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Mental Health Problems in a Music and Theater Workshop**

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**Acting Out: Enabling Meaningful Participation Among People With Long-Term Mental Health Problems in a Music and Theater Workshop**

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### **Abstract**

In this article, we explore what enables meaningful participation in a Music and theater workshop from a first- person's perspective of people with mental health problems. The study uses a hermeneutical phenomenological approach. Data were collected from qualitative in-depth interviews with 12 participants in a music and theater workshop located in a Norwegian mental health hospital. Data were analyzed through thematic analysis. Two overarching themes were identified: (a) *room for dignity* and (b) *a creative arena*. This study indicates that in order to enable participation for people with long-term mental health problems, it is important to facilitate activities that are flexible, person centered, and resource oriented, in which participants have the possibility to participate regardless of symptoms, functional ability, or whether they are hospitalized. In addition, having professionals who believe in creative growth and offer an illness-free zone that belongs to the participants in a hospital setting is of great importance.

*Keywords:* Recovery, Mental health and Illness, Lived experience, Social participation, Social Support, Users` Experiences, Qualitative research

### **Introduction**

People with long-term mental health problems participate in cultural activities less often (Bergem & Ekeland, 2006; Whiteford, 2000, 2004) and have greater difficulties addressing their concerns in terms of their rights and participating in organizations (Lindquist & Sèpulchre, 2015). Leisure activities are important parts of life for every individual, especially for people with limited employment prospects (Lloyd, King, Lampe, & McDougall, 2001). The aspirations for participation among people with mental health problems are similar to those of the wider community (Thornicroft, Rose, Huxley, Dale, & Wykes, 2002). The fact that people with long-term mental health problems sometimes are hospitalized complicates their ability to participate and enable continuity in their participation in their community. Their mental health conditions, the costs, and their need for transportation, either for themselves or through hospital staff, are barriers to their participation in leisure activities (Hudson, Loyd, & Schmid, 2001).

Cultural activities have a long connection with mental health (Lloyd, Wong, & Petchkovsky, 2007). Internationally, mental health hospitals have offered and seen the value of cultural activities since as early as the 1940s and 1950s (Pratt, 2004). Traditionally, these cultural activities are considered as treatment, such as music therapy and art therapy. In this study, we aim to shed light on the use of music and theater activities in a mental health hospital setting as a nontherapeutic offering for people with long-term mental health problems.

Increasing attention has been paid to the user perspectives of people experiencing mental health problems in health care politics, practice, and research (Thornicroft & Tansella, 2005). Mental health recovery is a critical and user-oriented paradigm that arose from the civil rights movement in the United States (Davidson, 2006; Davidson, Strauss, & Rakfeldt, 2010), which contributed first-person perspectives from people with mental health problems regarding their lived experiences of the phenomena of mental health problems (Deegan,

Anthony, & Rutman, 1996). Increased knowledge from first-person perspectives of mental health led to radical changes in the understanding of mental health and illness (Slade, 2009). The traditional focus on treating illness in order to produce clinical recovery (Lieberman, Kopelowicz, Ventura, & Gutkind, 2002) is shifting toward living a meaningful life despite symptoms (Borg & Davidson, 2008; Davidson, Tondora, & Ridgway, 2010). Thus, mental health recovery is no longer as much about clinical outcome as it is about recapturing one's role as a healthy and contributing citizen of one's community, which is a shift from a traditional medical model to a civil rights model of recovery (Borg, Karlsson, & Stenhammer, 2013; Davidson, Strauss, et al., 2010). Recovery literature frequently uses the terms *clinical recovery* (Lieberman et al., 2002), *personal recovery* (Anthony, 1993; Slade, 2009) and *social recovery* (Best, Bird, & Hunton, 2015; Repper & Perkins, 2003; Tew et al., 2012; Topor, Borg, Di Girolamo, & Davidson, 2011) to discuss recovery.

A valid understanding of recovery must be grounded in lived experiences (Slade, Williams, Bird, Leamy, & Le Boutillier, 2012). We understand recovery as a journey that can be experienced differently from one person to another and as a process. Slade, Leamy, et al. (2012) stated that a recovery process consists of connectedness, hope, identity, meaning in life, and empowerment (CHIME). Having a meaningful everyday life filled with activities is important to people's recovery processes. Although the importance of having a meaningful everyday life is well established in theories and research regarding recovery processes (Davidson, Tondora, et al., 2010; Salzman-Erikson, 2013; Slade, Leamy, et al., 2012), there is a growing interest to explore first-person perspectives related to participation in meaningful activities (Davidson, Shahar, Lawless, Sells, & Tondora, 2006; Deegan, 2005; Ness et al., 2013). In addition, less attention has been paid in the research literature to first-person perspectives related to participation in cultural leisure activities within mental health hospitals. Additionally, people with mental health problems have stated that the development

of mental health services should include prioritizing something meaningful for patients to do during the day and ranking future research on art in mental health highly (Thornicroft et al., 2002). Stickley and Duncan (2007) reported a growing awareness of the relationships between cultural activities and health.

Internationally, the number of projects involving cultural activities in community based mental health care is rapidly increasing. Existing research studies on recovery containing cultural activities, have been conducted, either in hospitals providing music therapy (Chhina, 2004; McCaffrey, Edwards, & Fannon, 2011; Rolvsjord, 2009; Solli, 2012; Solli & Rolvsjord, 2015; Solli, Rolvsjord, & Borg, 2013) or in local communities through community-based art (Faigin & Stein, 2010; Lloyd et al., 2007; Lund & Haugstad, 2013; Ness et al., 2013; Stacey & Stickley, 2010; Stickley, 2010; Stickley & Duncan, 2007; Stickley, Hui, Morgan, & Bertram, 2007). In Norway, despite hospital settings offering different kinds of cultural activities, there has been a lack of research literature on the use of cultural activities (Knudtsen, Holmen, & Håpnes, 2005). Little attention has been paid to leisure activities in relation to people with mental health problems and enhancing their ability to participate.

Therefore, the purpose of this study is to explore first-person perspectives regarding enabling the participation of people with mental health problems in cultural activities. The specific research question for this study is as follows: What enables meaningful participation in a music and theater workshop, located in a mental health hospital, from a first-persons perspective of people with long-term mental health problems?

### **Methodology**

A hermeneutical-phenomenological approach guided the research. Hermeneutical phenomenology attempts to find, describe, and understand the participants' subjective experiences by systematically determining the common and unchanging themes, or *essence*, of participation as a phenomenon (Starks & Trinidad, 2007; Van Manen, 1997). To this end,

we conducted qualitative, in-depth interviews with 12 participants in a music and theater workshop. We combined a thematic analysis inspired by Braun and Clarke (2006); Clarke, Braun, and Hayfield (2015) and Van Manen's (1997) phenomenology of practice to analyze and interpret the data. Following Finlay (2002, 2012) and Malterud (2011), we stressed a reflexive perspective, exploring how our intentions and preconceptions as researchers might have influenced the present study.

### **Music and Theater Workshop as a Research Context**

The research sample were drawn from a music and theater workshop affiliated with a mental health hospital in Norway. It was primarily a leisure activity for people with long-term mental health problems who were or had been hospitalized at district psychiatric centers or mental health hospitals in Norway. Secondly, the workshop functioned as a job-training facility in collaboration with the Norwegian Labor and Welfare Service (NAV). The music and theater workshop was open for participation with no exclusion criteria and regardless of diagnoses or previous experience with cultural activities. A theater director had been employed full time since the initiation of the music and theater workshop in 2003. Initially, the theater director went to all hospital departments to recruit patients. Later on, the participants entered in different ways. Some contacted the theater director directly, while others were recommended for participation by mental health professionals. However, most were invited by other participants.

Participants in the music and theater workshop had weekly rehearsals in which they read and acted out their own written scripts. In addition, each participant had the opportunity to make formal or informal appointments with the theater director or musicians to create or further develop their own lyrics and musical expressions. The music and theater workshop's philosophy was that creative processes and participation were possible for all but must occur on the participants' own terms. A basic working principle was to make people with mental

health problems co-creators. Developing participants' strengths and using the challenging phases of their health problems were central in the music and theater workshop. Participants were involved in all levels of the production process and collaborated with professional actors and musicians, both individually and in groups.

### **Ethical Considerations**

The Regional Committee for Medical and Health Research Ethics (REK) in Norway (2015/476/REK-Midt) approved this study. Participation was voluntary. Informed written consent was obtained prior to the interview, and the participants were informed that they could withdraw from the project at any stage, no questions asked. REK considered the participants as a vulnerable group and required a special consideration for the group's interest during the research process (National Committee for Research Ethics in the Social Science and the Humanities, 2006). The first author, Ørjasæter, had a clinical background but was not working with treatment in mental health care at the time. All participants were offered the opportunity to speak with a physician specialist from an outpatient clinic. The specialist's name, phone number, and e-mail address were given to the participants in an information sheet about the study. This person had the responsibility to clarify informants' situations and assess any needs. However, most of the interviewees already had, if required, a contact in the mental health system whom they could talk to after the research interview.

### **Recruitment**

To explore experiences regarding enabling participation, we recruited participants who had lived experiences from a music and theater workshop in a mental hospital in Norway. The inclusion criteria were experiences of long-term mental health problems and current or former participation in the music and theater workshop. The theater director distributed postage request for participation and consent to all 14 current participants and six of the former participants. Including the current participants, approximately 60 people with mental health

problems have participated in the music and theater workshop since its initiation. The theater director selected former participants who had experiences from workshop's initiation, and participants who have had roles or functions in the music and theater workshop that the current participants could not represent, including as teleprompters. Those who were willing to participate could contact Ørjasæter via e-mail, phone, or preaddressed envelope. Before the study was initiated, potential participants were invited to an informational meeting about the study.

### **Sampling**

Twelve people agreed to participate in the study. There were eight women and four men, ranging in age from 22 to 48 years. Their participation in the music and theater workshop ranged from nine months to 10 years. Their contact with the mental health system ranged from three to almost 30 years. All participants claimed that they had mental health problems that were classified as more than one diagnosis in diagnostic manuals like International Classification of Diseases and Related Health Problems - ICD-10 (World Health Organization, 1992) and Diagnostic and Statistical Manual of Mental Disorders - DSM-V (American Psychiatric Association, 2013). Some did not know how many psychiatric diagnoses they had, while most identified three to six concurrent diagnoses. The participants described experiences of psychotic symptoms, ADHD, bipolar diagnosis, different types of personality disorders, complex PTSD, dissociative disorders, anxiety, and symptoms of depression, in addition to the use of legal and/or illegal substances to varying degrees. All of them had received, or still received, various services related to their mental health problems from the municipality and/or hospital. The participants were given pseudonyms Anna, Benjamin, Carina, Dina, Emelin, Frida, Gabriel, Hermine, Isak, Jenny, Karoline and Ludvik to ensure their anonymity.

### **Data Collection**

The qualitative, in-depth interview was chosen as the method to gain insight into the experiences of the phenomenon of participation in the music and theater workshop (Kvale & Brinkmann, 2009). According to Kvale and Brinkmann (2009), the qualitative interview aims to obtain descriptions of the interviewee's lifeworld to interpret the described phenomenon. The descriptions referring to the lifeworld belonged within a phenomenological approach, while interpretation of the described phenomena belonged within a hermeneutical research tradition. Ørjasæter, a social worker with clinical therapeutic experience in the mental health field, conducted the interviews. Each participant was interviewed once. To become familiar with the music and theater workshop, Ørjasæter examined the location of the group and was present at a dress rehearsal, the performances and rehearsals; during video editing; and when one participant planned and conducted a workday at the music and theater workshop together with the theater director.

An interview guide with open-ended questions shaped the interview (e.g. "Can you tell me about your participation in the music and theater workshop?"). Prompt follow-up questions were asked when considered fruitful. The issues explored in the interviews included the participants' descriptions, and their contributions in the music and theater workshop, and their experiences of how their participation had affected their health and life in general. All interviews were conducted at locations suggested by the participants, most often in an office to which Ørjasæter had access, located in the same building in which the music and theater workshop had its sessions. One interview was conducted in a participant's office, a second in a participant's home, a third in a district psychiatric center at which the participant was hospitalized, and a fourth in a forensic hospital. The interviews ranged from 46 to 138 minutes (mean: 88 minutes) and were carried out between June and October 2015. All of the interviews were audio-recorded and transcribed verbatim.

## **Data Analysis**

Following a hermeneutical-phenomenological approach, the aim of the analysis was to capture, in detail, the participants' personal experience of participation and the researchers' interpretations of the participants' lived experience (Heidegger, 2007; Kvale & Brinkmann, 2009; Van Manen, 1997, 2014). However, the meaning or essence of a phenomenon is never one-dimensional but rather complex and manifold (Van Manen, 1997). All phenomena are both knowable and mysterious (Saevi, 2005). We tried to embrace the mystery of participation as a phenomenon rather than reduce the phenomenon into clearly defined concepts and theories to disclose its mystery (Marcel, 1950). Hermeneutical phenomenology opened up the diversity and uniqueness of participation as a phenomenon, rather than simplifying and generalizing it. By striving toward the richest and most manifold understanding of the phenomenon under investigation, we hoped to approach its essence (Saevi, 2005).

In qualitative studies, the researchers are the analytic tools and play an important role in the research process (Kvale & Brinkmann, 2009). Therefore, it was essential to clarify preunderstanding and knowledge at the beginning of the study (Malterud, 2011). We tried to have a phenomenological attitude of wonder—to make it possible to see the unknown in the known—and openness, which presupposes a critical self-awareness of our preunderstanding (Van Manen, 2014). Our pre-established ways of understanding were challenged and transformed through a reflexive dialogue with the data, colleagues, and co-authors throughout the research process (Finlay, 2012; Malterud, 2011). We combined a thematic analysis inspired by Van Manen (1997), Braun and Clarke (2006) and Clarke et al. (2015). Thematic analysis is a method identifying, analyzing, and reporting themes within the data and helping interpret research topics (Clarke et al., 2015). According to Van Manen (1997) themes are the stars that make up the universes of meaning we live through. Themes are not necessarily

dependent quantitative measures that are focused on what is captured in relation to the research question (Braun & Clarke, 2006). This study's central themes captured key elements of what the participants experienced as meaningful participation in the music and theater workshop. Analysis proceeded through the following steps.

**Become immersed in the data: Naïve reading.** To become familiar with and get an overall impression of the data, Ørjasæter spent time with the data in the beginning by undertaking the transcription, reading and rereading transcripts, listening to audio recordings, and making notes and reflections. Initially, the author's notes pertained to obvious meanings, but greater depth of insight was achieved after reading through the transcripts several times with curiosity and questioning.

**Generating units of meaning.** This step required identifying and labeling anything of interest about participation in the music and theater workshop. The authors shared and discussed generating units of meaning as a part of the analysis.

**Developing emerging themes.** We created a plausible and coherent thematic map of the data and reflected on the relationships between the themes. The most prominent, in terms of illuminating the research question, were chosen as central themes. We compared different themes and merged themes that represented similar meanings.

**Reviewing, defining, and naming themes.** Earlier themes were reconsidered. We asked whether the themes were good enough compared to what we wanted to describe. A review of each topic was used to consider whether a clear and distinct essence existed. Each interview and all speaking quotations were reviewed again. By questioning the data, new insights and perspectives emerged.

We created a thematic overview of the data. Based on selected quotations and reviews of the themes, Ørjasæter wrote "interpretative condensed synopses" for each subtheme. Finally, we selected sensible names (Braun & Clarke, 2006; Clarke et al., 2015) like *room for*

*dignity and a creative arena*, for overarching themes.

**Writing up an understanding.** Writing is an integral part of the analysis (Van Manen, 1997). Writing exercises the ability to see, and, according to Van Manen (1997), writing is the method. Writing is not a straightforward process. To justify the richness and ambiguity of experience in the informants' lifeworld, the authors submitted to a complex process of rewriting (i.e., rethinking, re-reflecting, and recognizing). We stressed writing a coherent story. To ensure quality, Ørjasæter held a meeting with the participants to discuss the findings and presented the findings at a national research conference held by the Norwegian Network of Disability Research.

NVivo Qualitative –data-analysis software version 11 (Qualitative Solution and Research International, 2015) aided the data. NVivo where used to organize notes, reflections and audio files, transcribe Interviews and developing emerging themes. The analysis was performed in Norwegian. In the final step, concepts and quotes were transcribed into English.

### **Findings**

We identified two central themes in what the participants in the music and theater workshop experienced related to enabling participation: room for dignity and a creative arena. Room for dignity explored what the participants experienced as meaningful in their meeting with professional musicians, actors, the theater director, and the other amateurs. Meanwhile, a creative arena pointed out the importance of the arena's design and focus to meaningful content for the participants.

#### **A Room for Dignity**

The majority of the participants spontaneously described human dignity as a key element to enable participation.

**Being allowed to be themselves** was crucial and meant feeling accepted as themselves without having to try to be someone else. In the hospital setting, many participants

acted out roles as they thought the mental health institutions and professionals expected or roles that gave them more benefits in the mental health system. Several participants experienced playing roles as challenging and time consuming. However, in the music and theater workshop, they felt taken seriously, no matter who they were or how they behaved. Hermine felt no need to spend energy trying to cover up who she was: “You don’t have to wear a fake smile to go to the music and theater workshop”.

When participating in the music and theater workshop, there was room for people to experience symptoms, such as inattention, hyperactivity, impulsivity, panic attacks, lack of energy, flight of ideas, and dissociative symptoms. The participants knew that others understood and accepted symptoms. Many had the impression that they had to be symptom-free to participate in leisure activities or different kinds of work. Frida had an earlier experience of being thrown out of a work-training project because of her symptoms:

I was thrown out of a work-training project focusing on nature, culture and health. They thought I had too much symptoms to continue. When I got in touch with the theater director, I was frustrated. However, the first meeting with the music- and theater workshop... It was nice, the way I was greeted - no problem or focus on my symptoms.

The fact that the participant had an opportunity to participate without question and with no need to explain themselves made it easier for the participants to be themselves. After being greeted with respect when participating while experiencing symptoms, Carina realized that she did not have to cover up her problems.

People come in different shapes, colors, and sizes here. You have seen people become manic or psychotic or whatever; you are used to it, so if someone comes who becomes psychotic or manic . . . I mean, of course it affects you, because you cannot help but

notice it, but there is still so much respect. It's alright; no one throws you out because "now you are being manic, so you have to go."

**To be seen, met, and understood as whole humans.** Many participants reported being stigmatized by mental health services. Stigmas included a feeling of not being seen, heard, or understood by professionals. Instead, patients' diagnoses and medical journals dictated how professionals met them. This led to a feeling that the mental health services only saw them as patients who were ill. While participating in the music and theater workshop, the participants described how none of the professionals evaluated them as patients. They felt that the theater director, the musicians, and their colleagues enjoyed the time they spent with them, respectfully, as human beings. The way the participants were treated - made them feel seen, met, and understood as whole human beings which contrasted with their experience with professionals in mental health services. Karoline highlighted the respectfully meeting with the professional musicians when they worked with her songs: "That someone had faith in you ... the musicians ... I did not experience that anybody had the attitude; 'Poor you - you are ill and we are healthy'. Nonjudgmental attitudes and open questions provided a feeling of being taken seriously and carefully listened to when talking, even though they were considered ill. Anna underlined the importance of nonjudgmental reception:

The people at the psychiatric unit only see problems. I feel I disappear behind problems in their eyes. I am there because I am ill, so that is all they see. A lot of me disappears. But the theater director didn't seem to care what was wrong with me or how long I had been in the system. . . . He did not care about problems and diagnoses, but rather what I wanted to do and what I found funny; other stuff. . . . He did not try to define you in every way or put you in a box. . . . I felt he saw the real me, more than most others.

Participation in the music and theater workshop was demanding because the

participants needed to be physically and mentally present, interact with others, try to tell a story, perform on stage, and use both body and voice at the same time when acting out a role. However, the fact that someone was interested in them as people and explored how much stress and how many tasks and new experiences they could manage gave them a feeling of being allowed to be a human being. As Ludvik pointed out:

I can't think of anything with which I could compare the accommodation of humans to such a degree, as in the close context we are talking about now, in the theater . . . you are kind of stretched pretty well. . . . It shows how strong human beings are when they are allowed to be human.

**To be allowed to use their own voices to communicate with the outside world.**

Despite the focus on patient involvement in mental health services in Norway, participants had negative experiences when it came to being heard as patients because they felt that the health professionals did not take them seriously due to their mental health problems. Some of the participants felt that their voices were barely audible compared to the voices of mental health professionals when talking about treatment, hospitalization, and use of medications. Participation in the music and theater workshop gave the patients an audible voice. Participation actually allowed the participants to have an opinion and disagree with professionals. Carina highlighted that not everything she said or did related to her mental health problems: "There is actually room for me to have an opinion. I am allowed to not agree with everything. I am allowed to have my own ideas; not everything has to be the sickness". Patients were allowed to voice their questions about human dignity in the mental health system strongly and could challenge a system in which the professional's voice traditionally had been the strongest. Carina continued:

I can say what I want and people listen to me. It's not like when I say what I want and then someone sits there and judges me, or disagrees, or just says that "people like you.

. . .” But on stage, no one interrupts me. No one says “You can’t say that!” . . . I actually have a voice. I actually get to speak up. That has actually been more important than I thought.

### **A Creative Arena**

The participants described the music and theater workshop as a creative arena that was open to everyone with mental health problems, regardless of any previous experience with cultural activities. The participants had different levels of experience when it came to music, theater, and scriptwriting. A few of them had formal drama or musical education. However, several had previous experience with various forms of music, theater, and writing for their own amusement and had varying degrees of ambition. The diversity in roles and functions that were needed to create music and theater productions gave all participants the opportunity to find something for themselves and provided a sense of mastery.

**Having the opportunity to explore and develop skills.** The participants’ healthy sides were in focus in the music and theater workshop. The participants’ inherent capabilities were adopted, so searching for resources to stimulate their capabilities was important. Participants spent time with the theater director in order to explore what they wanted to bring into the music and theater workshop. Jenny remembered that the theater director had wondered how he was supposed to use her in the music and theater workshop. In the end, he came up with a job that matched her perfectly.

Suddenly, one day, he says: “I know what you should do; prompter!” “So nice, I said”. “Does it involve acting on a scene?” “No”. “Then it is probably okay!” He neither explained nor let me see any videos about a teleprompter’s work. He wanted to build and shape me from the beginning and he really did. He quickly saw, that I had a gut feeling he possibly could use in that role.

The theater director tried to connect the participants with professional musicians and actors with whom to cooperate. These connections with professionals who had different artistic expressions and personalities provided variation in the patients' manuscripts, songwriting, and musical expressions and encouraged the participants' potential for development. The professionalism among the musicians and actors was important for the participants' artistic development. Isak emphasized that it would not have been a good idea to have a health professional do the theater director's work: "I don't think it is a good idea to give the job as theater director to a social worker or a nurse. . . . It would have to be someone who has expertise in theater."

Behavior change and symptom reduction are critical in therapy. However, in the music and theater workshop, negative symptoms and behaviors were harnessed positively. As the participants saw it, the theater director tried in collaboration with them to figure out how "the disturbing element" could be turned into a resource. Redefining symptoms and behaviors gave participants the opportunity to participate in symptom remission while providing a sense of mastery. Isak described an opportunity to use his extreme mood swings when interpreting roles. He got to experience his illness as a strength in creative processes. Through participation, he learned how to provoke different moods when performing.

I think that, my experience as bipolar, makes me a better actor. I try to be myself as much as possible in all roles. In acting, I have an opportunity to use my experiences . . . I had already experienced the fullest possible sense registry: from a world of darkness in which I thought about committing suicide to the feeling of being the coolest and toughest man in the world.

Benjamin noted that creativity, great capacity for work, and rambling ideas showed up in his manic phases. The theater director helped him sort out which ideas he could continue to work on. He had written several scripts, which subsequently were used in performances with

brilliant results. Prior to his participation in the music and theater workshop, both he and his network had rejected his ideas originating from his manic phases because they appeared rambling and useless.

There were maybe 10 ideas, but only one or two of these were usable. . . . Where someone else might see only noise, chaos and illness, and go: “Let’s just calm down and take some more meds.” Then he’ll just go in and “there it is!” He has found something worth building on amidst all the chaos.

**Having flexible solutions.** The music and theater workshop was a solution-oriented arena because all participants experienced how flexible the activities were. Together with the theater director, the participants created an arena in which attendance during the rehearsal and play was flexible. The focus on alternative solutions gave the participants’ courage to participate despite their challenges. All participants experienced some days or periods with greater difficulty regarding their own mental health condition. A culture developed in which the participants could inform the theater director of such days or periods ahead of rehearsals. Carina highlighted the importance of having their individual situations considered and the rehearsal adjusted to comply with their mental states, often with more continuity and fewer breaks in order to avoid long conversations between the participants.

The theater director get [sic] straight to the reading. He makes sure there’s continuity, so there aren’t too many breaks during which you have time to think. If I’m having a bad day, the breaks . . . you totally lose your concentration and get upset and stuff.

The music and theater workshop was different from other theater workshops because the participants felt that they had considerable influence and dared to ask the theater director and professional musicians to find alternative solutions. They made something out of a situation that others would have considered impossible. If an actor could not learn something by heart, the participants were convinced that other theaters would have said that the person

was not supposed to be an actor. The fact that several participants considered being physically close to and keeping a close distance with others challenging could have caused major difficulties in a theatrical production in which there is a lot of close contact between actors. Carina continued to describe how the theater director managed to find solutions that worked both for her and the production in general:

I dislike having people physically close to me. I prefer that people keep a distance. Then, when you're acting, you have to figure out the proximity you can handle, how close you're able to let them. . . . so I can start thinking that I am ruining everything by not wanting to stand close to that person, because it feels too close for me, but then the theater director can say: "It works just as well if he or she is over there," and then, strangely, it works out anyway.

All participants mentioned that alternative solutions were common in the music and theater workshop. During the interview, the number of alternative solutions the theater director and the participants had come up with surprised Carina:

So many alternatives that have been thought up here; it's amazing! When you sum it up like that, I'm thinking: "Oh my God, the number of solutions we are able to find!" . . . I've never realized that before. Oh my God, how much we manage to come up with whenever issues arise, and we make it work as if there weren't any issues to begin with! That's an accomplishment on its own.

**Having access to an illness free-zone.** Many of the participants had been in touch with mental health services for a long time due to their mental health problems and talked in different ways about feeling as though they had lost their freedom. Most of them had several long-term admissions during which the focus had been to map out deficiencies, abnormalities, and the negative impact these aspects had on their quality of life. These admissions contributed to a feeling of loss of freedom. They had submitted to a treatment regime and

taken on the role identity of an ill patient. They experienced losing the ability to make their own decisions and needing professional helpers to set their agendas. They were reminded constantly of their role as patients with locked doors; escorted exits; compulsory interventions; and day plans according to the hospitals' routines regarding meals, activities, and conversations. The music and theater workshop became an arena in which they no longer were considered ill but rather were singers, musicians, or actors. They were given an arena in the hospital that belonged to them rather than the system. The music and theater workshop was theirs alone, and neither therapists nor personnel were welcome unless they were invited or participated artistically or practically. Ludvik highlighted the fact that mental health professionals not being allowed to attend rehearsals had an effect on the participants' identities:

The gorilla in the hallway! That's the guards! . . . They have to wait outside, because we do not have guards with us in the theater. We do not use diagnoses on the actors. . . . Yeah, the guards had to remain in the hallway. . . You leave escorted exits and compulsory interventions behind. You're by definition deprived of your freedom indefinitely, and your freedom of movement has been restricted; then, you come to a door and you leave the psychiatric patient with compulsory interventions and escorted exits behind. You leave that behind, and become a human being, and an actor; then, you close the door behind you.

Several participants emphasized that participating in a music and theater workshop located in a mental health hospital was challenging. At first, there was inner resistance: The mental health services expressed skepticism about patients' participation in the music and theater workshop. Health professionals thought that patients from compulsory admission could not participate in the music and theater workshop on their own. They presumed that the patients were too sick to participate and could not see beyond their labeled roles as patients.

Isak had been discharged and was no longer entitled to treatment. For him, canceling his performances was not an option. A cancellation, in addition to his mental health problems, would have made everything worse for him. He felt that the health professionals should have understood that, but they did not:

The hospital said: No, that does not make sense. You cannot be admitted to an intensive care unit and act in a theater! That is not possible! . . . They said that made no sense, so I could no longer be that ill.

However, after a while, the hospital and health professionals shifted positively in support of patient participation in the music and theater workshop, so much so that they wanted to characterize it as a therapeutic service. The participants did not care for this at all, because as Ludvik and the others saw it, doing so would make the workshop part of the system and not a service only for the participants:

One professional group after another came and tried to claim that this was therapy.

That pissed us all off. The music and theater workshop is a therapy-free zone. If there is one thing we are sick of, it's therapy, diagnoses, and psychiatry. Can't we just be free of it for 5 minutes, right? Don't you dare come and steal this by calling it therapy, because it's theater! Forget it! I think that has destroyed the entire sense of freedom . . . . As soon you call it therapy, it belongs to the system. Then it's no longer a free space.

### **Discussion**

In our analysis, we highlight two central themes in what the participants in the music and theater workshop experienced regarding enabling meaningful participation: room for dignity and a creative arena. We will present our discussion around three overarching themes based on our findings. First, we will discuss the importance of continuity in leisure activities regardless of symptoms, functionality, or the participants' hospitalization status. Second, we will discuss the importance of having access to an illness free zone in a hospital setting. Third,

we will discuss the importance of having a resource-oriented focus in cultural leisure activities.

The overall impression of our findings is that participation in the music and theater workshop was highly appreciated among the participants. Interestingly, when the participants shared their experiences of participation in the music and theater workshop, they used their experiences from the mental health system as a contrast. Even though the music and theater workshop was organized in a mental health hospital, participants experienced the cultural leisure activity as something separate from it. In a way, two different paradigms (Slade & Longden, 2015) met when patients participated in the music and theater workshop.

### **Having Continuity in Leisure Activities Regardless of Symptoms, Functionality, or Hospitalization**

Traditionally, mental health systems are concerned with how to reduce or remove symptoms (Davidson et al., 2006; Slade, 2009). To reduce daily stress, people with mental health problems still meet with health professionals who advise them not to attend leisure activities or work until they are free of symptoms or have achieved a sort of stability (Davidson, Tondora, et al., 2010). Interestingly, attending the music and theater workshop was experienced as liberating, despite being emotionally and creatively challenging and requiring participants to handle uncertainty and changes in the music and theater production. For several of the participants in our study, symptoms increased during participation. However, symptom exacerbation could represent, or be a consequence of, movement throughout life rather than being understood as a relapse (Davidson, Tondora, et al., 2010) should not underestimate the importance of being challenged by activities that are experienced as meaningful (Davidson et al., 2006) even if symptoms increase for a while. This study suggested that health professionals not wait until people with mental health problems are free of symptoms to participate in leisure activities and work, which has been a

common strategy in mental health care (Davidson, Tondora, et al., 2010). Thus, it is important that practitioners encourage participation in such activities, and address barriers within the system for participation.

Traditionally, people with mental health problems are not allowed to continue leisure activities at the hospital after they are discharged, meaning they have to find activities in their local communities. Frequently switching between staying home and being hospitalized is a barrier to committing to leisure activities, which is why many of the participants had not experienced continuity in activities earlier and felt that continuous participation was impossible. The music and theater workshop filled this gap because it was open to all participants, regardless of hospitalization. Finally, patients could continue a cultural activity, even when experiencing symptoms, low functionality, and periods in which the symptoms were minimal or absent. In accordance with Ness et al. (2013) and Solli (2012), continuity in cultural activities is important for people with long-term mental health problems and should be strived for. This also is in line with mental health recovery, since people are likely to live with their mental health problems for a long time (Davidson, Tondora, et al., 2010) and need developing activities that are flexible enough to allow them to commit to the same activity regardless of their mental condition or where they are staying.

### **Access to an Illness Free Zone That Belongs to the Participants**

A number of participants had experienced stigmatization from health professionals in mental health care (Andersen & Larsen, 2012; Rao et al., 2009). The participants played roles (i.e., “wore a mask”) in almost every context, including their meetings with health professionals. They felt that participation in the music and theater workshop was so safe that they could remove the mask, which is in line with Stickley and Hui’s (2012) study in which participants experienced participation in an art project as a safe place where they could be creative with others who shared similar experiences. Using sociologist Ervin Goffman’s

(1992) concept of front- and backstage, performing gave the participants an opportunity to escape reality and wear a mask (i.e., frontstage). However, backstage, during rehearsal and when interacting with other participants and professionals in the music and theater workshop, they felt free rather than stigmatized. They had created a room together with the other participants in which they could be their authentic selves (Ness et al., 2013) and be accepted as such. Since many of them spent so much time wearing masks in their daily lives, being backstage together with the others felt just as liberating as being alone. We argue that participation in the music and theater workshop was just as much about unmasking oneself as it was about putting on the mask of a role.

It was liberating that the music and theater workshop was not part of a therapy service. No records (e.g., journals) were written about the rehearsals, and no discussions about their participation occurred in the hospital wards' treatment meetings. The music and theater workshop contrasted to music therapy, in which a traditional biomedical discourse/paradigm is adopted (Solli, 2012). Participation in the music and theater workshop was a nontherapeutic service in which the participants felt free from illness, treatment, and their status as mentally ill. This is concurrent with the findings from Solli and Rolvsjord (2015), who showed that many participants felt that they did not have many illness-free zones in their lives and highlighted the importance of having a free zone in a hospital setting. For that reason, there was opposition to mixing the music and theater workshop with therapy. There was also a strong fear that another arena in their life, which until now patients had experienced as resource orientated, felt ownership of, and found to be a place in which they could unmask, would become "pathologized" by health professionals or would be destroyed (Rolvsjord, 2009). This is also in line with Sticklely and Duncan (2007) who argued that having a distance from the medicalizing tendency may be required, if cultural activities are supposed to promote social inclusion, social capital, and reintegration. Facilitating a non-threatening environment in

cultural activities is of great importance (Stacey & Stickley, 2010). However, there is a discussion within the arts and health field about the distinction between the specific practices of art therapy (Stickley & Duncan, 2007) and music therapy (Solli, 2012; Solli & Rolvsjord, 2015) and the therapeutic benefits of cultural activities in health contexts (Stacey & Stickley, 2010; Stickley & Hui, 2012).

The participants in our study argued that outside of mental health institutions, music and theater were seen as leisure activities or work, and they questioned why participation by people with mental health problems in a music and theater workshop should automatically be perceived as therapy. We should not underestimate the importance of offering nontherapeutic cultural activities besides treatment led by people other than health professionals. These findings suggest that the mental health system should strive to offer more cultural leisure activities in which people with mental health problems may keep or develop illness-free zones, which will ultimately encourage participation.

### **Importance of Having a Resource-Oriented Focus**

The participants stressed the importance of meeting people who treated them as though they already were somebody (Davidson, 2003). The participants in Davidson and Johnson's (2013) study highlighted the small things that counted to them. We argue that the participants in our study supported these findings, when focusing on the importance of being asked questions about what they preferred doing creatively, feeling seen or heard, and experiencing being met in a respectful and nonjudgmental way. This is in line with Anderson (2012), who highlighted that how one begins to meet people creates the kind of conversations and relationship one can have with them. Similarly, Lund and Haugstad (2013) stressed the importance of people with mental health problems having experiences of being seen, heard, and understood, which enables meaningful participation in leisure activities.

An underlying philosophy in the music and theater workshop was that people generally are creative if given the chance (Levine, 1997). Having art professionals who believed in growth during illness and creating a person-centered (Rogers, 1967) and individualized approach (Brown & Kandirikirira, 2007) were important to make room for participation. This is consistent with the view of Stickley and Hui (2012) who argue that the theoretical foundation for the health benefits of the arts is located in the humanistic psychology literature, which person-centered and humanistic values (as expressed by Maslow and Rogers) are notably important in philosophy and the development of arts.

The music and theater workshop was a kind of trial arena in which the participants could play with different creative expressions. They were allowed the opportunity to try and succeed or to fail without fear. This environment gave the participants an opportunity to develop creative skills. Lloyd et al. (2007) expressed similar findings and pointed out the importance of having supportive relationships and a supportive physical environment to make participants feel safe enough to take risks and to be vulnerable in their creative journey. In our study, the fact that the participants felt safe when participating gave the art professionals the opportunity to challenge the participants with new tasks. The balance between completing the tasks they managed and the tasks they felt were challenging gave the participants the potential for creative growth, regardless of their earlier experiences with music and theater. Positive mastery experiences were critical and nurtured the participants' self-efficacy. The art professionals strove to frame these mastery experiences to the participants as being for actors and musicians, rather than for mentally ill patients, despite the fact that the material (songs, poetry, and scripts) came from experiences of living with mental health problems.

Many joined the music and theater workshop to have something to do during the week. However, after a while, the participants felt that it was liberating and inspiring to use their voices. According to Stacey and Stickley (2010) creative processes give people with

mental health problems an opportunity to express themselves and communicate to an audience. In our study, the participants redefined their symptoms and experiences through their participation. Their symptoms were used as resources, inspirations, or interpretations. Our findings show that cooperating with art professionals who likely saw their potential instead of their limitations gave the participants access to a full range of opportunities (Hammel et al., 2008). Similarly, Lloyd et al. (2007) argued that participation in cultural activities may lead to a new lifestyle when individuals identify themselves apart from their mental health problem. We argue that the focus on redefining symptoms gave the participants an opportunity to show and convince both the people surrounding them and themselves that they did not have to see their symptoms as a problem. By looking at symptoms in a new way, the participants could find strategies to live with and accept them. The participants' challenges decreased because they no longer needed to hide their symptoms or dedicate so much of their cognitive capacity to the symptoms' negative side effects.

Interestingly, the concept of normality seems to be wider in art than in mental health contexts. In art, there is more room for diversity, and "madness" is appreciated. Innovation in art requires people to go outside the box. In mental health contexts, being or doing something outside the box is seen as abnormal. Slade (2009) characterized the mental health system's tendency to use dichotomous scales to explore people in terms of normal–abnormal, sick–healthy, us–them, and patients as nonexperts–health professionals as experts. As a result, both health professionals and people with long-term mental health problems may internalize a narrow normality, and there are high chances that someone will end up outside the box. In a way, it is a paradox that a system that is supposed to help people has such small limits regarding what is normal, especially when few participants have the goal of becoming mainstream and would rather be unique yet still be treated like human beings, rather than as "a mental illness" (Deegan et al., 1996; Slade, 2009).

### **Limitations and Strengths**

We recognized some strengths and limitations in this study. The participants gave rich descriptions of their experiences in ways that we did not expect before the study began. People with long-term mental health problems were considered vulnerable informants by REK, but their contributions of their experiences and openness were extraordinary. They showed us the importance of bringing their voices into research because of their rich experiences and user-oriented perspectives. The understanding of participation generated by this study cannot claim to capture the full complexity of what people with mental health problems experience as meaningful participation. Our understanding was based on 12 interviews and can be explored and modified further through research and practice. Participants' observations could be an important supplement to provide complementary understandings and insight regarding what is important for enabling participation.

Other researchers may have viewed the data from a different angle. As in any qualitative study, subjectivity and the authors' backgrounds have influenced both the study design and analysis. Ørjasæter's background was shaped by her experiences as a therapist in in- and outpatient clinics in the mental health field. The second author, Ness has had extensive experience with social and psychological research, especially in family therapy, recovery from addiction, and mental health.

Mental health support is moving more towards community based rather than institutional settings in Western countries (Davidson, Strauss, et al., 2010). Even though our findings are from an institutional setting, the principles enabling meaningful participation, as we have discussed in this article, may have a wider interest and probably are experienced centrally even by people with mental health problems who live and are supposed to participate in their local community.

### **Conclusions**

In this article, we explore what people with mental health problems experience as meaningful participation in a music and theater workshop located in a mental health hospital in Norway. The findings highlighted that the mental health system should facilitate cultural leisure activities for people with mental health problems to a greater extent than they do currently. We have argued in support of the importance of having access to a music and theater workshop in close proximity to mental health hospitals, regardless of admission status. Despite being located in the hospital, cultural leisure activities should remain independent from therapy and be run by people with professional artistic backgrounds. This will give the participants greater chances to be treated as musicians and actors, not patients. A resource-oriented focus is important to enable participation. We need professionals who believe in creative growth despite mental health problems and who facilitate a flexible and person-centered approach. Since the participants had few illness-free zones in their everyday lives, having access to a nontherapeutic zone—free from diagnoses, therapy, and stigmas of the mentally ill—was paramount. This cultural free zone should contain opportunities for participants to try different creative expressions and encourage trial and error and trying again. Participation in the music and theater workshop could function as a starting point or springboard to participation in activities in the local community and strengthen patients' positivity regarding becoming a citizen (Horghagen, 2014; Sayce, 2016).

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