

ARTICLE

Process and experience of change in the self-perception of women prisoners attending music therapy: The qualitative results of a mixed-methods exploratory study

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ABSTRACT

Women form a minority (4.8%) 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 mental disordered offenders, there is a dearth of music therapists working in UK prisons. There is correspondingly little research into music therapy and women prisoners.

The current article presents the qualitative results of a mixed-methods doctoral study carried out by Dr Helen Leith (2014). Using qualitative data, the 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. Findings for 10 participants indicated that women prisoners attending music therapy experience a change in self-perception and engagement in music therapy translated into behavioural change outside the music therapy room. Through adaptive interpretative phenomenological analysis of semi-structured interviews, themes indicated that 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 programmes improved.

For severely disaffected prisoners, music therapy provided an appealing and motivating intervention, which served as an entry point to other programmes required for resettlement. Women prisoners not only showed an enhanced ability to attend the programmes required for their successful resettlement; music therapy created aspirations, which is of significance to downstream outcomes.

KEYWORDS

forensic music therapy,
women prisoners,
self-perception,
song-writing

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AUTHOR BIOGRAPHIES

The late **Helen Leith** was born in 1958. She studied bassoon and piano at the Musikhochschule Detmold, Germany. She later worked as a youth worker with young German women in France and Great Britain. For 25 years, Helen was a nun in a residential order in London. In 2005, Leith gained her Master in Music Therapy at Nordoff Robbins, London. She worked with women prisoners, from 2008 until her illness took hold, as 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 to undertake doctoral research, the qualitative results of which are reported in this article. Sadly, Leith died in 2014, shortly after having delivered her public PhD defence in Cambridge. In a tribute to Leith, it was written that there is 'no doubt that Helen has made an enormous impact on the prison [in which this research is based], not only in her music therapy work in the room with women, but also within the prison itself'. **Helen Odell-Miller** OBE is Director and Founder of The Cambridge Institute for Music Therapy Research at Anglia Ruskin University, Cambridge, UK. She undertook her PhD at Aalborg University, Denmark, and previously gained an MPhil from City University, in 1988. She trained as a Music Therapist at the Guildhall School of Music and Drama in 1976 and was a supervisor for Dr Helen Leith's PhD. [helen.odell-miller@anglia.ac.uk] **Jodie Blosska** is a Music Therapist and Clinical Research Fellow at The Cambridge Institute for Music Therapy Research. She studied Music Cognition and Psychology at McMaster University in Canada, where she obtained her BMus, before completing her MA in Music Therapy at Anglia Ruskin University in 2015. [jodie.bloska@anglia.ac.uk] **Clara Browning** is a Music Therapist working for Methodist Homes (MHA) and a special needs school in Cambridgeshire. She was previously a music therapy research assistant at Anglia Ruskin University, when she contributed to the work of this article. She studied Music at the University of Durham and completed her Masters in Music Therapy in 2017. [clara.browning@mha.org.uk] **Niels Hannibal** was born in 1960 in Copenhagen, Denmark. He graduated as a Music Therapist from Aalborg University in 1994 and defended his PhD in the same place in 2001. He is an Associate Professor in Music Therapy at Aalborg University, and was supervisor for Dr Helen Leith during her PhD research. Since 1995, he has worked as a Music Therapist in psychiatry, which is also his primary area of research. [hannibal@hum.aau.dk]

Note by the first author: This article is based entirely on the original research undertaken by Helen Leith, as published in her PhD, and summarises the study in article form. The authors for this article have had different roles in relation to the original manuscript and the subsequent writing of the article. Helen Odell-Miller and Niels Hannibal were supervisors for Leith's PhD research and as such helped Leith throughout the whole research process. In that sense, we both feel ownership to Leith's work, and we are both proud and honoured to be associated with this research. In order to give Leith's 'voice' we have kept to the original text as far as possible. Jodie Blosska and Clara Browning, who have assisted with the manuscript, are from Anglia Ruskin University. The article has added material to the original text and incorporated our views and reflections in order to present the unique work Leith carried out prior to her death in 2014.¹ Leith was aware we would eventually publish some of her work, but she could not be listed as an author as, sadly, we had not started writing the article before she died. I am grateful to Niels Hannibal, the other supervisor of her PhD at Aalborg University, and to Jodie Blosska and Clara Browning from Anglia Ruskin University – where Leith's mobility PhD Fellowship was also based in the UK – who assisted with the manuscript. Leith's full thesis is freely accessible through Aalborg University (see Leith, 2014).

INTRODUCTION

Women form a minority (4.8%) in the UK prison system (Prison Reform Trust, 2013), which is predominantly designed for men (Caulfield, 2010; National Offender Management Service, 2012; Smee, 2009; van den Bergh, Gatherer, Fraser & Moller, 2011; Corston, 2007). The proportion of mental health problems in these women is inordinately high compared to the general population: 78% female prisoners in the UK show signs of psychological disturbance, compared with 15% in the general adult female population (Plugge, Douglas & Fitzpatrick, 2006). Despite evidence for necessary therapeutic input (Corston, 2007), the specific needs of women, which differ considerably from those of men (Howard, Clark & Garnham, 2006; National Offender Management Service, 2012), continue to be neglected within the prison system.

A previous study carried out in London by Helen Leith and Mercedes Pavlicevic (Nordoff Robbins Research Department, 2009, 2010) evaluated music therapy input targeting female (ex-) offenders with emotional, psychological, mental health and/or substance misuse issues. The treatment programme offered music-therapeutic support to women who were struggling to engage with prison life and the resettlement process. It aimed to work with them during their passage through prison,

¹ See Atkinson et al. (2015) for a tribute to Helen Leith.

helping to support attitudinal change, and to encourage a readiness to engage with the resettlement pathway interventions² on offer within the prison. For those women released from prison, the project 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 used to help forge relationships between individuals and communities (Wood, 2006; Wood, Verney & Atkinson, 2004), thus promoting social inclusion. Overall, the major needs for the women seemed to be addressing psychological issues and self-esteem, reducing self-harm and enabling rehabilitation and resettlement.

The current article presents the qualitative results of a mixed-methods doctoral study undertaken by the late Dr Helen Leith (2014), which explored the process and experience of change in the self-perception of women prisoners attending music therapy. Dr Leith's results are outlined here by her doctoral supervisors, who supported her throughout the research process, and two research assistants who assisted with the manuscript. The authors' choice to report the qualitative results from Leith's study is based on her own emphasis on the interview data she collected, which was the primary focus of the research, where the quantitative data played a supplementary role. The authors present an abridged version of Leith's doctoral thesis, where her own words are presented with limited additional inclusions or alterations.

Leith's (2014) doctoral thesis focused upon music therapy as a unique treatment modality – active and perceptive simultaneously (Aldridge, 1996) – with a capacity to bypass verbal processing, directly access emotional components of self (Magee, 2002), allow issues to emerge in a non-threatening way (Allen, 2010) and embody concepts of self (Magee, 1999). Self-concept has been the focus of numerous music therapy studies with a wide range of client groups (Ahmadi, 2011; Aldridge, 1995; Aldridge, Schmid, Kaeder, Schmidt & Sawyer, 2005; Bensimon & Gilboa, 2010; Chambers, 2008; Colwell, Davis & Schroeder, 2005; Johnson, 1981; Magee, 1999; 2002; Magee & Davidson, 2004; McFerran, Baker, Patton & Sawyer, 2006). However, at the time of Leith's research, the issue of self-concept within music therapy sessions for incarcerated women was a novel topic. This is an important area of exploration considering 53% of women in the criminal justice system report having experienced emotional, physical or sexual abuse as a child, and over 50% have been victims of domestic violence (Prison Reform Trust, 2010; 2013; National Offender Management Service, 2012; Smee, 2009). Such experiences can have a profound influence on an individual's self-concept; identity can become a central issue for people affected by trauma, adverse life events or a life situation in which they experience themselves as labelled or stigmatised (e.g., 'offender') (Chambers, 2008).

In music therapy and psychology literature, the term self-perception is often used interchangeably with a number of synonyms (e.g., self-concept, self-image, self-identity, self-schema, etc.). Exploration of literature and consideration of the best approach to take resulted in Leith (2014, p. 51) defining self-perception 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)

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 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)

Leith (2014, pp.28-40) undertook a comprehensive literature review, covering three demographics of female prisoners: prison, forensic psychiatry, and juvenile offenders/at-risk youth. She was able to conclude that, within these three demographics, music therapy can contribute to development in the following areas:

- Interpersonal skills and relationships
- Personal development
- Sense of identity
- Emotional regulation and coping skills
- Alleviation of psychiatric symptoms
- Connection with reality in the here and now
- Insight
- Locus of control

Music therapy in correctional and forensic psychiatry has been seen to alleviate symptoms of mental illness (Coddling, 2002). This is in line with findings from research in general psychiatry (Gold, Heldal, Dahle & Wigram, 2005; Gold, Solli, Krüger & Lie, 2009), where music therapy has been seen to have the capacity to enhance functioning, reduce disability effects of mental illness and decrease the number and length of depressive episodes. It is also considered to provide valuable links to reality, where the concrete medium of physically playing an instrument may help 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, has 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).

Music therapy has been found to facilitate the reduction of stress and anxiety, allow for the constructive release of emotions and target realistic, time-limited goals (Gallagher & Steele, 2002; Loth, 1996; Thaut, 1989). For mentally ill offenders with limited insight and verbal capacity, it can offer a non-verbal means of self-expression and allows a space to reflect on interpersonal behaviour, acknowledge negative feedback and gain insight into learned patterns of behaviour (Cohen, 1987; Smeijsters et al., 2011). Music therapy sessions could challenge a prisoner's sense of identity (O'Grady, 2009) and facilitate the search for positive alternative self-concepts (Hoskyns, 1995), as it can offer an experimental play space where learned patterns of behaviour can be explored and new ways of functioning can be experimented with. Chambers (2008) discusses the development and maintenance of a self-identity that is personally acceptable as a "mega-conflict" (p.356) for those living within the cultural constraints of an institutional life. The author found that the use of pre-composed songs in music therapy contributed towards the resolution of this conflict, by facilitating the creation of an alternative identity so that the individual was no longer solely defined by their label of mentally disordered offender.

Within the general prison population, music therapy has been found to create a bridge between subjective and objective thought processes (O'Grady, 2009), help 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 imposes (O'Grady, 2009). It has also helped to create and nurture links between 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 also related 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; the music therapy sessions enhanced the capacity to self-reflect on personal coping mechanisms, behavioural problems and the individual's index offence. Furthermore, reflection on interpersonal behaviour can facilitate the development of social and communication skills (Skylstad, 2009), which could potentially have a beneficial impact on relationships.

Music therapy goals with young offenders and youth-at-risk shares the aims and objectives of music therapy with the adult population in both prison settings and forensic psychiatry. Music therapy has been found to provide a relaxing and playful supplement to cognitive behavioural programmes (Smeijsters et al., 2011; Wyatt, 2002). It addresses immediate issues such as accessing and expressing feelings, managing volatile emotions and decreasing hostile behaviour. However, it can also address longer-term outcomes by helping 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).

The unique capabilities of music therapy, the high percentage of victimised women in prison and the stigma surrounding incarceration call for further research into the self-perception of women prisoners attending music therapy.

This article has been published on behalf of the late Helen Leith (the main researcher) by her supervisors, Helen Odell-Miller and Niels Hannibal, and music therapy research assistants Clara Browning and Jodie Bloska. Ethical approval was granted by Anglia Ruskin University and the National Research Ethics Service Committee East of England, Essex, in 2011.

OBJECTIVES

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. The present study investigated the process and experience of change in the self-perception of women prisoners attending music therapy. Specifically, the research sought to answer the following questions:

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?

These questions sought to explore the phenomenon of change in self-perception as a dynamic process. In her full dissertation, Leith (2014) further aims 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.

Repertory Grid

As the main researcher also was the music therapist on the project, The Repertory Grid (RepGrid) Technique (Kelly, 1955) was used to elicit some of the constructs underlying her understanding of music therapy and women prisoners. The interpretation of the data produced through the RepGrid interview (see Leith, 2014, pp. 45-49) aimed to explicate some of the implicit assumptions and

expectations she brought to the clinical work and research project. From the information gained from the interpretation of the data analysis, Leith (2014, p. 49) extrapolated 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.

Study design

Leith (2014, p. 50) explained that including both qualitative and quantitative data in her study would help minimise personal bias and counterbalance strengths and weaknesses in her design. Minimising bias is, of course, an issue, given the fact she was both therapist creating the data and researcher analysing the same data. This resulted in the overall mixed-method strategy. The study followed a flexible mixed-methods study design (Robson, 2002), incorporating both qualitative and quantitative data. The data were collected concurrently, and the primary focus was on the qualitative data. This means that the analysis of interview data is the primary source, whilst questionnaires and other information had supplementary value to the overall findings and conclusions.

Retrospectively the mixed-method design showed to be an eminent choice, as Leith could use the findings to build her discussion, argumentation for her findings and her conclusion. This analysis and discussion is in the authors' view done, as can be seen further in the text, with transparency and clarity; which shows the high standard of Leith's ability to navigate between being engaged as a therapist but also being respectful to the findings. She also illustrated how to utilise the RepGrid analysis as a means to avoid bias influencing the study in a harmful way.

METHODS

Participants

Twenty-two participants were recruited to the programme; 12 were unable to complete due to various reasons (transferred out of prison [4], mental health [1], conflicting schedules [1], unmanageable risk [2], incomplete data [1] and other unknown reasons [3]). Ten participants were therefore included in the final results (see Table 1 for details). Potential research participants either 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. The following prisoners were eligible for inclusion in the study:

1. Prisoners of all categories (remand, convicted, sentenced, lifers, Indeterminate Public Protection prisoners, Prolific and Priority Offenders, Restricted Status prisoners)
2. Prisoners with mental health difficulties (e.g. anxiety/mood/traumatic stress, personality and bipolar disorders, schizophrenia, depression, parasuicidal behaviour, substance misuse)

- Prisoners showing self-isolating or challenging behaviour, and prisoners with no access to other activities due to their Restricted Status

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 of foreign languages. However, those suffering from mental health problems or struggling to survive within the prison system were prioritised for a non-research place.

Music therapy sessions

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. The participants attended weekly or biweekly individual music therapy sessions of 45 minutes in length. For the purposes of this study music therapy lasted between eight sessions and 12 months. If needed, the individual could continue to attend music therapy after completing the study. Participants were encouraged to structure the sessions according to their needs. Many participants 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. Others were intent on losing 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-making in later sessions. A number of music therapy methods were used in the sessions. The choice of content was entirely client-led and song-writing was the method most frequently chosen (see Figure 1).

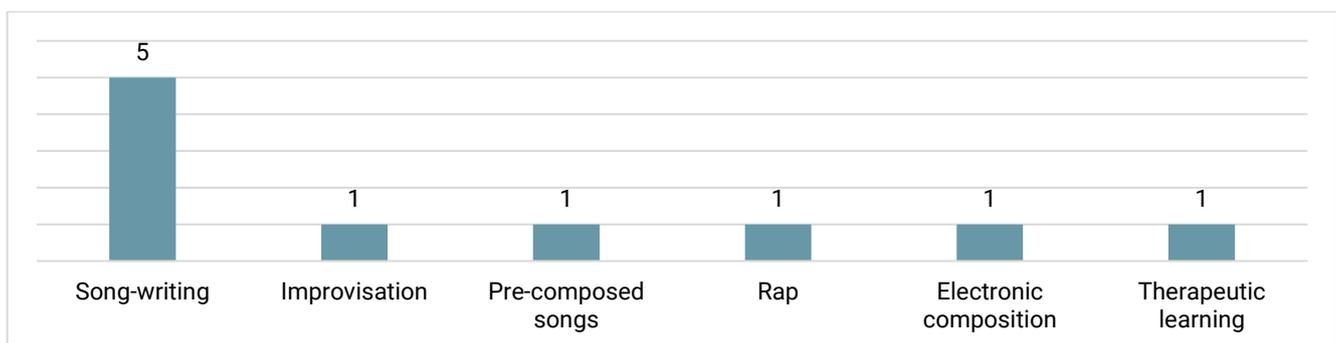


Figure 1: Clinical methods

Semi-structured interviews

Research participants took part in pre-, mid-, and post-treatment semi-structured interviews in order to capture the individual participant's experience and process in music therapy, their relationship to music, their change in self-perception and their engagement or non-engagement in prison

interventions. Participants in short-term therapy, lasting 8 weeks, were interviewed pre- and post-treatment. Participants in long-term therapy 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 (pre-treatment and 8 weeks). The length of interviews varied from 16-52 minutes. The following table gives relevant background information on the research participants, the clinical method they engaged in and the interviews they completed:

ID	Duration	Referral reasons	Clinical method	Offence	Age	Interviews
A	12 months	Isolation	Electronic composition	VATP [†]	30-39	PreT/8wk/PostT
B	11 months	Bereavement	Therapeutic Learning	VATP	50-59	PreT/8wk/PostT
C	10 months	Parasuicidal behaviour, isolation	Song-writing	VATP	40-49	PreT/8wk
D	9 months	Parasuicidal behaviour	Improvisation, song-writing	Drugs	30-39	PreT/8wk/PostT
E	8 sessions	Bereavement	Song-writing	Drugs	21-29	PreT/PostT
F	6 months	Parasuicidal behaviour, isolation	Singing pop songs	VATP	18-20	PreT/8wk/PostT
G	6 months	Bereavement, isolation	Song-writing	Drugs	40-49	PreT/8wk/PostT
H	8 sessions	Child adoption	Song-writing	Drugs	30-39	PreT/PostT
I	8 sessions	Relational problems	Rap	Burglary	18-20	PreT/PostT
J	4.5 months	Child adoption	Did not engage	Drugs	30-39	PreT/PostT

Table 1: Participant demographic information (Note: Participants C, D, E, F, G and J were selected for interview analysis)

[†]Violence Against the Person (VATP)

The choice of semi-structured interviews allowed the interviewers to be guided by the interview schedule rather than constrained by it (Smith, 2003), and enabled them to probe interesting areas that emerged in conversation. Research assistants were 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, and avoid bias. Participants were interviewed by the same research assistant for all of their interviews to facilitate the building of trust and to allow for

follow-up questions relating to previous interviews. The interview schedule was designed to cover the following topics linked to the research questions:

1. Music in everyday life (role, musical preferences, previous musical experience)
2. Self-description (strengths, difficulties, areas of desired change)
3. Engagement in resettlement programmes (employment, programme attendance)
4. Music therapy (expectations, fears, outcomes)

Questionnaires

Whilst the current article does not report the questionnaire data, it makes reference to the questionnaires in relation to the selection of semi-structured interviews for analysis. Self-report and staff observation questionnaires included:

- The Rosenberg Self-Esteem Scale (Rosenberg, 1965); a self-report scale used to measure self-esteem
- The Life Effectiveness Questionnaire (adapted to include both the YAR-PET [Youth at Risk Program Evaluation Tool] and the ROPELOC [Review of Personal Effectiveness and Locus of Control] versions) (Neill, Marsh & Richards, 2003). These provide both a self-report and staff observation scale to measure personal change in the following areas: personal abilities and beliefs, social abilities, organisation skills, active initiative/involvement, overall life effectiveness, internal/external locus of control, community engagement, communication skills, problem solving, goal setting, conflict resolution, respect and personal boundaries and self-esteem

The questionnaires were administered at baseline, session 4, session 8 and then every 8 sessions until the participant exited from the study. A final measurement when the participant exited the study completed the administration.

DATA ANALYSIS

Selection criteria

The semi-structured interview data of six participants were selected for thematic analysis (see Table 1). Adapted methods based upon Interpretative Phenomenological Analysis (IPA) (Smith, 2003) were used to analyse and interpret the data. These cases represented different treatment lengths and reflected proportionately the engagement of participants with varying music therapy methods.

The selected interviews provided four case samples of participants who engaged well with the therapeutic process (C, D, F, and G). One case (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 inconsistencies or contradictions with regard to the validated self-report questionnaires also used in the study. 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, as cited in Barbour, 2001, p. 1116). 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 in 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.

Thematic coding

In order to guard against 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 worked as a team. They both undertook the thematic coding of the interviews. Extensive 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 (for further information, see Leith 2014, p. 92). 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

Within participant analysis

Both researchers collated two tables for each participant, one for self-perceptions and one for music (see Figure 2). 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 subcategories. 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 participants' 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' (see Leith, 2014, p. 83, 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 (pre-treatment, eight weeks or post-treatment) (see Figure 2).

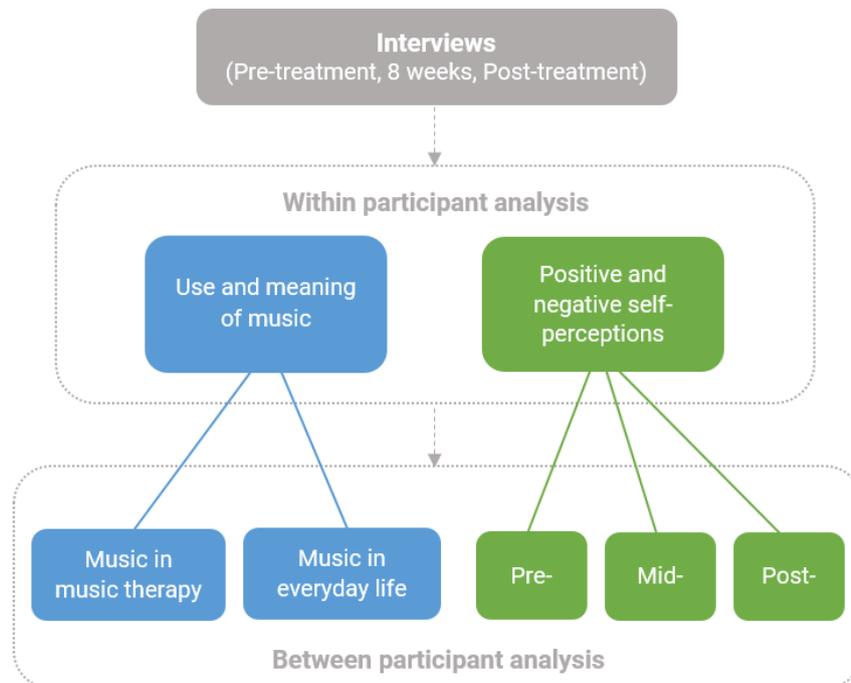


Figure 2: Coding themes and categories

RESULTS: SELF-PERCEPTION

The questions relating to topic 2 of the interview schedule (self-description) 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:

I tend to mix really well with people. I don't ever go out. When I'm here, I'm always in my cell. (Participant G, 1st interview)

To get an in-depth understanding of how participants experienced and perceived themselves, inference 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 (see Figure 3). Participants C, D, E, G, and 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 developed maladaptive behaviours to help them survive in dysfunctional families. These can be categorised as 'internalising' and 'externalising' behaviours.

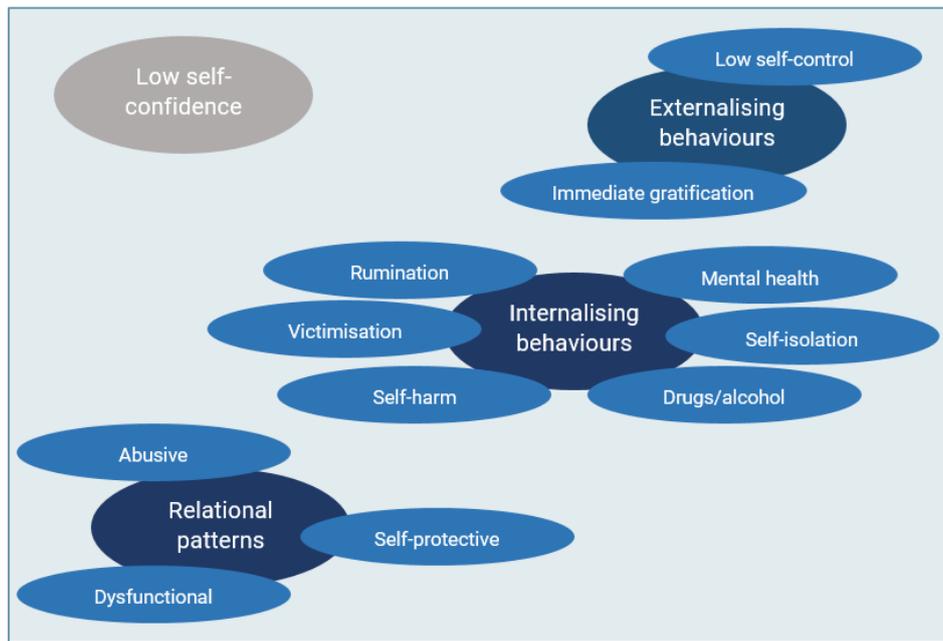


Figure 3: Self-perception categories and subcategories

Internalising behaviours

Internalising behaviours are characterised primarily by processes within the self where the experience of problematic emotions and energy are directed inwards (Matsumoto, 2009). Participants C, D, E, F, G, and J mentioned six core areas of internalising behaviours in their pre-treatment interviews (see Figure 4). 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.

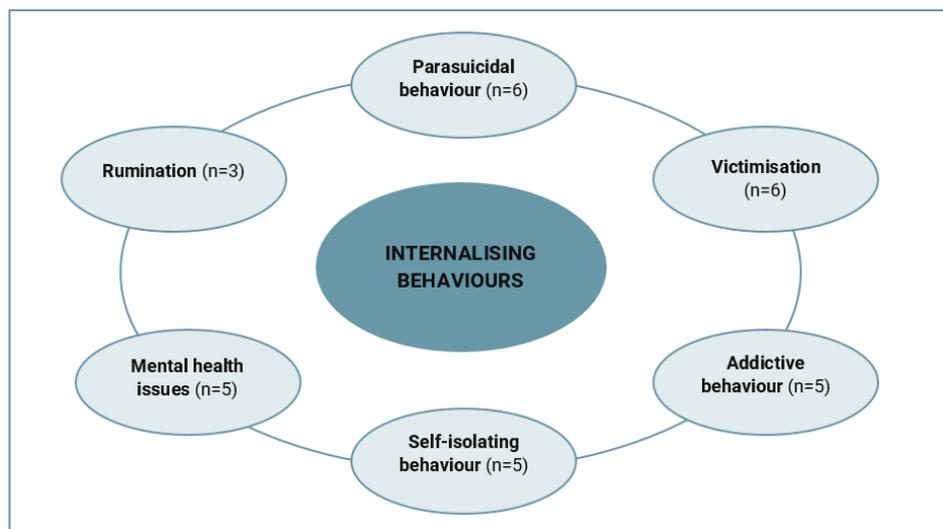


Figure 4: Pre-treatment internalising behaviours (n = number of interviewees mentioning a theme [a total of 6])

Parasuicidal behaviour

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 (National Health Service, 2018). 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. Table 2 reports on participants’ 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	Five-six 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 age eight	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

Table 2: Pre- and post-treatment parasuicidal behaviour

Pre-treatment, participants C, D, E, G, and 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. This included both suicide attempts and self-mutilation, often on a prolific scale, as well as drug use or risky behaviour. Participant G had extended periods when she was free of parasuicidal behaviour and only self-harmed in response to negative life events.

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

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 months so far I haven’t self-harmed. (Participant D, 2nd interview)

And they saw this in relation to their engagement in music therapy:

It [music therapy] stopped me self-harming. (Participant E, 2nd interview)

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. (Participant F, 2nd interview)

Addictive behaviours

Another self-destructive behaviour was the use of chemical substances and/or alcohol to self-medicate. Pre-treatment, participants C, D, E, F, and 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:

I think I used drugs to block out the fact that I felt different. (Participant D, 1st interview)

I used drugs to suppress feelings about my mum. (Participant E, 1st interview)

I find it so hard to deal with all those emotions, which is why I've suppressed it for so long with drugs. (Participant J, 2nd interview)

In addition to this, participants C and 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. Table 3 below reports on participants' pre- and post-treatment addictive behaviour:

ID	Pre-treatment	Post-treatment
C	Alcohol dependence, not engaging with programmes	Working with Alcohol Relapse Prevention team and Alcoholics Anonymous
D	Addictive eating behaviours, not engaging with programmes Chemical substance misuse, engaging with Counselling, Assessment, Referral and Throughcare (CARAT) drug treatment team	Working one-to-one with cognitive behavioural programme 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 Addictive eating behaviours	No change No change

Table 3: Pre- and post-treatment addictive behaviour

Victimisation, vulnerability to exploitation, locus of control

Participants also made statements indicative of victim mentality, much of which was on the relational levels of domestic, sexual, or emotional abuse. An overwhelming desire to fit in and be loved left participants vulnerable to abuse, and feelings of being judged or misunderstood could result in

defensiveness and mistrust. Table 4 below reports on participants' pre- and post-treatment victimisation behaviour:

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

Table 4: Pre- and post-treatment victimisation and locus of control

Post-treatment, participants who had previously been easily intimidated and victimised reported standing up for themselves:

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 ... we both made the steps of challenging these people but having to do it in a non-aggressive way. (Participant D, 3rd interview)

Participant D had become aware of her victim identity and the need to address it. There was a sense of pride and achievement in those who had learnt to stand up for themselves:

It's made me a much better person to think that I'm not going to do this [comply to others] no more. (Participant G, 2nd interview)

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

At first 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. (Participant D, 2nd interview)

Rumination

Pervasive negative thought patterns were experienced by participants C, D, and F:

“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” (Participant D, 2nd interview)

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

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. (Participant C, 2nd interview)

[Getting it down on paper] makes me sort of feel, well, things aren’t as bad as I might think they are. (Participant C, 2nd interview)

I have the logic now to be able to try and iron out my faults as I think of a song. (Participant F, 3rd interview)

Self-isolating behaviour

The participants found it difficult to join in general prison life and activities, and reacted to this by isolating themselves. Many of them were doing so-called ‘in-cell’ work, as they reported lacking the self-confidence to mix with other prisoners and engage with prison programmes:

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. (Participant F, 2nd interview)

Table 5 below reports on participants’ pre- and post-treatment self-isolating behaviour:

ID	Pre-treatment	Post-treatment
C	In-cell work	Engaging with Gym, Education and Programmes
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
F	In-cell work	Engaging with Education and Programmes
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

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

Post-treatment, participants C, F, and G reported that they had begun engaging in out-of-cell activities and mixing with other prisoners more:

Normally I'd just sit and observe, whereas now I interact a bit more ... 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. (Participant G, 3rd Interview)

Participant D reported feeling more confident about moving around the prison independently:

Before I was really scared to come off the wing, apart from when I used to come over for therapy ... [NAME] used to come and get me because I wouldn't come on my own, but, like, the last week or so I've been coming off the wing on my own ... I didn't even think about it. Normally I get quite panicky. (Participant D, 2nd Interview)

Mental health

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, and J's existence:

I think more than anything, it's more and more depression that plays a bigger part on my offending. (Participant J, 1st interview)

Post-treatment, participants C and D, who had reported feeling depressed, now said they were feeling happier:

I feel quite positive. I feel quite positive most of the time now. (Participant C, 2nd interview)

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. (Participant D, 3rd interview)

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

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. (Participant E, 2nd interview)

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. (Participant F, 3rd interview)

Externalising behaviours

Externalising 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 as a major issue underlying externalising 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.

Pre-treatment, all six participants 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. 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:

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... (Participant C, 1st interview)

Post-treatment, participants C, E, F, and G reported an increased ability to regulate their reactions in stressful situations:

Before, I would fly off the handle and start storming off and shouting and banging the doors ... 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] IEP³ (Participant C, 2nd interview)

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

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... (Participant F, 2nd interview)

Participant F saw this as a new coping mechanism:

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 (Participant F, 3rd interview)

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

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. (Participant D, 3rd interview)

³ 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.

Self-confidence

All six participants described themselves as lacking in self-confidence in their pre-treatment interviews. Participants C and F also mentioned having low self-esteem. In their mid-term and post-treatment interviews, participants C, D, E, F, and G reported feeling much more confident:

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. (Participant C, 2nd interview)

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. (Participant F, 2nd interview)

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

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 and [has been proposed] as a primary determinant of emotional and motivational states and behavioural change" (Matsumoto, 2009). Growth in perceived self-efficacy was relevant to individual participants' pathway through the custodial sentence:

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. (Participant C, 2nd interview)

Significantly, it was also relevant to downstream outcomes post-release:

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. (Participant F, 3rd interview)

Creative self-expression and musicality

Prior to music therapy sessions, some participants enjoyed creative activities, and one participant (F) defined herself in terms of her creativity and musicality. Others were more reticent and insecure:

I think I'm tone-deaf. So God knows what the music will sound like. (Participant C, 1st interview)

I was a little bit embarrassed because I'm not a singer or I ain't got a voice. (Participant G, 2nd interview)

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 G, 3rd interview)

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

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. (Participant C, 2nd interview)

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. (Participant G, 3rd interview)

They identified themselves with songwriters and musicians:

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. (Participant C, 2nd interview)

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 star or a musician, do you know what I mean? I was just, like, singing along and making it up as I go along. (Participant G, 3rd interview)

RESULTS: THE ROLE OF MUSIC

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 the participants, music played an important role in their everyday life:

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. (Participant F, 1st interview)

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... 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. (Participant F, 1st interview)

An analysis of the data showed six different functions of music in everyday life: relationships, memories, emotional regulation, communication, coping strategy and narratives (see Figure 5).

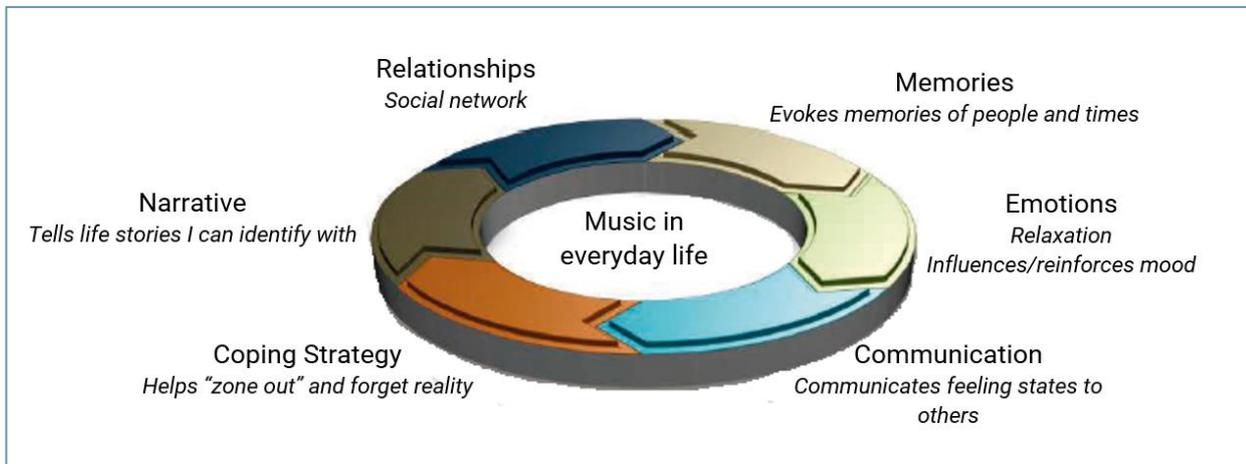


Figure 5: Functions of music in everyday life

Music in music therapy

Music as a medium in music therapy shared the six functions that music played in the everyday life of the participants. However, close analysis of the data revealed mechanisms specific to music therapy within these functions (see Figure 6). Additionally, a cluster of themes emerged around self-confidence and self-esteem, which were not evident in the data on music in everyday life.

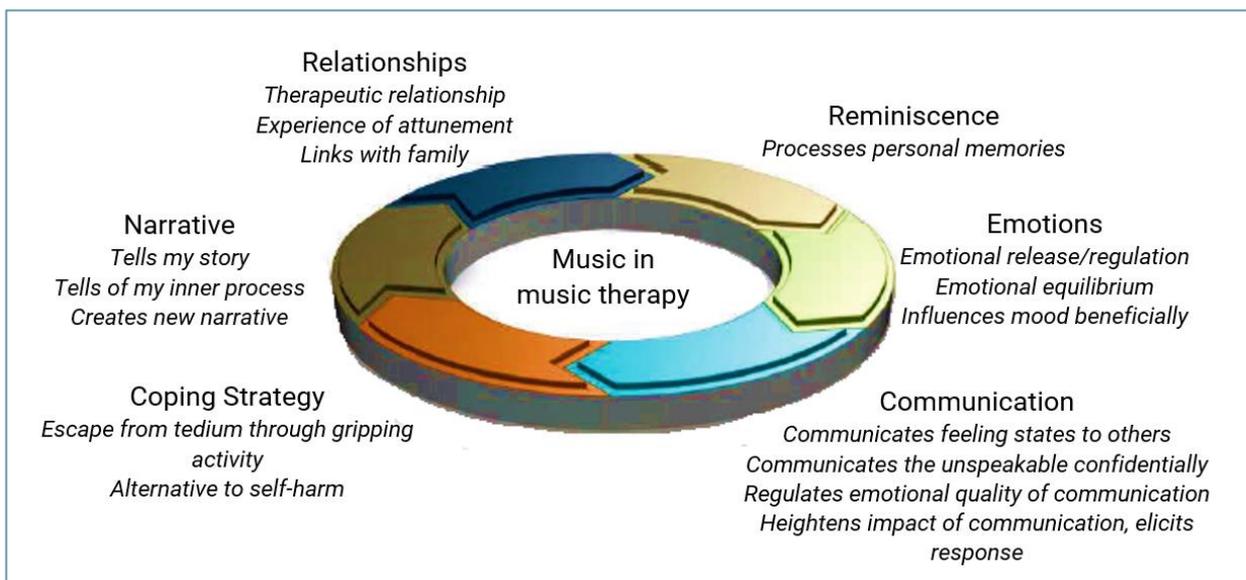


Figure 6: Functions of music in music therapy

Self-confidence

Eight elements of music in music therapy were identified that related to self-confidence outcomes: agency, healthy risk-taking, motivation, pleasure, sense of achievement, skill acquisition, purposeful activity, and perceived self-efficacy (see Figure 7). There was a complex interplay between the

individual elements. With the exception of Participant J, all participants reported a growth in self-confidence in their post-treatment interviews and linked this to the attendance of music therapy:

I never used to sing in front of every, anybody; now I sing in front of everyone.
(Participant F, 3rd interview)

[The music] made me more confident and more upfront. (Participant G, 3rd interview)

I've come out feeling really good, do you know what I mean? I feel confident like I said. (Participant D, 2nd interview)

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. (Participant C, 2nd interview)

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. (Participant E, 2nd interview)

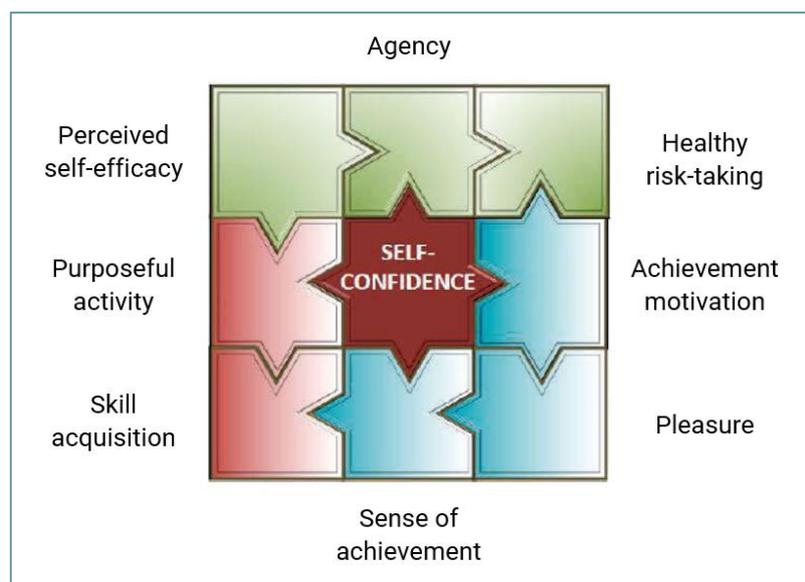


Figure 7: Self-confidence and related outcomes

SUMMARY OF FINDINGS

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. 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 internalising and externalising behaviours, were amenable to change.

There was indeed a positive change in the way that research participants saw themselves and this impacted on their ability to engage in prison interventions, but also had positive effects on other areas such as parasuicidal and challenging behaviour. These benefits appeared to be directly linked to

the use of music as a therapeutic medium in the sessions; indeed, the only participant who did not engage with the music also failed to make any significant changes in the way she saw herself. Although short-term therapy was not necessarily contraindicated, substantive gains were only made if a participant attended music therapy for more than three months. Short-term therapy required careful timing so as not to be subsumed by the overwhelming anxieties that arose pre-release.

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. An increase in self-perceived efficacy had implications for positive downstream outcomes, as a feeling of mastery in one domain, namely music, translated into a feeling of overall effectiveness. It could be hypothesised 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.

The findings from interview data revealed clear change in self-perception, whilst the questionnaire data was less convincing. However, it is possible that this subjective experience of change in self-perception was of crucial importance in helping research participants exit from their position of disengagement and start engaging with prison programmes. Data from the prison database on engagement patterns of individual research participants indicated clearly the positive impact change in self-perception had on participants' ability to renounce self-isolation and engage with prison programmes and resettlement interventions (see Leith, 2014, p. 131, Table 5-9).

DISCUSSION

The findings confirm a number of points highlighted by previous literature regarding music therapy for women prisoners. Music therapy, specifically in the form of song-writing, offered women prisoners an unparalleled opportunity to confront their often conflicted and painful pasts (Daveson & Edwards, 2001). Furthermore, sessions provided a relaxing and playful supplement to other verbal programmes (Smeijsters, Kil, Kurstjens, Welten & Willemars, 2011) and a creative 'play space' to explore alternative self-concepts (Hoskyns, 1995; O'Grady, 2009).

Music therapy was shown to have a positive effect on internalising and externalising behaviours. Not only did the sessions facilitate 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. There is a possible link between improved self-control and perceived self-efficacy in line with the mastery experience of music therapy, as shown in Pool and Odell-Miller's (2011) investigation into music therapy and aggression.

Whilst earlier studies did not examine whether behavioural gains made in these areas in sessions transferred to situations outside of music therapy (Coddington, 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 programmes and interventions.

The issue of positive self-identity was as central for prisoners as for other client groups affected by stigmatisation. The present study shows that song-writing can be a powerful tool in the process of recreating a positive sense of self and enabling women prisoners to gain a deeper understanding of their internal and external realities. The song-writing process seemed to enable the creation of a new narrative in the form of lyrics and music. Recent research suggests that identity in prisoners might be reconfigured when participants rediscover themselves through music and reconnect with parts of their identity related to being human, rather than being a prisoner (Tuadstad & O'Grady, 2013); when performing music, the participants experienced themselves as musicians rather than as criminals or prisoners. This was corroborated by the current study, where music therapy sessions were strongly linked to feelings of mastery, achievement, and pride.

Tuadstad and O'Grady's (2013) meta-synthesis also confirmed other findings of the current study, namely that music therapy functioned as a coping strategy, helping inmates escape the harsh realities of prison life. Additionally, they found that music therapy provided some prisoners with temporary respite from negative thoughts, traumas, and pains as well as offering an "alternative" reality, to momentarily "replace the need for drugs by providing an ecstatic, transcendent world of enjoyable musical experiences" (Tuadstad & O'Grady, 2013, 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.

LIMITATIONS

Analysis of the semi-structured interviews required extrapolation and thus this data could be less reliable and at risk of bias. However, due care was taken to extrapolate researcher bias and pre-understanding by employing independent researchers to assist with data collection and analysis. Additionally, cross-checking of the data-analysis by PhD supervisors and peer debriefing acted as a useful counterbalance against the dangers of over-interpretation of the data.

Attrition was a considerable issue during this project. Participants were transferred out without warning and 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 halfway through the project, when the prison agreed to put a hold on research participants until they had completed the programme.

The effect of observation bias 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. 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 prisoners elected to take part in the project, rather than being assigned to it.

This study was conducted solely by Helen Leith as music therapist and researcher. Her unique personality and musical skills must be considered an important factor in the therapeutic process and such factors are not discussed in this article. Her unique background of spending 20 years as a member of a Benedictine community gave her special prerequisite for empathising with this population (Leith, 2014, p. 42). Her way of initiation and building relationships with the woman was surely based also on these skills and experiences. However, it is important to notice that the women

actually described their relations to the music more than the relations to the therapist. This underlines how having music as a therapeutic intermediate medium between client and therapist is of importance to people who are so limited in their ability to engage and communicate their inner state of mind, regulate their emotional response and to learn from experience.

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 process is predictive of behavioural change in women prisoners attending music therapy
- 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 importance to positive downstream outcomes in women prisoners attending music therapy
- Song-writing is a particularly relevant clinical intervention for this population

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 the 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.

CONCLUSION

This study arose from Leith's clinical work with disengaged women prisoners. After a period in music therapy, she 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 programmes and interventions. Her experience of working with these women in and beyond prison in community settings taught her that their sense of identity was not only formed by their family and societal elements but also by their offending history. The qualitative results of her doctoral research indeed show a positive change in women prisoners' self-perception and the impact of this on their ability to engage in prison interventions and on their mental health.

The current findings are important as they correspond to areas considered to be of significance in gender-specific resettlement needs. Music therapy could be a necessary precursor to cognitive behavioural programmes if these were to be absolved successfully. Indeed, for severely demotivated

women prisoners failing to progress through the system, music therapy could act as entry point, creating the necessary preconditions for subsequent successful engagement with resettlement interventions.

If identity is the 'mega-conflict' conceived by Chambers (2008), music therapy offered participants an unparalleled 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 rewrite 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 of knowledge in the evidence base for music therapy in prisons. The findings indicate that music therapy contributes to the resettlement process and sits comfortably within either resettlement paradigm. Music therapy was able to address both criminogenic risk factors and protective factors simultaneously, adapting its focus to the requirement of the immediate moment. For disengaged, demotivated prisoners, music therapy offers a playful, enjoyable space in which they can acquire new skills without even being conscious of the fact. Music therapy is accepted more readily than more conventional programmes, perhaps due to the music therapist not being seen as a member of the regime as well as music appealing to most people. 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.

Leith embarked on this journey assuming music therapy offered a less-threatening alternative to verbal therapy. Following this research, she considered music therapy to be a starting point, a foot in the 'door' that is often kept resolutely closed to prison staff. She 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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Ελληνική περίληψη | Greek abstract

Η διαδικασία και η εμπειρία της αλλαγής στην αυτοαντίληψη φυλακισμένων γυναικών που παρακολουθούν μουσικοθεραπευτικές συνεδρίες: Τα ποιοτικά αποτελέσματα μιας διερευνητικής μελέτης μικτών μεθόδων

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ΠΕΡΙΛΗΨΗ

Οι γυναίκες αποτελούν μια μειοψηφία (4,8%) στο σωφρονιστικό σύστημα του Ηνωμένου Βασιλείου το οποίο έχει σχεδιαστεί κατά κύριο λόγο για άνδρες. Ένας μεγάλος αριθμός φυλακισμένων γυναικών έχει βιώματα ψυχικού τραύματος και κακοποίησης τα οποία κουβαλάει και εντάσσει στο σωφρονιστικό σύστημα. Η συχνότητα των προβλημάτων ψυχικής υγείας είναι δυσανάλογα υψηλή σε σύγκριση με τον γενικό πληθυσμό. Παρά την αύξηση του αριθμού των μουσικοθεραπευτών που εργάζεται στην εγκληματολογική ψυχιατρική [forensic psychiatry] στο Ηνωμένο Βασίλειο παρέχοντας θεραπεία σε ψυχικά διαταραγμένους παραβάτες, υπάρχει έλλειψη μουσικοθεραπευτών που εργάζονται στις φυλακές της χώρας. Αντιστοίχως οι έρευνες που αφορούν τη μουσικοθεραπεία σε σχέση με τις φυλακισμένες γυναίκες είναι ελάχιστες.

Το παρόν άρθρο παρουσιάζει τα ποιοτικά αποτελέσματα μιας διδακτορικής μελέτης με μικτές μεθόδους που πραγματοποίησε η Δρ. Έλεν Λιθ [HelenLeith] (2014). Χρησιμοποιώντας ποιοτικά στοιχεία, η μελέτη διερευνά το κατά πόσο υπάρχει αλλαγή στην αυτοαντίληψη των φυλακισμένων γυναικών που παρακολουθούν μουσικοθεραπευτικές συνεδρίες και, αν συμβαίνει αυτό, το κατά πόσο παρουσιάζουν μια βελτιωμένη ικανότητα ως προς τη συμμετοχή τους σε παρεμβάσεις επανεγκατάστασης. Τα ευρήματα που προέκυψαν από δέκα συμμετέχουσες έδειξαν ότι οι κρατούμενες που παρακολουθούν μουσικοθεραπευτικές συνεδρίες βιώνουν μια αλλαγή στην αυτοαντίληψη και ότι η εμπλοκή τους στη μουσικοθεραπεία μεταφράζεται σε συμπεριφορικές αλλαγές εκτός του μουσικοθεραπευτικού χώρου. Μέσω της προσαρμοστικής ερμηνευτικής φαινομενολογικής ανάλυσης [adaptive interpretative phenomenological analysis] ημιδομημένων συνεντεύξεων, οι θεματικές που προέκυψαν έδειξαν ότι οι συμμετέχουσες παρουσίασαν αύξηση της αυτοπεποίθησης, της αυτοεκτίμησης, της αυτο-αποτελεσματικότητας και των κινήτρων για επίτευξη, ενώ ενίσχυσαν και άλλα χαρακτηριστικά τους τα οποία σχετίζονται με την επιτυχή επανεγκατάστασή τους. Ταυτόχρονα, υπήρξε μείωση του αριθμού των αυτοτραυματισμών ή των επιπτώσεων που προκαλούσε η συμπεριφορά τους, ενώ βελτιώθηκε η παρακολούθησή τους σε άλλα προγράμματα.

Για τις βαριά αποξενωμένες κρατούμενες, η μουσικοθεραπεία παρείχε μια ελκυστική και ενθαρρυντική παρέμβαση που χρησίμευσε ως σημείο εισόδου σε άλλα προγράμματα που απαιτούνται για την επανεγκατάστασή τους. Οι κρατούμενες δεν επέδειξαν απλώς μεγαλύτερη ικανότητα να παρακολουθήσουν

τα προγράμματα που απαιτούνται για την επιτυχή επανεγκατάστασή τους, αλλά μέσω της μουσικοθεραπείας απέκτησαν φιλοδοξίες, γεγονός που είναι σημαντικό για μεταγενέστερα αποτελέσματα.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

εγκληματολογική μουσικοθεραπεία, γυναίκες κρατούμενες, αυτοαντίληψη, συγγραφή τραγουδιών