 1.00
Active involvement	*d* = .48	Self-confidence	*d* = 1.19
		Problem solving	*d* = 1.20

Brown = no effect Red = small effect Blue = moderate effect Green = large effect

Comparable effect sizes were found only for the factors 'Conflict resolution', 'Social effectiveness', and 'Healthy risk-taking' (small effect size), 'Self-efficacy' and 'Locus of control' (moderate effect size). There was a greater consensus for large effect sizes where findings for five factors - 'Achievement motivation', 'Goal setting', 'Self-esteem', 'Reflexivity', and 'Self-confidence' - coincided with those of the self-report results.

5.2.3. ROSENBERG SELF-ESTEEM QUESTIONNAIRE

The effect size calculation for the Rosenberg Self-Esteem Questionnaire showed a large effect size of 1.31. This compared well to the results of the LEQ-ROPELOC/YAR-PET questionnaire of which showed large effect sizes (*d* = 1.24/*d*=.95 respectively).

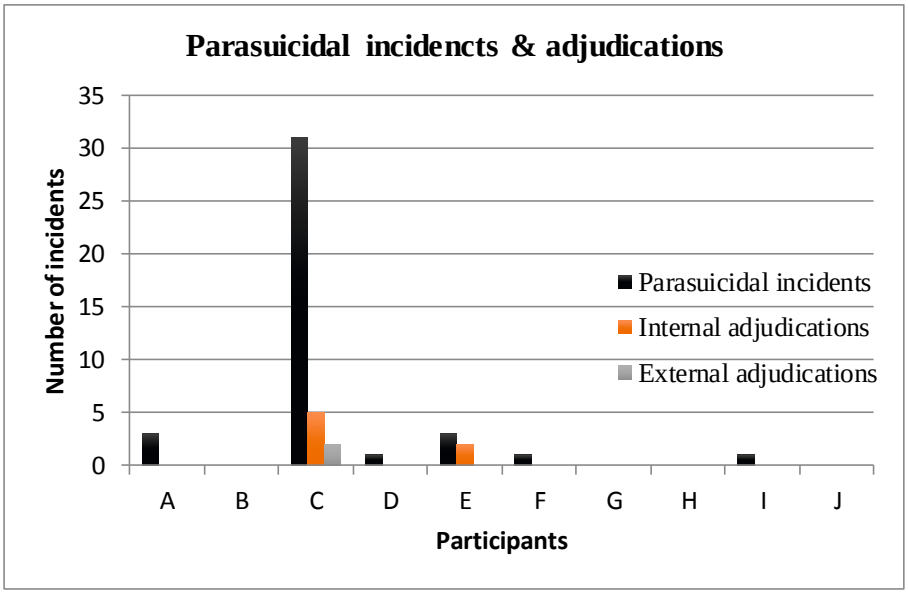
5.2.4. PRISON DATA

Parasuicidal incidents and adjudications

Figure 5-7 shows the number of parasuicidal incidents and adjudications logged during the period the research participants were attending music therapy. This data will be explored in depth in the individual case studies (5.3.1, 5.3.2). The isolated cases of parasuicidal behaviour noted for participants F & I were logged during the

festive period surrounding Christmas and could be indicative of the heightened distress felt at separation from family and friends at this special time of the year.

Figure 5-7 Parasuicidal incidents and adjudications



Engagement with prison resettlement interventions

Participants A, C, E, F, & G were either unemployed or doing in-cell education when they started music therapy. Participants B, D, H, I, & J were in full time employment. All participants, however, were characterised by an unpreparedness to engage with the prison resettlement programs required for their resettlement. Some programs offered by the prison and by third sector voluntary agencies were educational, targeted literacy and aimed at improving employability. Others addressed criminogenic needs such as relational or behavioural deficits, or substance misuse. Yet others address non-criminogenic needs such as personal development or psychological problems (Table 5-8 & Table 5-9 show the participants' patterns of engagement following their engagement with music therapy. These implications of patterns will be explored more closely in the individual case studies (5.3.1, 5.3.2 & 5.3.3).

Table 5-8)

Table 5-8 & Table 5-9 show the participants' patterns of engagement following their engagement with music therapy. These implications of patterns will be explored more closely in the individual case studies (5.3.1, 5.3.2 & 5.3.3).

Table 5-8 Program categories

Literacy	- Basic/Higher Literacy - Basic/Higher Numeracy - New CLAIT (basic IT skills)
Vocational	- Kleaning Akadamy - Food & Hygiene Levels 1 & 2 - Graphic Design - Business Studies - Papercraft Business Qualification - Beauty Therapy - Textiles Business Qualification - Indian Head Massage - Card Craft - Jewellery Making
Educational	- Health and Social Care - Study Skills
Cognitive Behavioural	- A>Z (motivational program supporting engagement in pro-social activities and desistance.) - Anger and Me - Self-management Program
Relational	- Family Matters - Domestic Violence Awareness Program
Substance misuse	- PPTSP (Prison Partnership Twelve Steps Program) - Alcohol Relapse Prevention Program - Alcohol Throughcare Program (one-to-one preparation for release) - Detox Program - CARAT (Counselling, Assessment, Referral, Advice, and Throughcare)
Psychological	- Looking after yourself (10 week program offered by Mental Health Inreach Team for self-harming women) - Psychotherapy
Personal development	- Mind, Body, and Soul - Creative Arts - Changing Tunes (Music Education and Performance) - Power to Change - Script-writing - STRETCH Program - Creative Writing - Money Management - Personal Development - Musical Theatre Workshop

A 04/12-04.13	B 05/12-04.13	C 05/12-03.13	D 08/12-04.13	E 08/12-11/12	F 09/12-04/13	G 10/12-03/13	H 10/12-12/12	I 11/12-01/13	J 11/12-02/13
In-cell work	Employed in Inductions	In-cell work	Wing cleaner	Unemployed	In cell work	Unemployed	Wing cleaner	11/13 Kleaning Akadamy	Servery Worker
09/12 Alcohol Relapse Prevention	10/12 Psychotherapy	06/12 Anger and Me	11/12 Food & hygiene 1	09/12 Gym	10/12 AA	11/12 Gym	10/12 Alcohol Relapse Prevention	12/12 Domestic Violence Awareness	12/12 Food & Hygiene Level 2
10/12 Anger and Me	02/12 Healthcare Culture Change	06/12 New CLAIT	12/12 SCU orderly	09/12 Wing cleaner	11/12 New CLAIT	01/13 Kleaning Akadamy	10/12 Black History Month		Kitchen Worker
11/12 Psychotherapy		08/12 Gym	12/12 Power to change	10/12 Gym	12/12 Basic Numeracy	01/13 Gym	10/12 Servery Worker		12/12 Anger and Me
Maths GCSE (date unknown)		08/12 Higher literacy	12/12 CARAT group	11/12 Wing cleaner	01/13 Health & Social Care	02/13 Basic Literacy	12/12 Alcohol Throughcare		01/13 A-Z
		08/12 Alcohol Relapse Prevention	12/12 Domestic Violence Awareness	11/12 Gym	01/13 Laundry Worker	02/13 Gym			01/13 Self-management
		08/12 Health and Social Care	01/13 Chapel Orderly		01.13 Jewellery making	03/13 Basic Numeracy			01/13 Family Matters
		09/12 Kleaning Akadamy	01/13 Kleaning Party		01/13 Business Studies				02/13 Hairdressing
		10/12 A-Z	01/13 Self-management		02/13 Higher Numeracy				
		10/12 Mind, body & Soul	02/13 Detox programme		02/13 Basic Literacy				
		10/12 Looking after yourself	03/13 Family Matters		02/13 Kleaning Akadamy				
		10/12 Gym	04.13 Indian Head Massage		03/13 Graphic Design				
		10/12 Alcohol Throughcare			03/13 Card Craft				

Table 5-9 Participant engagement patterns with prison interventions and programs

N.B. Participants C, D, & F were in long-term therapy and had the opportunity to participate in a large number of programs over time. A had very limited access to group programs both because of her Restricted Status[22] and her mental health problems. Participants B & J were in full-time employment. Participant G had little access to programs because of security concerns. Participants E, H, & I were in short-term therapy.

[22] Restricted Status prisoners are considered to pose a particular threat to public safety if they were to escape and are held under tightly controlled conditions with no freedom of movement. They are similar to Category A prisoners in the male estate.

Table 5-10 Participant engagement patterns with prison interventions and programs continued

A 04/12-04.13	B 05/12-04.13	C 05/12-03.13	D 08/12-04.13	E 08/12-11/12	F 09/12-04/13	G 10/12-03/13	H 10/12-12/12	I 11/12-01/13	J 11/12-02/13
		11/12 Creative arts			03/13 Script writing				
		11/12 Gym			03/13 Creative arts project				
		11/12 Jewellery making			03/13 Basic Numeracy 3				
		12/12/ A-Z			03/13 Changing Tunes				
		01/13 Wing cleaner			04/13 STRETCH project				
		01/13 Self management			04.13 Creative writing				
		01/13 Safer Custody Bakery group			04/13 Beauty therapy				
		01/13 Family matters			04/13 Paper Craft Business Qualification				
		02/13 Changing Tunes			04/13 Self-management				
		02/13 Bible studies			04/13 Graphic design				
					04/13 Money management				
					05/13 Personal development				
					05/13 Study skills				
					05/13 Textiles business qualification				
					05/13 Musical Theatre workshop				

5.3. BY WAY OF TRIANGULATION

In this section qualitative and quantitative data sets will be triangulated using the data of three participants as exemplars. These case studies aim to enable a comprehensive view of the phenomenon under study.

5.3.1. CASE STUDY PARTICIPANT C

Pre-treatment

Participant C was well known to the prison from previous sentences when she had consistently failed to engage with the prison. She was renowned for her challenging behaviour. She had difficulty regulating her emotions, which expressed itself through impulsive, angry behaviour:

> C/1/99-109 "To me anger's an easier emotion to show than sad and upset, so I tend to show anger more of, as an emotion than I show anything else." (I) How do you show it? (C) I'll argue. I'll look for confrontation. Um, in the prison, say, I've done graffiti on my walls about officers which isn't very nice and I've sent letters to the officers that aren't very nice and stuff, so…and um, lots of… on the house block I was turning my music up a bit loud. I've got quite a quick temper, quite an angry person, yeah… it's been common for… yeah, most of my life probably. (I) And what does it take to kind of light that fuse on a quick temper? (C) Being told 'no'."

Participant C's tendency to react impulsively, without regard to long term consequences led to problems with the authorities, a situation which had become entrenched, with Participant C acting out in response to what she perceived to be negative staff expectations:

> C/2/88-92 "I have a thing about uniforms, I don't really like uniforms and because I'm working… they may be officers but not in the uniform or whatever, the staff are in uniform I tend to communicate better with the ones that aren't in uniform I think… Yeah, I've always had… put… well for the last 3 or 4 years I've had problems with authority."

In the months preceding her recruitment to the research program Participant C's parasuicidal behaviour had increased alarmingly. 29 incidents were logged in one month alone. When Participant C was referred to the project she had just been discharged from hospital where she had had knives and forks removed from her

stomach. She had nearly died under anaesthetic. Participant C's parasuicidal behaviour started in early adulthood and was a response to childhood sexual abuse by close male members of her family.

Participant C's parasuicidal behaviour had the function of communicating unbearable feeling states to the people around her. It was also fed by a tendency to ruminate and internalize negative feedback:

> C/1/180-185 (I) "What would you change about yourself if you could? (C) My *negative* thinking a lot of the time… thinking negative thoughts, um… that's there's no hope. That I will slip back into bad ways… Um…I don't know really. If I hear something negative about myself or something that I don't want to hear. Somebody can be perfectly honest with me and I might just be saying I don't want to hear, then I'll think quite negative thoughts about it so… (I) Does it spiral with you? Do you hear something and then start to turn in on yourself and then continue to get worse? (C) [INTERRUPTS] Yeah, it gets into a vicious circle."

The Mental Health Inreach Team referred participant C to music therapy because she was failing to engage with the team and with the prison in general. She was assessed for suitability and agreed to attend music therapy when offered a place, although she felt that she was 'tone deaf'. She then consented to be part of the research program. Participant C attended weekly music therapy sessions until she was transferred out to another prison 11 months later. Her attendance was excellent. In periods of crisis she attended sessions twice a week.

Post-treatment

After an initial period when Participant C used the music therapy sessions as a talking space, she started using songwriting as a medium with which to address her issues:

> C/2/172 "We were talking basically because I had quite a few issues that I needed to resolve. Now I'm still resolving those issues but I'm using… beginning to use music to resolve them as well, which I didn't think you could really do. I didn't see the connection between the music and the different issues and how you could sort of do it. That's what we're doing now so…"

In music therapy Participant C found an effective and potent way of communicating inner processes and distress to the outside world:

> C/2/14 "It's just getting it out and letting other people know how I have felt and why I've been possibly like I have been with the battles I have had with people."

> C/2/50 "I've had some therapies before but I think… I don't know singing the actual words are quite… some of the words that I've used are quite powerful… so, it's probably… I'm probably getting more across by putting it to verse than I would by actually just saying it."

Participant C used songwriting as a reflexive tool. It helped her process past abuse and create a new narrative, in this case a new script for the immediate future of the remaining time of her custodial sentence:

> C/2/52 "Take the song that I done, it was about an experience that I had here so it started off quite angry and as if I was out on a limb type thing but as the song progressed then I came to my senses and I'm no longer the fool that I was and stuff like that and now the song ends where I am now obeying prison rules and enhancement is my goal type of thing. So, it's given me… I'm writing things that I'm working towards as well. (I) That's really interesting. So, it's kind of like it's not only the release is in the communication, (C) [INTERRUPTS] it's goal setting."

> C/2/100 "The major goals are to keep my cell clean, not to graffiti it, to get enhanced, to stay off basic instead of standard… I said obey the rules didn't I? Yeah, obey the rules, get enhanced, possibly get to house block 4, which is the enhanced prisoners, get my TV back, I haven't got a TV at the moment…"

Reflecting on past events and working toward future goals helped Participant C start to learn to resist her impulses towards immediate gratification and start to think of the potential consequences of her behaviour and how to adapt her behaviour so as to pursue long-term goals:

> C/2/110-114 "Before, I would fly off the handle and start storming off and shouting and banging the doors and stuff like that. I've only done that once or twice in about 3 weeks now. I just tend to bite my tongue a bit and think you know, when I want to get enhanced I can't afford to get an IEP, I want to do this and I want to do that, so I can't afford to not do certain things or I can't afford to muck up, so… (I) So it's almost like you've always just got 1 eye on the longer term? … Instead of the shorter term and is that new to you? (C) Yeah because I've never thought about long-term things before. I mean, obviously I've got to work towards getting out and stuff like that but I'm not think… I'm not thinking that sort of term wise at the moment because I've got another court case coming up but I know that sooner or later when my court case

> is over I've got to think… well, I've got to work towards so and so because I'll be getting out in a certain time and stuff like that. So I know I'm going to have targets to reach before I get out."

In her second interview Participant C reported a change both in her own behaviour and in staff perception and expectations:

> C/2/66 "Before, when I was sort of fighting and that, I thought that is what the staff had come to expect of me, so that's what I was doing and I didn't think they could see… they would recognise the change in me. But they had. This time around I have changed and the staff are noticing it, that I'm being polite, I'm doing what I am told and not fighting 'em and stuff like that. They talk to me differently when I'm not up against them and when I'm not disobeying them, if you like. So their tone is completely different, the way they respond to you is different. It's completely different."

Participant C also reported feeling much more confident than previously:

> C/2/62 "Just knowing that I can do certain stuff is a boost to my confidence. Knowing that I can get across how I am feeling and stuff boosts my confidence because if I am having a shit day, I'll write something shit, which might not be for confidence at the time but when I look back on it and think well, it wasn't really that bad, then it will raise my confidence again and think oh well, it wasn't really that bad. So I get a boost in confidence."

> C/2/178 "[I'm] more confident in myself. More confident that I will succeed in certain things; I wasn't confident at all before. Yeah, more confidence, more self-esteem. I'm surprised at what I've done so far. I'm hoping to do quite a lot more."

The increase in self-esteem together with the impact of an increased ability to reflect on possible consequences of actions on relations with staff prompted an increase in Participant C's perceived self-efficacy:

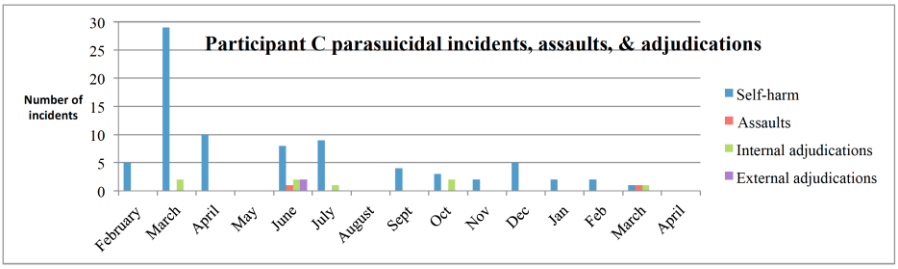
> C/2/70 "It makes me feel good [when staff respond positively to changes in behaviour] because I think… *I* didn't think I would change as much as I have in the few weeks that I have. I didn't think it was possible but because I'm aiming towards enhancement and stuff like that, it's making me feel quite confident that I *can* do it."

Analysis of prison data (logs of parasuicidal incidents, assaults, and adjudication) showed a dynamic interplay between external events and Participant C's responses (Figure 5-8). In July 2012 Participant C spent 2 weeks in solitary confinement on

the Separation and Care Unit as punishment for several charges including assaulting an officer. These resulted in both internal and external adjudications[23]. In September she stopped taking medication in the hope that her mental health would decline prior to a court case in October. In November she made a serious suicide attempt in which she left a suicide note for officers to find. In December the number of parasuicidal incidents spiked in response to incarceration during the Christmas period. Participant C's behaviour deteriorated rapidly in March 2013 in response to a perceived unjust relocation from the house block for enhanced prisoners back to normal location. She entered in to hunger strike and assaulted an officer. The prison, concerned that the situation could become entrenched and feeling that they had failed to facilitate positive change in the prisoner, responded by transferring her out to another prison establishment without warning.

Participant C's responses to negative life events could create the impression of entrenched behavioural patterns, which were resistant to change. However, an analysis of the entire treatment period showed an overall reduction in the number of incidents, particularly parasuicidal incidents (Figure 5-8). This was in direct contradiction to the perception of prison staff, who believed that the situation was escalating irretrievably when they transferred Participant C out to another prison establishment.

Figure 5-8 Participant C parasuicidal incidents, assaults, and adjudications



Triangulating prison data (parasuicidal, assaults and adjudication logs with program engagement logs) allowed another interesting picture to emerge, which contradicted the perception of staff working with Participant C (Figure 5-10). Rather than regressing, Participant C showed a much more differentiated response. Her level of engagement with prison programs and resettlement interventions improved over

[23] Offences against prison discipline entail an adjudication following procedures outlined in Prison Service Instruction 47/2011. This is generally held by an internal adjudication board that has the power to withdraw privileges (such as television, association etc.) as a punishment. Serious offences can be referred to the police for investigation and can lead to an external adjudication held by a judge with power to add days to the custodial sentence.

time, despite recurring negative life events. Seen in this context parasuicidal and challenging behaviour were not indicative of overall deterioration. They could be interpreted as dysfunctional, learnt coping strategies, which could be reduced over time, and which did not exclude concurrent improvement in other areas of life.

Significant areas of change can be seen from Participant C's pre and post-treatment LEQU-ROPELOC/YAR-PET self-report scores (Figure 5-9). These were primarily related to growth in self-confidence (self-confidence, self-esteem, overall effectiveness), the ability to participant and benefit from group interventions (open-thinking, ability to set and achieve goals, reflexivity) and the capacity to make plans for her future (achievement motivation). This is also reflected in the analysis of prison data and triangulation of data sets (Figure 5-10).

Figure 5-9 Participant C pre & post-treatment LEQ-ROPELOC/YARP-PET scores

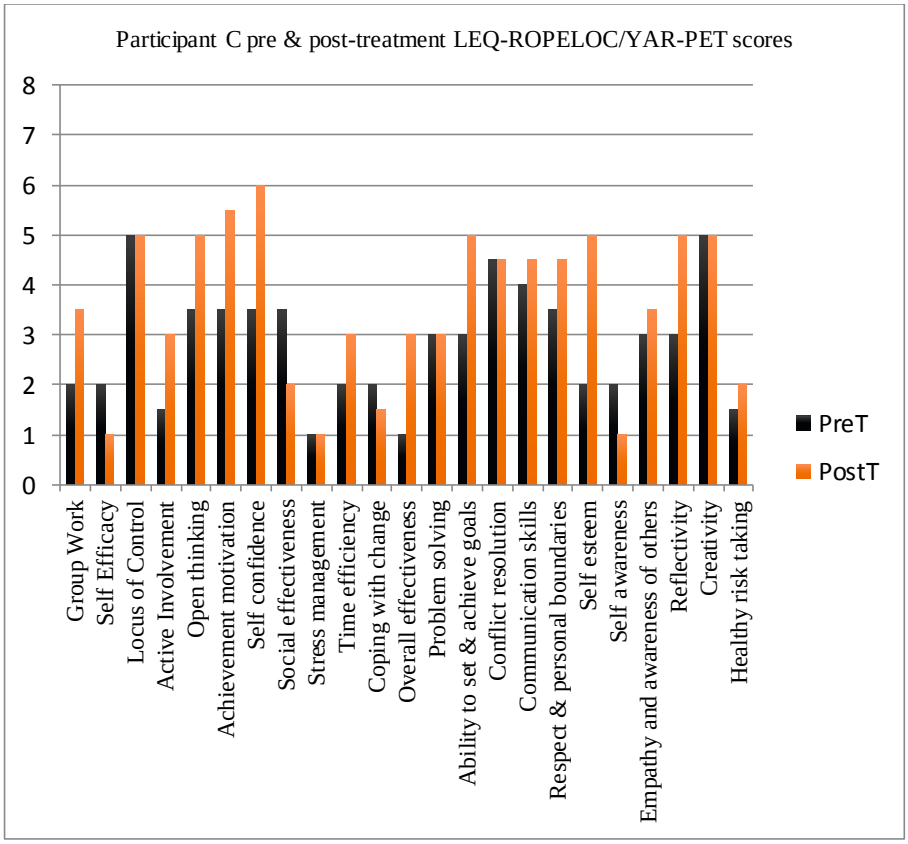
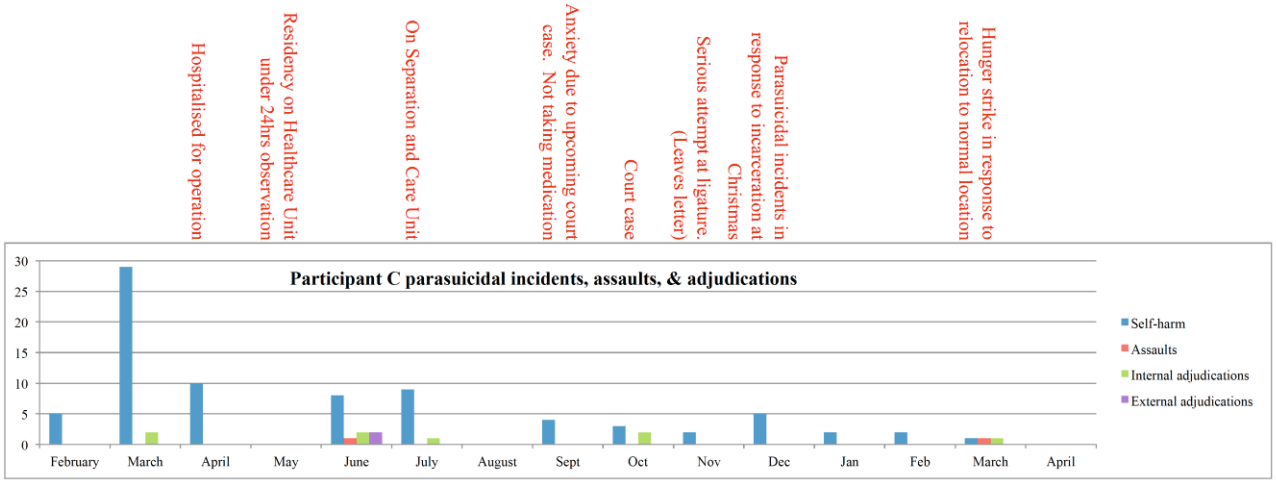


Figure 5-10 Participant C triangulation of data sets



5.3.2. CASE STUDY PARTICIPANT F

Pre-treatment

Participant F was still a young offender[24] when she started music therapy. She had a history of substance misuse and had been in and out of prison several times:

Of all of the participants, Participant F had the least difficulty describing herself and her defining characteristics. When asked to describe herself she said:

> F/1/42 "I've got quite low self-esteem though. I come across as quite cocky, outward-going, bubbly, but it's all a front. Underneath I'm really like insecure and stuff."

> F/1/54 "But then the people that really, really notice me, they'll say to me… they'll say to you probably that she's very loud, very bubbly, very funny, but she's got a lot of layers and in some ways she's quite introverted."

Her underlying lack of confidence led her to self-isolate. She failed to engage with prison programs:

> F/2/32 "Before, when you saw me last I was unemployed and stayed in my cell all day, every day, because I didn't have the confidence to come out."

Participant F was also a 'prolific self-harmer'. Her parasuicidal behaviour was entrenched and had started when she was eight years old in response to early childhood abuse. Like many women who have suffered extensive childhood abuse she had difficulties regulating her emotions leading to anger management problems and self-harm.

Participant F was a very suitable candidate for music therapy and her attendance was excellent. She attended 19 of 20 possible sessions, and the session she missed was due to a scheduling conflict. She had a clear understanding of what she wanted to achieve in music therapy and chose to sing pre-composed songs in her music therapy sessions:

> F/2/48 "I wanted to be more confident in my singing. I wanted to understand how to write and read music better and play music better and like work on my breathing and stuff like that."

[24] 18-20 years of age

In her first interview Participant F defined herself spontaneously as musical and creative:

> F/1/10-16 "I sing. I write music as well. I play the piano as well… I would describe myself as a creative person."

> F/1/40 "I could like be sat there and then suddenly a melody will come into my head and I'll write it down, because I can write music as well, so… like the melody will come into my head and I'll write that down and then I'll like fit words to go with the melody and stuff like that, so… it's mad."

Music was a major component of her social identity and helped her create a social network:

> F/1/48 "Everyone like back on the wing or at home and stuff like that know about my music… I'm always singing… walking around the wing or walking outside… anything, I'm always singing so they all know that I love music and I'm crazy about it."

> F/1/111 "I love meeting up with people that are musically talented and if they're not musically talented, just the fact you can sit there and share your music with them."

Her talent got her recognition from staff and peers alike and her musicality was presented as a saving grace:

> F/3/123 "They said stuff like you're really good singer, you're wasting your life. You should try the X-Factor or you should do something with your talent."

> F/1/36 "Everything revolves around the music because if I didn't have music then I'd be rubbish. Seriously."

However, despite having an excellent voice and innate musicality, Participant F was not confident in her own abilities:

> F/2/210 "If you were watching through my first few sessions, I'd walk all round the room and I'd stand in the corner so no one could hear me."

Post-treatment

When asked in her post-treatment interview how she would describe herself now Participant F responded:

> F/3/42 "Free-spirited, bubbly, confident… yeah."

Towards the end of her music therapy treatment Participant F's belief in her own ability and talent had increased. She started attending a music educational performance-based program with a vocal trainer and was confident enough to record and submit a song for the Koestler Awards[25]:

> F/3/32-40 "Its brilliant, they've just entered me for the Koestler awards'. (I) Okay. (F) Do you know what that is? No? It's a competition for like people that can sing, play music or do art and it's for every prison in the country… (I) Oh wow. (F) And I sang Adele, Something Like You and they recorded it and they sent it off… [I feel] much more confidant. I wouldn't have done it if it weren't like music therapy and [THERAPIST NAME]. I never used to sing in front of every, anybody; now I sing in front of everyone."

> F/2/210 "If you were watching through my first few sessions, I'd walk all round the room and I'd stand in the corner so no one could hear me, but now I know personally that I'd come in a room and maybe a couple of weeks, maybe even months or whatever, I'll be sat here at the keyboard singing and [THERAPIST NAME] will be sitting in the corner… I know I can get there. I've just got to put my mind to it and just do it."

> F/3/57 (I) So you feel… have the changes happened because the music is there or is it to do with how you feel or what has made you feel like you can sing in public? I mean, I'm using the word feel twice but what has made you feel that you can… you know, what has broken down the barrier for you? (F) [THERAPIST NAME]…(I) Yeah? (F) It is just [THERAPIST NAME] because like she doesn't judge you, she's like if you make a mistake you just work through it; do you know what I mean? She's not like: Oh, for God's sake you've done that wrong, or something like that. So she's just helped to build up my confidence and made me realise that I do have a talent, so I should do something with it.

Participant F had learnt to use music to calm herself and help herself relax:

> F/3/88 "I use music to calm me, do you know what I mean? Like make me feel calmer and relax."

Singing allowed her to discharge and regulate destructive emotions positively:

[25] The Koestler Trust has an annual competition for which offenders can submit works in a multitude of art forms. (For further information see http://www.koestlertrust.org.uk/pages/awards.html)

> F/2/73-79 "I feel that's a good way to express yourself… I feel… I don't know, it's just… you can put so much emotion into when you're singing. Instead of getting like angry, shouting and punching and something and punching a wall or whatever just sing. I mean I feel like a totally different person now… (I) When you're feeling emotional and you use it to sing does it make you feel… how does it make you feel?" (F) Better… It's hard to explain. I can be really, really angry and then I'll sing and it's like I've just like took a calm pill, like a chill pill. I'm fine. It's really weird."

Since attending music therapy Participant F had stopped self-harming, much to her own surprise:

> F/2/60 "Didn't think I'd ever stop self-harming…. I have been self-harming since I was 8. Never thought I would stop self-harming. So that was completely unexpected."

> F/2/26 **"**I wouldn't say it's all because of music therapy but it has helped *a lot*. It has made me realise that I don't have to do that I can take it out by writing music and stuff. If I'm pissed off, I'll write a really angry song. If I'm like feeling down, I'll write like a sad song or if I'm happy I'll just write a happy song. It's a different coping mechanism. Instead of picking up a blade and slicing myself, pick up a pen and write a song."

In her second and post-treatment interviews Participant F described herself as confident and able to engage in normal prison life and interventions. This was contrary to her expectations:

> F/2/61 "I never thought I'd like feel confident enough to like come out of my cell and like go to education and now I just feel totally different. It's weird. It's good though."

> F/3/150 "When I first started music therapy and stuff like that, I done what's called in-cell work, where you don't come off the house block and you just stay in your cell the whole time, because I didn't have the confidence to mix in big groups and stuff like that. But now I go to work like a normal prisoner, whatever normal is."

Overall Participant F's perceived self-efficacy had improved:

> F/2/20 "I had really bad low like self-esteem before I started, but then working with [THERAPIST NAME] has helped me realize that I could do anything as long as I set my mind to it."

> F/3/108 "I've come so far now and I've learnt so much so I don't think I'd ever go back to how I used to be. Everyone's going to have like their bad days when things happen to them, but I'm a stronger person now, so I know I'll overcome it."

> F/2/214 "(I) And that's something you've learned from the sessions? That you can? (F) Yeah, I know I can do it. I've just got to put my mind to it. All things come with time, isn't it?"

Participant F now felt more able to think forwards and plan for a future rather than just coming in and out of prison on a revolving door basis:

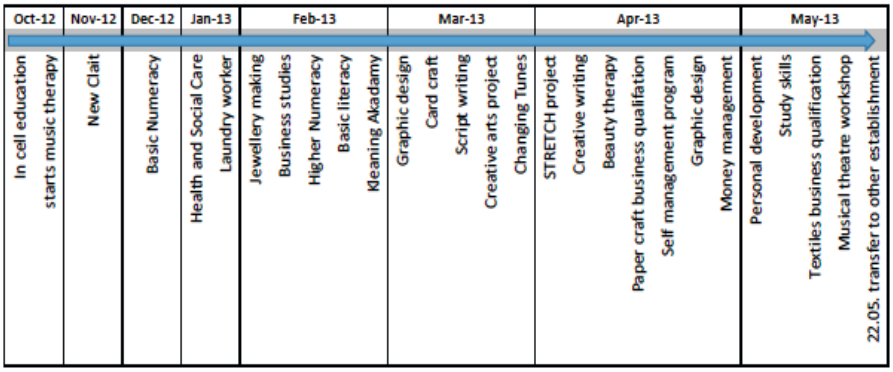
> F/2/63 "Hopefully when I get out of here I'm going to go back to college and stuff like that but I never did that before and we just go out, come in and doing drugs and whatever. I feel I want to do something with my life now.… I had really bad low like self-esteem before I started but then working with [THERAPIST NAME] has made me realise that I could do anything as long as I set my mind to it."

When asked whether she would be interested in prison programmes Participant F said she would be interested in:

> F/1/115 "All creative stuff… Like the music, the Changing Tunes, this music therapy, creative arts, all different art projects. I like all that sort of stuff. When it comes down to the boring like maths and English, I'm not on it thank you."

The following time line shows Participant F's progress from in-cell education to prison programs. It is interesting to note not only the variety of programs she attended, but also the fact that they were by no means exclusively creative. They included some personal development programs, some educational programs and some programs with a focus on future employability.

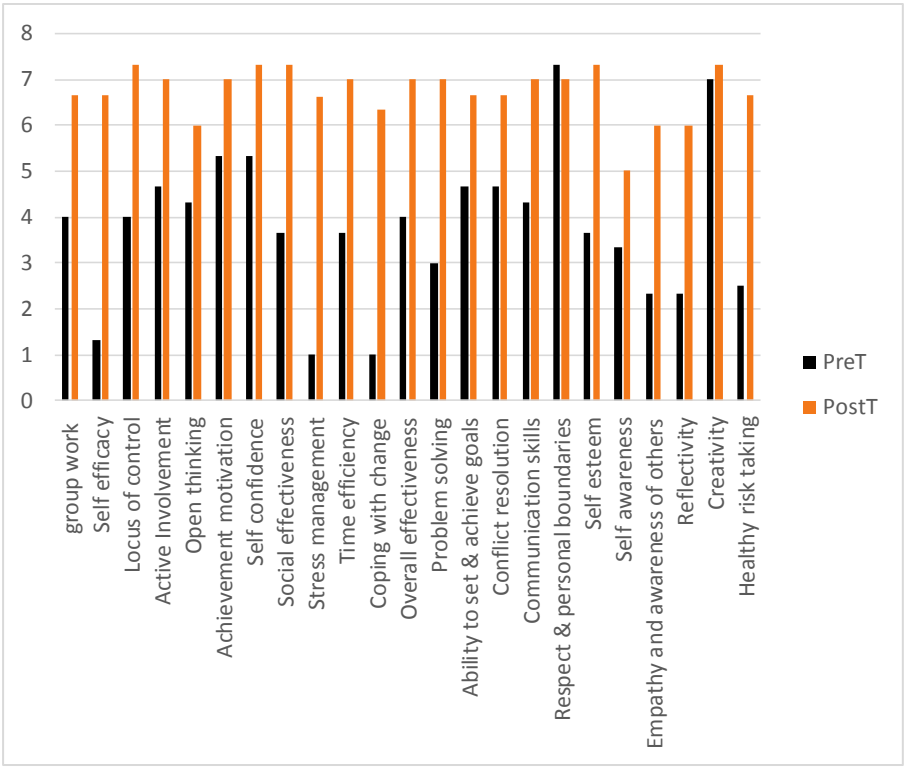
Figure 5-11 Participant F participation patterns in prison programs



The analysis of Participant F's interviews and LEQ-ROPELOC/YAR-PET scores show significant change in areas related to self-harm (stress management and coping with change), confidence (self-confidence, self-esteem, self-efficacy, overall effectiveness), agency (locus of control, active involvement), and aspirations (achievement motivation, group work, time efficiency).

The following table shows the scores of all items in Participant F's LEQ-ROPELOC/YAR-PET self report questionnaires:

Figure 5-12 Participant F pre and post-treatment LEQ-ROPELOC/YAR-PET scores



5.3.3. CASE STUDY PARTICIPANT E

Pre-treatment

Participant E was a 'revolving-door' offender with repeated chemical substance misuse related offences. Her relationships to significant others was central to her sense of well being and she experienced herself as abandoned and alone, following

her mother's death. The loss of her mother made her suicidal and she had attempted an over-dose before returning to prison. Her brother was serving a prison sentence and she had no connection with the rest of her family:

> E/1/86 "Yeah, so I've got no mum, no dad, no nan… you know mum's brothers are all dead, there's two in Scotland or whatever but they had nothing to do with my mum, they didn't turn up to her funeral so we don't know. So, we haven't got any family as other people have do you know what I mean? It's awful. That's why I tried to take my own life, I just didn't want to be on my own"

Participant E's dread of being alone left her vulnerable to abusive relationships both inside and outside of prison:

> E/1/42 "I met a partner who used to beat me up and beat me up and beat me up and he was a really nice person obviously and I found out he was on drugs, you know and he ended up introducing me to drugs, then before I knew it I woke up and I was like sniffing and stuff and I thought I had a cold and he was like no, if you have some of this it will make you feel better, you've got a habit. So then I had a habit to Heroin and then it was Crack Cocaine. So then he knew I needed him and it just went from bad to worse to an absolute nightmare."

This vulnerability to abusive relationships led to low self-esteem and exploitation.

> E/1/42 "I was basically abused by men so that's why I've got no self-esteem."

> E/1/50 "I'd do anything for anyone and that's why I'm sometimes…it's a good thing [that I'm always ready to help] but sometimes it's a bad thing because it gets me into a situation, like being in prison where I'd do anything for anyone… like I'd say, oh it wasn't them it was me and I'd be running like that in prison. So it's a good thing in some respects but you know…"

Post-treatment

Songwriting proved an effective tool to help Participant E mourn her mother and come to terms with her death:

> E/2/13 "(I) What do you think it is about writing the poems and making it into the song that's helped you? (E) Writing things down. (I) Have you ever done that before? (E) No. (I) Never? (E) No. (I) Do you think you will continue to do that now? (E) Yeah. I started writing in the diary now and speaking to Helen on the day about how I'm feeling about my mum and that each day, and I wouldn't have done that."

An increase in reflexivity enabled her to start thinking about the longer-term consequences of her actions and to not act on angry impulses:

> E/2/29 "(I) And do you think you noticed a change in yourself? (E) Yeah, definitely. (I) What do you think has changed? (E) My way of thinking. (I) What do you mean? (E) Like my way of thinking and whereas before… like I had to stop and think and sort of resolve the situation before acting upon it sort of thing. (I) So before you'd just act… (E) Act upon, yeah… (I) You wouldn't think? (E) Yeah, I wouldn't think. (I) Whereas now…? (E) Yeah."

This statement from her post-treatment interview, however, was in direct conflict to a reduction of two points in Participant E's LEQ-ROPELOC/YAR-PET score for the factor 'problem solving' (Figure 5-14).

Participant E reported mental health benefits from music therapy with regard to her sense of well-being:

> E/2/52 "When I come back from music therapy I'm more happier sort of thing."

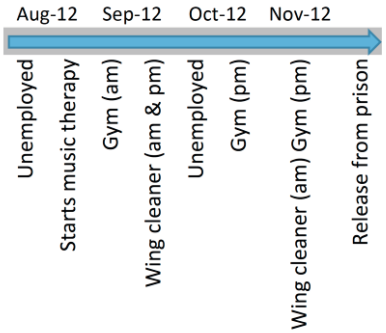
She also reported an increase in self-confidence since attending music therapy:

> E/2/54 "Now I've become a bit more confident than I was before, I wouldn't have done that and I wouldn't have got up and sung… I even got up and sung."

However, whilst Participant E's LEQ-ROPELOC/YAR-PET score for the factor 'self-confidence' rose by two points, her score for 'self-esteem' fell by two points (Figure 5-14)

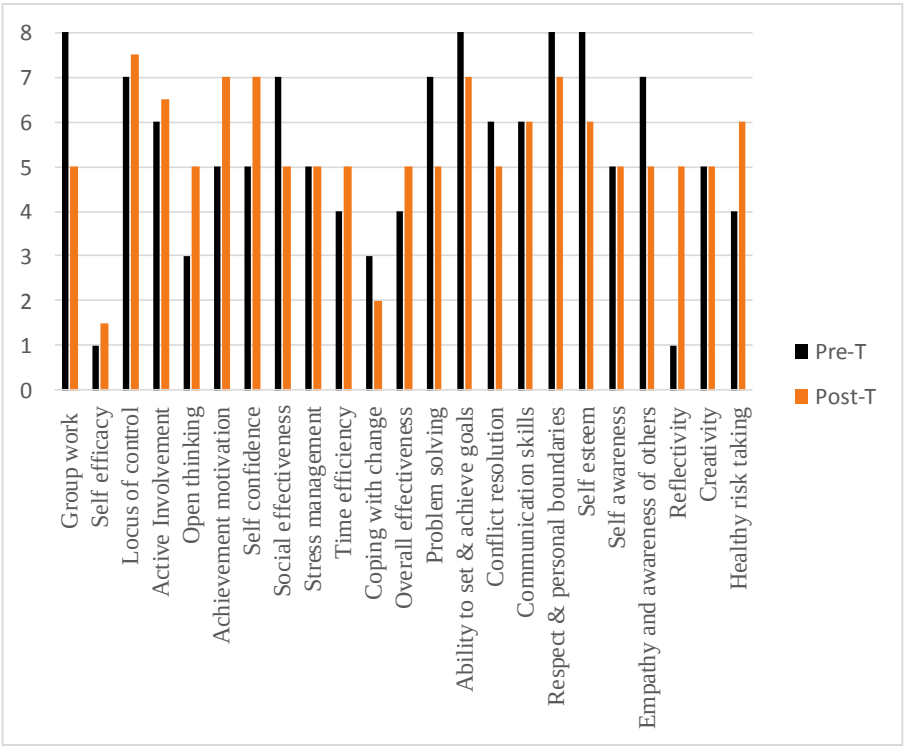
Overall, Participant E's pre and post-treatment LEQ-ROPELOC/YAR-PET scores showed a decrease or stagnation in a high number of factors (decrease n=9, static n=4). She also showed minimal change (0.5 out of a possible 7.5) in a further 3 factors (Figure 5-14). This was atypical when compared to other participants' scoring patterns. Whilst many participant showed stagnation or decrease in individual factors this was generally restricted to one or two of each category. Participant E showed significant gains in only 7 of 23 factors.

Figure 5-13 Participant E engagement patterns with prison programs



Participant E's engagement with prison programs and employment fluctuated according to her mental state. She was unemployed when she started music therapy and had one further period of unemployment whilst attending. Her main focus was on earning money to support her nicotine addiction rather than on attending programs, which would help her address her offending behaviour:

Figure 5-14 Participant E pre and post-treatment LEQ-ROPELOC/YAR-PET scores



Contradictory findings such as the discrepancies between qualitative excerpts from Participant E's interviews and quantitative findings from the LEQ-ROPELOC/YAR-PET scores are perhaps reflective of the often-conflicting

statements of people such as Participant E, who are actively addicted to chemical substances. However, it is also possible that Participant E gained greater insight and self-awareness through attending music therapy and that this made her more conscious of the difficulties she had and of the personality traits, which contributed towards her problems. Thus her scores could reflect a more realistic understanding of herself.

CHAPTER 6. DISCUSSION

The following section will discuss the data presented in Chapter 5 with reference to the original research questions. It will discuss the research findings from a clinical perspective and relate these to relevant theoretical frames. It will consider the methodology used and evaluate the study. It will also consider possible links between the findings and researcher pre-conceptions and bias. In a final section it will consider potential directions for future research.

This research study intended to explore the self-perception of women prisoners. It aimed to establish whether there was a change in the self-perception of women prisoners attending music therapy, and, if so, whether this had an effect on their ability to engage in prison resettlement interventions. It also sought to investigate what effect different treatment lengths had on the outcomes of music therapy.

This mixed methods study approached the phenomenon from a range of different perspectives. It investigated change in areas of behaviour, which might be considered indicative of change at a higher self-conceptual level. By doing this it aimed to establish whether self-reported changes in self-perception translate into changes in behaviour and engagement outside the music therapy room through triangulation of the data sets.

6.1. FINDINGS IN RELATION TO RESEARCH QUESTIONS

6.1.1. RESEARCH QUESTIONS 1 & 2: PROCESS AND EXPERIENCE OF CHANGE IN THE SELF-PERCEPTION OF WOMEN PRISONERS ATTENDING MUSIC THERAPY

Research question 1 aimed to establish whether there was a process of change in the self-perception of women prisoners with non-psychotic mental health problems attending music therapy. Research question 2 aimed to gain some insight into the nature of the experience of change in self-perception.

The analysis of the qualitative data found many self-statements indicative of change in the way women prisoners saw and described themselves pre and post-treatment. As this sometimes required extrapolation this data could be regarded as less reliable and at risk of bias on the part of the data analysts. However, triangulation of qualitative and quantitative data sets confirmed these findings.

Results showed that whilst static factors such as dysfunctional family backgrounds and histories of abuse could not be changed, dysfunctional ways of relating such as

self-isolating or challenging behaviour, for example, could indeed be revised. Thus behaviours linked to past experiences of pervasive and enduring abuse, expressed through internalizing and externalizing behaviours, were amenable to change. However, the process involved in facilitating change was multi-layered and complex. Change could not be linked to one single LEQ-ROPELOC/YAR-PET factor. There was a complex interaction between multiple factors with change in one domain often bringing about change in another related domain. Thus, for example, increased self-confidence contributed to a change in perceived self-efficacy. This, in its turn, had a positive impact on an individual's sense of agency, leading to a more mature attitude to risk and an enhanced capacity to think of longer-term consequences rather than immediate gratification.

Interestingly, where change was not reported in the post-treatment interviews this could be traced back primarily to Participant J and occasionally to Participant E. Both participants were still actively addicted to chemical substances. Neither was engaging with detox programs. This could indicate that participants who are actively addressing their addictive tendencies should be targeted for recruitment to music therapy if substantial changes in self-perception are to be made.

It is of interest that both participants showed stagnant scores in the LEQ-ROPELOC/YAR-PET domains of self-efficacy, locus of control and self-awareness. This could indicate that they felt that their lives were largely defined by outward events and that they were not yet able to take responsibility for themselves and their criminal offence. It is nonetheless surprising to find that both participants scored an increase in their degree of self-confidence. However, in an environment with few one-to-one therapeutic interventions it is possible that gains scored could be due to the mere fact that research participants had the opportunity to attend some form of therapy, regardless of whether they chose to use this space productively in a musical sense, as did Participant E, or whether they declined to engage with music as a therapeutic medium, as in the case of Participant J.

Participant J's self-statements in her pre and post-treatment interviews were and remained overwhelmingly negative. She found the idea of making music with the therapist embarrassing and preferred to talk in her sessions. Comparing Participant J's overall results with those of other participants it does seem that in declining to engage musically with the music therapist Participant J was depriving herself of a powerful therapeutic medium.

For those participants who engaged wholeheartedly with the music therapeutic process and built up a therapeutic alliance with the therapist, the experience of change would appear to have been overwhelmingly and often for the individual surprisingly exhilarating, empowering and liberating. The most important area of gain was growth in self-confidence/self-esteem with the related areas of agency, perceived self-efficacy, purposeful activity, skill acquisition, sense of achievement,

pleasure, achievement motivation, and healthy risk-taking. It could be hypothesized that growth in these areas was of particular import because it was associated with motivation and future aspirations. Participants who developed aspirations both for the immediate and the longer-term future all showed gains in achievement motivation, active involvement, agency, goal setting and time efficiency, all important elements for successful engagement with resettlement interventions.

Because self-perception is a subjective and complex phenomenon, measuring change in self-perception is notoriously difficult. Perhaps it is less important to capture whether or not there has indeed been an objective process of change in this domain. What is important is the subjective feeling the individual has of change and the meaning that they attach to it. As with perceived self-efficacy it is the perception of the individual that something has changed and that they are now able to do and be things that were previously impossible that is empowering. It is possible that the experience of change in self-perception, rather than objective measurable change, was of crucial importance in helping research participants exit from their position of disengagement and start engaging with prison programs.

6.1.2. RESEARCH QUESTION 3: EFFECT OF CHANGE ON PARTICIPANTS' ABILITY TO ENGAGE WITH PRISON PROGRAMS AND RESETTLEMENT INTERVENTIONS

Data from the prison database on engagement patterns of individual research participants indicates clearly the positive impact change in self-perception had on participants' ability to renounce self-isolation and engage with prison programs and resettlement interventions. This was supported by the effect size calculations of the self-report LEQ-ROPELOC/YAR-PET questionnaires; factors such as 'group work', 'achievement motivation', 'goal setting', 'overall effectiveness', 'time efficiency', and 'self-esteem' and 'self-confidence', all relevant to the ability to engage in group programs, showed large effect sizes.

Interestingly this was not entirely corroborated by the findings of the LEQ-ROPELOC/YAR-PET Staff Observation Questionnaire. Here 'group work' showed no effect at all and 'time efficiency' only a small effect. One explanation for this startling difference in perception is that staff completing the questionnaire were recruited primarily from those on the residential house blocks. These members of staff had no opportunity to observe and evaluate participants' engagement with prison programs and resettlement interventions. Furthermore, the high quotient of different members of staff completing the pre and post-treament questionnaires meant that staff did not share the same base-line and so might not appreciate change.

6.1.3. RESEARCH QUESTION 4: EFFECT OF TREATMENT LENGTH ON THE ABILITY TO ENGAGE WITH PRISON PROGRAMS AND RESETTLEMENT INTERVENTIONS

A breakdown of effect size calculations in to short, medium, and long-term music therapy showed clearly that, to achieve significant results, attendance needed to be for 3 months or longer. This is in line with other music therapy 'dosage' research (Gold et al., 2009). This is not to say that short-term therapy is contra-indicated; it also achieved some large effect sizes. However, negative effect sizes (n=7 factors) for short-term therapy showed that there were clearly areas where improvement could not be achieved in such a short period of time. Possibly more relevant than the length of therapy was the proximity to release, with release-related anxieties and stress factors impacting substantially on an individual's capacity to engage at a more profound level than mere attendance. Clinical experience indicates that short-term, project-focussed therapy can be of great use to the individual. However, it would be best to place this as far away from the release date as possible.

These conclusions, however, need to be treated with caution. They cannot be generalized, even within the hosting prison, let alone within the wider female prison estate, as it is not proven that the sample was representative of the wider population. Not only was the number of participants necessarily small for the qualitative research section of the study. There was an imbalance between participants in short-term (n=2), medium-term (n=4), and long-term (n=4) therapy and no categorisation according to offence or other demographic details.

6.2. CLINICAL PERSPECTIVES

6.2.1. CLIENT GROUP

This study aimed to work with the 'normal' prison population. Given the high incidence of mental health problems amongst (women) prisoners the only criteria for exclusion from the study was acute psychosis. This means that diagnosis did not play a role in the selection of research candidates. The large number of participants with extended and pervasive experience of abuse was reflected in high rates of trauma-related conditions such as PTSD, mood and anxiety disorders. Many of the participants would have fitted the diagnostic criteria for one or more personality disorders. Psychiatric conditions, however, were generally unknown to the researcher or undiagnosed.

6.2.2. THERAPEUTIC INTERVENTIONS

A number of music therapy interventions were available for the research participants. These ranged from songwriting to therapeutic learning. The majority

of participants chose to write songs in their music therapy sessions. This was unexpected. Clinical experience led the researcher to anticipate an equal distribution between songwriting, improvisation, and performance of pop songs. It is possible that songwriting offered a non-threatening opportunity for participants who needed to re-visit past events and/or offence-related issues.

Why songwriting?

In songwriting text, music and finished recording acted as transitional objects in the dual Winnicottian sense of a comfort object and of a bridge between two people (Winnicott, 1971). This helped alleviate performance anxiety in early sessions. Listening back in the presence of the music therapist allowed the participant to 'hear' herself from the outside and to reflect on the content of the text. This is triangulation in the philosophical and psycho-analytical sense of the word, where 'we come to know our own mind through discourse with another mind about something external to both of us'(Cavell, 2011). Working on a text together helped to objectify painful and traumatic experiences, allowing a participant to process them and helping her gain insight into her own internal world.

Musical form such as rhythm, melody, timbre, and harmony added depth to the song lyrics. They deepened the emotional landscape and created a multi-dimensional experience of the original script. The combinational of all four elements not only structured content; they acted as a musical container for powerful emotional experiences, allowing participants to express distressing feelings without resorting to parasuicidal or challenging behaviour. This both intensely personal yet open expression of feelings is far removed from the private, solitary expression of feelings through self-mutilation, and transforms emotional expression from a destructive act into one of creativity[26].

Songwriting also helped on another level. Music therapists with experience of this client group have noted that offenders often find symbolic thinking difficult. They tend to favour what Nolan (1983) calls 'action oriented forms of expression'. These often manifest through a prisoner "acting out" (behavioural incidents) or "acting in" (parasuicidal behaviour). Over time, this process of psychoanalytical triangulation facilitated growth in the ability to think symbolically much as Winnicott outlines in his theory of the transitional object (Winnicott, 1971).

Furthermore, songwriting helped establish links both within and beyond the narrow confines of the prison, helping a prisoner keep hold of the reality of their past and future life outside the prison walls. At the same time it helped break down the

[26] Thoughts developed in clinical supervision with UK music therapist and Jungian analyst Ann Sloboda.

barriers of silence surrounding abuse, giving a voice to a population that is both marginalised and silenced.

Songwriting created a "ripple effect". What started as an essentially solitary activity, with the woman writing a poem alone in her cell, became an increasingly communitarian enterprise. The music therapist became involved in the creative process. Links were established with other prisoners and staff when the woman shared her work with others on the house block and gained recognition from both peers and staff alike. The final product in the form of an audio recoding helped maintain links to family on the outside. In some cases the work was put into the public arena when participants submitted their work for competitions such as the Koestler Awards. Most crucially, perhaps, songwriting allowed often painful and distressing past histories to be re-formed into a more manageable format for the individual and thus become amenable to processing.

Perhaps most significantly, as far as future desistance is concerned, songwriting enabled participants to rewrite their life script and create a new narrative. An offender's personal life story needs to be owned, integrated and transformed if they are to desist from crime. A subjective change in the person's sense of self and identity is needed – often away from one of 'powerless victim' towards a more agentic self. Songwriting can contribute to this process and provide a lasting documentation of the struggle and process of transformation.

6.3. RESEARCHER PRE-UNDERSTANDING AND BIAS

Before embarking on this research an Epoché and RepGrid analysis (3.1) showed that I anticipated that music therapy would contribute to the resettlement process of women prisoners. I had expected most gains to be made in the areas of creative emotional self-expression, impulse control, reflexivity, self-awareness and inner locus of control. I assumed that growth in the ability to self-reflect and to take responsibility for oneself and one's actions (inner locus of control) would have a positive influence on the process of integrating the criminal offence. I believed that a revised perception of self, catalysed by this process, would enable the individual to move on.

I had not anticipated the extent of the impact gains in self-confidence and self-efficacy would have on the capacity of an individual to engage with prison programs and resettlement interventions. Because self-confidence and self-efficacy are interlinked with a number of other LEQ-ROPELOC/YAR-PET factors (agency, perceived self-efficacy, purposeful activity, skill acquisition, sense of achievement, pleasure, achievement motivation, and healthy risk-taking) their influence was considerable, not the least because they created aspirations for the future. Creating aspirations for the future was linked yet again to a number of other LEQ-ROPELOC/YAR-PET factors that were highly relevant to effective resettlement;

these are, to cite only a number of them: achievement motivation, active involvement, agency, goal setting and time efficiency.

Furthermore, I had not foreseen the influence music therapy could have on entrenched, dysfunctional behavioural patterns such as parasuicidal and self-isolating behaviour. Whilst parasuicidal behaviour is not directly linked to resettlement, self-isolation is an area of considerable concern for prison authorities endeavouring to engage severely disaffected prisoners. Self-isolation was often linked to deficits in self-confidence and self-esteem, again linked to past experiences of abuse resulting in parasuicidal behaviour.

I had originally seen music therapy as a less intimidating alternative to verbal resettlement interventions. I now consider music therapy to be a starting point. I would thus revise the role of music therapy from that of adjuvant therapy, to 'entry point' for prisoners who are, for whatever reason, failing to engage with the resettlement process.

6.4. METHODOLOGICAL CONSIDERATIONS

RCTs, the golden standard in research, are notoriously difficult to conduct in prison settings. 80% of RCT's conducted in criminology produced non-significant results (Farrington & Welsh, 2005). RCTs in music therapy in this field are still uncommon and struggle in the same way (Gold et al., 2013). Only one Chinese study has achieved significant results (X.J Chen, Hannibal, & Gold, 2013).

Qualitative research studies have had more success. However, they are not considered to provide the evidence of meaningful outcomes increasingly required by service commissioners. This study followed a mixed methods study design with the primary focus on qualitative data. Nevertheless the descriptive statistics provided invaluable numeric evidence, which functioned both as a crosscheck of the validity of the qualitative findings and helped establish possible correlations between outcomes of music therapy and behavioural change in everyday life of the research participants.

This study adopted a pragmatic approach in its choice of a mixed methods study design. The focus was on the qualitative data. The quantitative data played a supportive role. Data was collected concurrently. Data collection proved difficult in a prison setting as participants could be moved out to other establishments without a moment's notice. A number of participants were lost to the program before they had completed it because of this issue. However, collecting a range of different data sets minimized the effect of difficulties encountered as one data set could be used to confirm or disconfirm another. Moreover, it was possible to revise the study protocol following an evaluation of the first three months to mitigate damage as much as possible. In the case of an RCT this would have been impossible.

Such a pragmatic approach, particularly the concurrent collection of data, ensured that a complete set of data could be collected for each research participant before they exited the program. Post-release follow-up would not have been appropriate and video link follow-up with participants transferred out to other prison establishments would not always been feasible as not every establishment had a functioning video link facility.

This confirms Blanchette & Brown's (2006) observation that multi-method research adopting integrated strategies is well adapted to research in this complex and challenging setting, giving not only evidence in terms of numerical outcomes but also nuanced insight into the phenomenon. Rather like a radiologist using CT and MRI scans to stage a diagnosis of cancer, this mixed-methods study design not only allowed 'slices' of the participant's reality to be analysed but also provided 'multi-plane' images, thus adding soft tissue to the bare skeletal image.

6.5. REVISITING THE LITERATURE

6.5.1. MUSIC THERAPY

The research findings of this study confirm a number of points outlined in the literature review of October 2011. Music therapy, in the form of song-writing, offered women prisoners an unparalleled opportunity confront their often conflicted and painful pasts (Daveson & Edwards, 2001). Music therapy provided a relaxing and playful supplement to other verbal programs (Smeijsters et al., 2011). It offered a creative 'play space' in which alternative self-concepts could be explored and experimented with (Hoskyns, 1995; O'Grady, 2009).

Surprisingly, as with the pre-conceptions of the researcher of this study, increase in self-confidence was not showcased as a primary outcome of music therapy with this population. However, the findings of the current study highlight the importance of gains in self-confidence and other related areas such as self-efficacy and achievement motivation in preparing the ground for later downstream outcomes by facilitating engagement with resettlement programs.

One finding of this study was confirmed by more recent contributions to research in this field. Music therapy was shown to have a positive effect on internalizing and externalizing behaviours. It not only facilitated change in dysfunctional ways of relating (Lawday & Compton Dickinson, 2013); participants who had initially acted out in the search of immediate gratification started thinking of longer-term consequences after attending music therapy. There is a possible link between improved self-control and perceived self-efficacy in the mastery experience of music therapy, as has been shown in Pool & Odell-Miller's (2011) investigation into music therapy and aggression.

Whilst earlier studies did not examine whether behavioural gains made in these areas in music therapy sessions transferred to situations outside the music therapy room (Codding, 2002), this study showed conclusively that this was indeed the case. Thus, music therapy exercised not only a supplementary role as initially anticipated; for disaffected, self-isolating prisoners, it provided an entry point and acted as catalyst for engagement with prison programs and interventions.

Another interesting finding of the current study relates to empathy. One of the claims made in practice-based case studies, including recent literature, is that music therapy has a role to play in the development of empathy and victim awareness in offenders (Compton Dickinson & Gahir, 2013; Hughes & Corman, 2013). This assumption was not entirely substantiated by the findings of this study. Here "Empathy and Awareness of Others" barely showed a small effect size (Cohen's *d* .29) in the LEQ-ROPELOC/YAR-PET Self Report Questionnaires. However, the intuitive assumption that music therapy enhances empathy and victim awareness would appear to be shared by more than just the music therapy community. The effect sizes calculated from the LEQ-ROPELOC/YAR-PET Staff Observation Questionnaire showed a moderate to large effect size (Cohen's *d* .79). Such inconsistent results highlight the need for further research into music therapy and empathy before claims can be substantiated.

Interestingly the gains from community music programs in prisons were seen predominantly to be in the area of self-development (skills acquisition and increased self-efficacy resulting from an experience of mastery), life skills (self-confidence, self-belief etc.), and the development of more positive, alternative self-concepts, all outcomes of this research study and other recent music therapy studies. Here music making, both in music therapy and in community music projects, played a central role with regard to self-development, especially areas such as motivation, mastery, confirmation, self-image, and self-esteem (Tuastad & O'Grady, 2013)

However, difficulties were encountered when research into community music programs attempted to establish possible correlations between the outcomes of individual projects and behavioural change in everyday life (Cox & Gelsthorpe, 2008; De Viggiani et al., 2010; Dunphy, 1999). The current study corroborated the difficulties to be expected when researching in the restricted confines of a prison environment. However, it showed promising results, not the least perhaps because music therapy provision was generally longer-term and music therapy provision was well embedded in the hosting establishment. The supportive stance of the prison governor and her Senior Management Team possibly facilitated more reliable access to prison data.

The issue of positive self-identity was as central for prisoners as for other client groups affected by stigmatization. The present study shows that songwriting can be

a powerful tool in the process of recreating a positive sense of self. It enabled women prisoner to gain a deeper understanding of their internal and external realities. This is a significant expansion of Chambers' (2008) identity-construction through the metaphors contained in the words of well-known songs. There is namely a difference between identity-construction formed by proxy, through identification with the life experience of a popular artist expressed in the lyrics of well-known songs, and the highly personalised process of the creation of a new life script through the development of a new narrative in the form of lyrics and music of an individual's song. Recent research in the form of a meta-synthesis of two dissertations (Tuastad & O'Grady, 2013) suggests that identity in prisoners might be reconfigured when participants rediscovered themselves through music and reconnected with parts of their identity related to being human rather than being a prisoner. This meant that when performing music they experienced themselves as musicians rather than as criminals and prisoners. This was corroborated by the participants in the current study and was strongly linked to feelings of mastery, achievement, and pride.

Tuadstad and O'Grady's meta-synthesis also confirmed other findings of the current study; namely that music therapy functioned as a coping strategy, helping inmates escape the harsh reality of prison life, providing some prisoners with a temporary respite from negative thoughts, traumas, and pain. Interestingly, music therapy also offered an "alternative" reality, using music to momentarily "replace the need for drugs by providing an ecstatic, transcendent world of enjoyable musical experiences" (p.222). Although this did not emerge in the thematic coding of the current study it is conceivable that this was an aspect enjoyed by its participants, as all with the exception of one had histories of substance misuse. It could also be another explanation for why music therapy helped participants desist from parasuicidal behaviour.

6.5.2. RESETTLEMENT

At the time of the literature review accompanying this study there was no research investigating the interface between music therapy and resettlement paradigms. Hakvoort and Bogaerts (2013) address this explicitly in their recent paper in which they develop a theoretical model which sits firmly within the RNR paradigm. It favours a cognitive behavioural approach to work in forensic psychiatry and focuses on dynamic risk factors. Other recent papers following a psychosocial approach to music therapy with prisoners are more inclined to identify with protective factors (Gold et al., 2013) but do not attempt to outline a theoretical model, with the exception of Chen et al. (Xi Jing Chen, Leith, Aarø, Manger, & Gold, 2013). These papers show that music therapy has the potential to straddle both RNR and GLM paradigms. As shown in the current study it can address both dynamic risk factors and protective factors at the same time, according to the needs of the individual and the focus of the institution.

As Hakvoort and Bogaerts (2103) point out, music therapy meets the 'responsivity' criteria of the Risk-Needs-Responsivity model of the 'what works' paradigm. A warm therapeutic relationship is considered particularly salient for women (Blanchette & Brown, 2006) with the therapist showing strong relational skills and endorsing positive efforts. Because music therapy works 'with' rather than 'on' the offender, it enables the individual to discover and develop self-efficacy and agency, both important attributes for desistance from crime.

The psychosocial music therapy approach with the general prison population focuses on client strengths and resiliencies. In a similar way to feminist therapy it presupposes an egalitarian collaboration between client and therapist and the cautious application of diagnostic labels (Blanchette & Brown, 2006). Strength-based approaches may be particularly applicable to women, due to the lower risk they pose. As Blanchette and Kelly point out (p.52), "there is a good possibility that women's strengths/capabilities could serve as protective factors and thus increase desistance."

Reinforcement, as Hakvoort and Bogaerts (2103) name it, or self-efficacy enhancement techniques in resettlement terms (Blanchette & Brown, 2006), is encapsulated in the mastery experience of music therapy. This is potentially of particular relevance for women prisoners, as increased self-efficacy is considered to enhance other protective factors such as self-esteem and self-confidence. Whilst this remains to be conclusively established, findings from the current study seem to indicate that perceived self-efficacy could be of considerable importance to positive downstream outcomes. A high level of self-efficacy is considered to be of relevance to the desistance process (F McNeill et al., 2012). Strengthening a sense of self-efficacy provides a "bridge between current circumstances and a possible future" (National Offender Management Service, 2012 p.26) thus opening the path for future aspirations, allowing women to take control of their lives and achieve their goals (Van Voorhis et al., 2010). Given the difficulties encountered in the thorny process of growth towards desistance, self-efficacy could legitimately be considered a key element in the desistance process. It determines the challenges a person is willing to face and the extent to which they are prepared to continue in their efforts despite failure (Bandura, 1989).

Music's capacity to evoke, express and regulate emotions is also of relevance to the desistance process, which appears to be accompanied by a diminuation of negative feelings and an increase in positive feelings (Farrall & Calverley, 2005; Healy, 2013). As the current study shows, songwriting offers an excellent medium with which to work over time with negative feelings of regret, shame and guilt, gradually replacing them with positive feelings such as pride and achievement.

The importance of a creative play space, identified in the music therapy literature (Hoskyns, 1995) is crucial both at a micro-level such as the rehearsal of anger-

management strategies (Hakvoort & Bogaerts, 2013) and at a macro level of rehearsing and internalizing new life scripts essential to future desistance (Rumgay, 2004). Finding opportunities to rehearse a new life script is considered essential to the claiming of a new identity so crucial to desistance (Giordano et al., 2002). Music therapy offers not only the opportunity to rehearse but also the opportunity to create a new life script in the form of songwriting. As Tuastad & O'Grady (2013) found, establishing a new identity can start before release as offenders reconnect through music making with other parts of their identity that are not related to being a prisoner. Alternatively, music therapy, particularly songwriting in music therapy can also help an individual reconnect with a past or lost self, thus preserving continuity of self in the process of creating a new identity (Healy, 2013; Maruna & Roy, 2007).

Music therapy could also connect with Giordano et al's (2002) theory of desistance. At the entry point of the process, music therapy helps create a cognitive openness to change (see large effect sizes for problem solving and opening thinking of the LEQ-ROPELOC/YAR-PET Self-report Questionnaire). By providing a motivating experience it could act as a 'hook for change' or 'turning point', enabling an individual to make the first steps toward envisaging a replacement self as they work on reconstructing their identity.

6.6. EVALUATION AND LIMITATIONS

The qualitative data was the principle focus of this mixed-methods study. Therefore it will be evaluated primarily according to qualitative principles. However, limitations with regard to the quantitative data will be discussed concurrently, wherever applicable.

Due care was taken to extrapolate researcher bias and pre-understanding in the Epoché and RepGrid of this study. Furthermore, research assistants were employed to eliminate any influence from these on the data collected in the semi-structured interviews; an independent music therapist researcher coded the semi-structured interviews separately for the same reason. As member-checking was not considered feasible, cross-checking of the data analysis by the PhD supervisors and peer-debriefing at PhD courses acted as a useful counterbalance against the dangers of over interpretation of data.

Unfortunately there was a difference in maturity and experience between the two research assistants. The second research assistant was younger and had no experience of this client group or setting. As the research interviews were not transcribed until data collection had ended this meant that the researcher was not aware of the effect this had on the quality of the data collected and failed to re-brief her accordingly. The first research assistant had abundant experience of women at this particular prison and was well versed in qualitative interviewing techniques and

provided a wealth of data for analysis. Her questions were open-ended and she followed-up on promising leads. However, whilst the second research assistant had theoretical knowledge of interview techniques she often failed to follow-up on interesting leads and sometimes asked leading questions, thus compromising the quality of the data collected.

Furthermore, in the data analysis phase the primary researcher and independent music therapy researcher did not code in precisely the same manner. However, it was possible to amalgamate both data analysis sets in such a way that the integrity of the data was not compromised.

Contextualization was considered an important aspect of this study, given the complex interplay between self-perception and environment. Thus great care was taken to understand participants within the context of their personal background and setting, and to provide comprehensive background data. However, the prison environment impacted on several aspect of the research project, meaning that a number of issues outlined below needed to be resolved following evaluation of an initial period.

Attrition was a considerable issue during this project. Research participants were transferred out without warning, access conditions were changed in accordance with security concerns. Therapeutic approaches had to change to adapt to the changed situation. Attrition issues were only addressed satisfactorily half way through the project when the prison agreed to put a hold on research participants until they had completed the program.

High staff turnover and the continual redeployment of staff to other tasks meant that the Staff Observation Questionnaire was rarely completed by the same member of staff pre and post-treatment. This diminished the value of this data considerably and meant that conclusions could not be effectively drawn.

Prison data was also not reliable and showed considerable gaps when compared to the data collected by the researcher. This meant that it had to be treated with caution. Fortunately other data sets could be used to corroborate findings thus raising its reliability.

Furthermore the effect of observation bias (Hawthorn effect) cannot be ruled out. One-to-one therapeutic situations are rare in prison. The sheer fact of having access to music therapy could have contributed towards the outcomes of all the research participants of this study. However, it could not be avoided given the nature of the setting. It is also impossible to exclude therapist effect as no other therapists were employed by the prison that could have been involved in the project. Moreover, there is also the probability of selection effect as prisoner elected to take part in the project rather then being assigned to it.

Another weakness of this study is the fact that only 60% of the qualitative data collected but 100% of the quantitative data was analysed due to the time constraint imposed by the health condition of the primary researcher. It is hoped that this has been counterbalanced by the inclusion of the outlier and one negative case in the selected sample. The quantitative data played not only a supportive but also a confirmatory role when findings from the qualitative data were questionable. Furthermore they provided an important complement to the qualitative data as confirmatory indicators of change.

The need to resort to imputation in the early data of three participants is a further weakness of this study. It is hoped that the conservative approach adopted might mitigate the effects of this requirement.

Given the length of the LEQ-ROPELOC/YAR-PET Self-report Questionnaire a degree of respondent fatigue could be expected. Here the prison context was possibly a favourable element. It is possible that the questionnaire provided a welcome activity in the long hours of lock-up. Certainly research participants filled in the questionnaires conscientiously and with care, as could be seen by thoughtful comments inserted next to some questions. A random check of a number of factors across measurements of random participants showed no indication of respondent fatigue, which confirms the quality of the data collected.

Once a participant started to engage in other programs, it was not possible to attribute progress or changed behaviours or changes in self-perception exclusively to music therapy. The number of confounding variables was too considerable. However, this study does not attempt to attribute change exclusively to music therapy. It sees music therapy as the beginning of a snowball process; fulfilling the function of catalyst can thus be seen as an accomplishment to be celebrated rather than lamented. This means that the primary aim of music therapy treatment – to help a participant transition out of self-isolation into engagement – has been achieved.

Because of the primarily qualitative focus of this study findings cannot be generalized to the wider prison population. They are very restricted in as much as they refer specifically to the group of 10 research participants recruited to this program. They could conceivably be relevant to the wider miscellany of the general female prison population given that the sample was representative of the wider population. However, they are by no means transferable to the male prison population and cannot be generalized to offence or diagnoses specific sub-groups. However, the value of this study is defined less by an incapacity to generalise findings across the population and more by its potential to furnish tentative thoughts about how music therapy might interface with resettlement interventions and thus provide the basis for an emerging theory of music therapy in this setting.

6.7. SECONDARY FINDINGS

This study found that music therapy was not only relevant for disaffected, self-isolating women prisoners; it was also of relevance for those who were held in isolation from the wider prison community because of the risk they posed. For these prisoners music therapy offered an appealing intervention in which a prisoner's capacity to relate appropriately with the music therapist in individual music therapy, and with other prisoners in group music therapy could be observed and tested under controlled conditions.

It is possibly because of this factor that the perception of music therapy held by prison staff and authorities changed over time from that of a 'soft' leisure activity to an intervention that was highly relevant to the prison because of its capacity to engage prisoners who were particularly difficult to manage. This meant that music therapy enjoyed the support not only of the senior management team but also of the prison governor and the Controller[27].

Another unexpected finding was the importance of songwriting as a clinical intervention for this specific population. A Chinese study (X.J Chen et al., 2013) suggests that improvisation is an appropriate intervention for male Chinese prisoners. It would be interesting to establish whether such a different finding has its roots in cultural or gender differences.

6.8. FURTHER PATHWAYS FOR RESEARCH

Since the inception of this study there has been an increase of music therapy research in this field. The findings of this study bring new knowledge to the field and hope to contribute to government policy making in the UK and elsewhere. There is a need for further research to see whether the findings of this study can be corroborated. This would help establish whether these findings were at least due in part to a therapist effect or whether active music making in music therapy has the capacity to catalyse change in self-perception. This would be best achieved through a multi-site investigation in different women's prisons initially in the UK and then internationally.

This research would test hypotheses arising from this study:

- Engagement in the music making process is predictive of behavioural change in women prisoners attending music therapy

[27] The Contoller is the representative of the Ministry of Justice in contracted prisons, whose role is to monitor whether contract terms and conditions are being adhered to by the prison.

- Increased self-confidence and self-esteem are linked to increases in perceived self-efficacy in women prisoners attending music therapy
- Perceived self-efficacy is of important to positive downstream outcomes in women prisoners attending music therapy
- Songwriting in music therapy is a particularly relevant clinical intervention for disaffected women prisoners

This particular study focuses on the resettlement of women prisoners. It would be of interest to conduct a similar study in the male prison estate to see whether the findings are gender-specific or not. This could give rise to an interesting debate as the desirability of an increase in self-confidence in male prisoners has not yet been established.

Another area of interest would be to investigate downstream outcomes by accompanying prisoners 'through-the-gate' and working with them post-release in thee community, as is done in Norway. This would provide evidence not only concerning reconstruction of an acceptable self-identity post-release but also for music therapy's impact or lack of impact on recidivism.

CHAPTER 7. CONCLUSION

This study arose from my own clinical work with disengaged women prisoners. After they had engaged for a period in music therapy I observed what appeared to be a positive change in the way they saw themselves and a corresponding change in their ability to engage with prison programs and interventions. My experience of working with these women in and beyond prison in community settings taught me that their sense of identity was not only formed by their family and societal elements but also by their offending history.

This study set out to explore whether there was a change in self-perception in women prisoners attending music therapy and, if this was the case, whether there was a change in their ability to engage in prison resettlement interventions. It also aimed to gain insight into the optimal 'dosage' required to bring about this change.

A mixed-methods design was chosen so as to enable an exploration of the topic from multiple perspectives in the hope that this would not only provide rich data but also provide conclusive evidence and a deeper understanding through the triangulation of data sets. Given the study's focus on qualitative data, and the precarious state of health of the primary researcher the sample size was necessarily small, so that it could be brought to conclusion within a reasonable amount of time and with feasible expenditure of energy.

Analysis of the data sets showed that there was indeed a positive change in the way that research participants saw themselves. This not only beneficially impacted on their ability to engage in prison programs and interventions but also had positive effects on other areas such as parasuicidal and challenging behaviour. These benefits would appear to be directly linked to the use of music as therapeutic medium in the music therapy sessions. The only participant who did not engage with the music failed to make any significant changes in the way she saw herself.

Although short-term therapy was not necessarily contra-indicated, substantive gains were only made if a participant attended music therapy for more that three months. Short-term therapy required careful timing so as not to be subsumed by the overwhelming anxieties, which arose pre-release.

Greatest gains were made in changes in self-confidence, self-esteem and related areas. An increase in perceived self-efficacy and overall effectiveness had implications for positive downstream outcomes as a feeling of mastery in one domain, namely music, translated into a feeling of overall effectiveness.

These findings were significant as they corresponded to areas considered to be of significance in gender-specific resettlement needs. Music therapy could be a necessary precursor to cognitive behavioural programs if these were to be absolved successfully. Indeed, for severely de-motivated women prisoners failing to progress through the system, music therapy could act as entry point, creating the necessary pre-conditions for subsequent successful engagement with resettlement interventions.

If identity is the 'mega-conflict' conceived by Chambers (2008) music therapy offered participants an accessible opportunity to explore, rehearse and perform a new identity, often encapsulated in the lyrics of a song, before experimenting with this new identity in other settings within the prison. Not only were women prisoners able to re-write their future script; they were able to re-form often painful, horrific biographies into a more manageable format, both processing and integrating past traumatic events at the same time.

This research provides another piece in the evidence base for music therapy in prisons. It contributes to an emerging picture of a new discipline, which can contribute to the resettlement process and sit comfortably within either resettlement paradigm. It was able to address both criminogenic risk factors and protective factors, simultaneously adapting its focus to the requirement of the immediate moment. For disengaged, de-motivated prisoners music therapy offers a playful, enjoyable space in which they can acquire new skills without even being conscious of the fact. Thus a gate can be opened up which unlocks a productive pathway through the prison system for the individual and hopefully impacts on later downstream outcomes.

I embarked on this journey assuming music therapy offered a less-threatening alternative to verbal therapy. I now consider music therapy to be a starting point, a 'foot in the door' that is often kept resolutely closed to prison staff. I would thus revise the role of music therapy to 'entry point' for prisoners who are, for whatever reason, failing to engage with the resettlement process.

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APPENDICES

Appendix A. Participant Information Sheet

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Participant Information Sheet

Section A: The Research Project

Music Therapy and Women Prisoners

You are invited to take part in a research project. Before you take part it is important that you understand what is being researched and what it would involve. Please take time to read the following information carefully. If you have any questions please do not hesitate to ask. You may also talk to others about it. If you do not want other prisoners to know, you could talk to a member of staff you trust.

1. **Purpose and value of study**
   This project looks into the effect music therapy has on the way a woman feels about herself. It is trying to find out whether music therapy can help a woman join in prison programmes and interventions.

2. **Invitation to participate**
   You are invited to participate in this research project.

3. **Who is organising the research?**
   This study is being organised by Helen Leith, Music Therapist at HMP Bronzefield.

4. **What will happen to the results of the study?**
   The results of this study will form part of a PhD thesis. The material will be presented at academic and professional conferences and published in academic journals. Your name or personal details will not be mentioned.

5. **How is the research funded?**
   The research is funded by a Mobility Fellowship granted by Aalborg University, Denmark.

6. **Who can I contact for further information?**
   If you wish further information you can contact Helen Leith through Chaplaincy at HMP Bronzefield.

2 Draft Participant Information Sheet

Section B: Your Participation in the Research Project

1. **Why have I have been invited to take part?**

   You have been invited to take part because you have put in a General Application for music therapy or because a member of staff has referred you to music therapy

2. **Can I refuse to take part?**

   Yes, you can refuse to take part in the study. This will not affect your management. If you would like music therapy but do not want to take part in the study you will be offered a regular place for music therapy as long as you have been assessed as suitable for music therapy. If there isn't a free place you will be put on the waiting list.

3. **Can I opt out at any time, and how?**

   Yes, you can opt out of the study at any time. You do not have to give any reasons. Just tell the researcher that you want to stop taking part. The form at the bottom of the Consent Form will help you do this. Opting out of the study will not affect not affect you prison status, management or sentance plan. It will also not effect your music therapy. If you want you can continue to attend music therapy until you are ready to end therapy.

4. **What will happen if I agree to take part?**

   - If you agree to take part you will be invited to a meeting with the music therapist. The meeting will take about 45 minutes. You can ask any questions you have about music therapy, and about the study. You will be asked to complete a questionnaire. This will help the music therapist understand how you feel about yourself and what you feel your difficulties are. You will be asked to fill in the same questionnaire every 8 sessions for as long as you take part in the programme. A copy of the questionnaire is attached to this Information Sheet for you to look at.
   - You will be asked to meet with an independent research assistant twice; once before you start and once after you end the programme. She will interview you to hear about what you want and expect from music therapy and what you think about the programme. These interviews will take about 45 minutes each. During the interviews you can say you do not want to answer a question. You can also stop at any point without giving a reason. The interviews will be recorded.
   - You will attend weekly one-to-one music therapy for as long as you and the music therapist agree is necessary. The music you make in music therapy sessions will be recorded.

5. **Are there any risks involved and if so what will be done to ensure my wellbeing/safety?**

   - Other prisoners might make comments. We will not tell other prisoners that you are taking part so that they cannot put you under pressure or make you feel uncomfortable.

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- Sometimes people feel distressed if they have discussed something painful in music therapy. If you are feeling distressed at the end of a music therapy session the music therapist will ask you who you would like her to get to support for you. This might be your ACCT manager, your spur officer or a prison chaplain, for example. She will also come and see you later in the day to see how you are coping.

6. How will confidentiality be safeguarded?

Your sessions will be treated in the same way as normal music therapy sessions. They will be confidential unless you tell the music therapist something that she has to pass on. This would be

- any behaviour that is against prison rules and can be adjudicated against
- anything related to child protection
- anything that threatens prison security

The music therapist might also have to break confidentiality if you tell her you are going to harm yourself or someone else or commit suicide. This is so that you can be helped and supported if you are feeling distressed.

7. How will anonymity be safeguarded?

We will not share information with prison or probation staff unless you would like us to. Your name will not be recorded on interview transcripts, questionnaires or audio recordings. A code number will be given to all data collected from you. Anything which might identify you will be removed before publication.

8. Are there any special precautions I must take before, during or after taking part in the study?

No, you don't need to do anything special at any stage during this study.

9. What will happen to any information/data that are collected from me?

- the interview recordings and transcripts will be kept safely and any details which could identify you will be taken out of the text.
- The questionnaire forms will kept safely. Your name will not be on the form and it will be given a code so that you cannot be identified.
- The recordings of music from music therapy sessions will be kept safely. They will be given a code so that you cannot be identified. Any speech will be deleted.

This is to make sure that you cannot be identified.

All data will be destroyed securely when the PhD has been finished in compliance with the Data Protection Act 1998.

4 Draft Participant Information Sheet

10. Are there any benefits from taking part?

There are no financial benefits or losses from taking part. However, you may find that you feel better and find it easier to cope. If you would like, we can let your Offender Manager know that you are taking part in the programme and that you have successfully completed it. This could be put on your sentance plan and OASYS Report.

11. How your participation in the project will be kept confidential

No one will be told that you are taking part unless there is someone you would like to know such as your Offender Manager.

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

Appendix B. Participant Consent Form

Department of Communication and Psychology
Kroghstraede 3
9220 Aalborg Øst
Denmark
Tlf. +45 9940 9940
Fax +45 9815 9434
inst-kom@hum.aau.dk
www.kommunikation.aau.dk

PARTICIPANT CONSENT FORM

NAME OF PARTICIPANT:

Title of the project:

Music Therapy and Women Prisoners

Main investigator and contact details:

Helen Leith
c/o HMP Bronzefield
Woodthorpe Road
Ashford
Middlesex
TW15 3JZ

Supervisors:

Prof Helen Odell-Miller, PhD
Deputy Head of Music and Performing Arts Department
Principal Lecturer MA Music Therapy
Anglia Ruskin University
Cambridge

Assoc. Prof Niels Hannibal, PhD
Institute for Communication and Psychology
International PhD Programme in Music Therapy
Aalborg University
Denmark

1. I agree to take part in the above research. I have read the Participant Information Sheet. I understand what I will be doing in this research. All my questions have been answered.
2. I understand that I am free to stop taking part in the research at any time. I do not have to give a reason and it will not affect my management.
3. I have been told how the information I give will be taken care of confidentially and how my identity will be protected.
4. I am free to ask any questions at any time before and during the study.

5. I have been given a copy of this form and the Participant Information Sheet.
6. I understand that this work may be published for academic purposes but that all identifying factors will be disguised.

Data Protection: I agree that the personal data which I give can be processed. This will be for purposes connected with the Research Project only and in compliance with the Data Protection Act (1998).

Name of participant (print).....

Signed..... Date.....

Name of witness (print).....

Signed..... Date.....

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

If you want to stop taking part in the research, please complete the form below and return to Helen Leith.

Title of Project:

Music Therapy and Women Prisoners

I WISH TO OPT OUT OF THIS STUDY

Signed: _____ Date: _____

Appendix C. Rosenberg Self-esteem Scale

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ROSENBERG SELF-ESTEEM SCALE

	STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree
1.	I feel that I am a person of worth, at least on an equal plane with others.	○	○	○	○
2.	I feel that I have a number of good qualities..	○	○	○	○
3.	All in all, I am inclined to feel that I am a failure.	○	○	○	○
4.	I am able to do things as well as most other people.	○	○	○	○
5.	I feel I do not have much to be proud of.	○	○	○	○
6.	I take a positive attitude toward myself.	○	○	○	○
7.	On the whole, I am satisfied with myself.	○	○	○	○
8.	I wish I could have more respect for myself.	○	○	○	○
9.	I certainly feel useless at times.	○	○	○	○
10.	At times I think I am no good at all.	○	○	○	○

http://www.wwnorton.com/college/psych/psychsci/media/rosenberg.htm

Appendix D. Staff Observation Questionnaire

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LEQ-ROPELOC/YAR-PET INDEPENDENT EVALUATION TOOL
Observer Sheet

Observer Nr: **Participant Nr:**

Postition: **Date:**

Relation to prisoner

(e.g. ACCT manager, Personal Officer, Spur Officer etc)

INSTRUCTIONS: Described below are 24 different aspects of an individual's personal and social capacities. Please rate YOUR PERCEPTION of the degree to which the prisoner appears to be effective in each of the areas. Simply rate based on what you have observed of her - do not discuss with other members of staff. Writing your ratings in the boxes, using a scale from 1 to 8, as follows:

False	More false than true		Neither true or false		More true than false		True
1	2	3	4	5	6	7	8

	AREA OF PERSONAL DEVELOPMENT	RATING
1.	**Group work** Is able to integrate into a group and contribute appropriately	
2.	**Self Efficacy** Is able to handle things and find solutions in difficult situations	
3.	**Effective leadership** Leads effectively when a task needs to be done	
4.	**Locus of control** Believes that her actions and efforts determine what happens to her	
5.	**Active Involvement** Uses action and energy to make things happen	
6.	**Open Thinking** Shows openness and adaptability in thinking and ideas	

False	More false than true		Neither true or false		More true than false		True
1	2	3	4	5	6	7	8

7.	**Achievement motivation** Puts effort into achieving the best possible results	
8.	**Self-Confidence** Has confidence and belief in her personal ability to be successful	
9.	**Social Effectiveness** Is competent and effective when communicating and operating in social situations.	
10.	**Stress Management** Is able to remain calm and in control of herself in stressful situations	
11.	**Time efficiency** Is able to plan and manage her time efficiently	
12.	**Coping with Change** Is able to cope with change	
13.	**Overall effectiveness** Is effective in all aspects of life	
14.	**Problem Solving** Is effective in addressing her problems	
15.	**Ability to Set & Achieve Goals** Is effective at setting and achieving goals	
16.	**Conflict Resolution** Effectively heads off and resolves interpersonal and group conflicts	
17.	**Communication skills** Communicates effectively in interpersonal and group settings	
18.	**Respect and Personal Boundaries** Appropriately respects personal space, touch, and rules of conduct	
19.	**Self-Esteem** Shows a sense of personal worth and value	
20.	**Self awareness** Is able to identify how she is feeling and communicate this appropriately to others	
21.	**Empathy and awareness of others** Shows an awareness of other people's feelings and needs. Is able to identify with other people's experiences	
22.	**Reflectivity** Uses journaling to reflect on her experiences	
23.	**Creativity** Expresses thoughts and feelings creatively such as through art, music, drama	
24.	**Healthy risk-taking** Takes healthy risks (not too risky, not too cautious) for the sake of her health and well-being	

Appendix E. Self-report Questionnaire

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Final version 27/05/2011

LEQ-ROPELOC/YAR-PET – Participant Sheet

Participant Nr: **Date:**

PLEASE READ THESE INSTRUCTIONS FIRST
This is not a test - there are no right or wrong answers.

This is a chance for you to look at how you think and feel about yourself. It is important that you:

- are honest
- give your own views about yourself, without talking to others
- report how you feel NOW (not how you felt at another time in your life, or how you might feel tomorrow)

Your answers are confidential and will only be used for research. Your answers will not be used in any way to refer to you as an individual.

Use the eight point scale to indicate how true (like you) or how false (unlike you), each statement over the page is as a description of you. Please do not leave any statements blank.

False Not like me						**True Like me**	
1	2	**3**	**4**	**5**	**6**	**7**	**8**
This statement doesn't describe me at all. It isn't like me at all		More false than true		More true than false		This statement describes me very well. It is very like me.	

SOME EXAMPLES

A. I am a creative person. 1 2 3 4 5 (6) 7 8

(The 6 has been circled because the person answering believes the statement "I am a creative person" is sometimes true. That is, the statement is sometimes like him/her.)

B. I am good at writing poetry. 1 (2) 3 4 5 6 7 8

(The 2 has been circled because the person answering believes that the statement is mostly false as far as he/she is concerned. That is, he/she feels he/she does not write good poetry.)

C I enjoy playing with pets. 1 2 3 4 5 ~~(6)~~ (7) 8

(The 6 has been circled because at first the person thought that the statement was mostly true but then the person corrected it to 7 to show that the statement was very true about him/her.)

If still unsure about what to do, ASK FOR HELP.

1

False Not like me						True Like me	
1	2	3	4	5	6	7	8
This statement doesn't describe me at all. It isn't like me at all		More false than true		More true than false		This statement describes me very well. It is very like me.	

STATEMENT		FALSE Not like me							TRUE Like me
CI01	When I have spare time I always use it to paint	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
GW02	I cooperate well when working in a group	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
SEF03	No matter what happens I can handle it	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
LC04	I believe I am responsible for all my actions	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
AI05	I prefer to be actively involved in things	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
OT06	I am open to new thoughts and ideas	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
AM07	I try to do the best I possibly can	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
SC08	I know I have the ability to do anything I want to do	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
SE09	I am confident in social situations	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
SM10	I can stay calm in stressful situations	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
TE11	I use my time well	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
CC12	I cope well when things change	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
OE13	Overall, in all things in life I am effective	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
PS14	I work hard at solving what's causing me problems	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*

STATEMENT		FALSE Not like me							TRUE Like me
GS15	I have specific goals to aim for	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
CR16	I resolve my conflicts with other people	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
CS17	People understand me when I am talking	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
RPB18	I behave appropriately towards other people	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
SES19	Overall I have a lot to be proud of	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
SA20	I understand myself	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
EAO21	I am aware of other people's feelings	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
RF22	I write about my thoughts or feelings in a journal or in poetry	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
CSE23	I have lots of creative ways to express my thoughts and feelings	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
RT24	I am good at deciding whether a risk is worth taking	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
CI25	I solve all mathematics problems easily	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
GW26	I am good at cooperating with other people	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
SEF27	I can handle things no matter what happens	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
LC28	If I succeed in life it will be because of my efforts	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
AI29	I like to be active and 'hands on'	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
OT30	I am open to different thinking if there is a better idea	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
AM31	I try to get the best results when I do things	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
SC32	When I put my mind to something I am confident I will succeed	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*

SE33	I am competent and effective in social situations	*1 2 3 4 5 6 7 8*
SM34	I stay calm when things go wrong	*1 2 3 4 5 6 7 8*
TE35	I plan and use my time efficiently	*1 2 3 4 5 6 7 8*
CC36	I cope well with changing situations	*1 2 3 4 5 6 7 8*
OE37	My overall effectiveness in life is high	*1 2 3 4 5 6 7 8*
PS38	I solve problems to the best of my ability	*1 2 3 4 5 6 7 8*
GS39	I prefer to set my own goals	*1 2 3 4 5 6 7 8*
CR40	If there is a conflict I try to improve the situation	*1 2 3 4 5 6 7 8*
CS41	I communicate well with people	*1 2 3 4 5 6 7 8*
RPB42	I have problems respecting other people's personal space	*1 2 3 4 5 6 7 8*
SES43	Most things I do I do well	*1 2 3 4 5 6 7 8*
SA44	I know what makes me tick	*1 2 3 4 5 6 7 8*
EAO45	Sometimes I don't understand other people's needs	*1 2 3 4 5 6 7 8*
RF46	I use a journal as a way of coping with things that are happening to me	*1 2 3 4 5 6 7 8*
CSE47	I have difficulty finding creative ways to express myself	*1 2 3 4 5 6 7 8*
RT48	I avoid actions which risk my health and well-being	*1 2 3 4 5 6 7 8*
CI49	I prefer things that taste sweet instead of bitter	*1 2 3 4 5 6 7 8*
GW50	I like working and learning with other people	*1 2 3 4 5 6 7 8*

SEF51	No matter what the situation is, I can handle it	1 2 3 4 5 6 7 8
LC52	My own efforts and actions are what will determine my future	1 2 3 4 5 6 7 8
AI53	I like being active and energetic	1 2 3 4 5 6 7 8
OT54	I find it difficult to change the way I think about things	1 2 3 4 5 6 7 8
AM55	In everything I try to do my best to get the details right	1 2 3 4 5 6 7 8
SC56	I believe I can do almost anything I set out to do	1 2 3 4 5 6 7 8
SE57	I communicate effectively in social situations	1 3 4 5 6 7 8
SM58	I can stay calm and overcome anxiety in almost all situations	1 2 3 4 5 6 7 8
TE59	I am efficient in the way I use my time	1 2 3 4 5 6 7 8
CC60	When things around me change I cope well	1 2 3 4 5 6 7 8
OE61	Overall in life I am a very effective person	1 2 3 4 5 6 7 8
PS62	I am effective at solving what is causing me problems	1 2 3 4 5 6 7 8
GS63	Having goals makes my life more satisfying	1 2 3 4 5 6 7 8
CR64	I can't deal with conflict	1 2 3 4 5 6 7 8
CS65	I understand other people when they are talking to me	1 2 3 4 5 6 7 8
RPB66	I understand issues of personal space, touch and appropriate behavior toward other people	1 2 3 4 5 6 7 8
SES67	Overall, most things I do turn out well	1 2 3 4 5 6 7 8
SA68	I find it difficult to understand myself sometimes	1 2 3 4 5 6 7 8
EAO69	I am quite aware of how other people are feeling and what they are thinking about	1 2 3 4 5 6 7 8
RF70	I enjoy using a journal to think about what is going on in my life	1 2 3 4 5 6 7 8

CSE71	**I express my thoughts and feelings creatively through things such as music, art, poetry**	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***
RT72	**I balance my risk-taking – I am neither too risky nor too cautious**	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***

SUMMARY

This book explores the interface between music therapy and resettlement. It will be of interest to music therapists working forensic settings, particularly for those working with women in prison. This book is also for those interested in gender-specific resettlement questions and in the resettlement of women prisoners in particular. It will give music therapists, forensic psychologists and others working in the field an insight into the workings of music therapy with this complex population.

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