

# **Aesthetic deprivation: the role of aesthetics for older patients in hospital**

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30<sup>th</sup> August 2014

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## **Declaration**

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university. It consists entirely of my own work, except where indicated in the text. I agree that the library may lend or copy the thesis upon request.

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## Summary

While arts have been integral to all cultures, it is a relatively recent research phenomenon to explore and examine the association between arts and health and well-being (Johnson and Stanley, 2007). This research centres on the concept that aesthetics, the arts and culture are important for well-being and that hospitals may be aesthetically deprived environments. The research area of interest is the experience of older patients in acute hospital regarding aesthetics before, during and after hospital stay.

The overall research question is '*What is the role of aesthetics for patients in hospital?*' Specific aims of the research are to identify patient preferences and perceived benefits regarding aesthetics, before, during and after hospital stay; to explore the role of aesthetics in older patients' lives, in the context of what changing health does to one's aesthetic infrastructure; to explore the extent to which the hospital environment is aesthetically-deprived or enriched for each patient; to develop a Survey of Aesthetic and Cultural Health to begin to map patients engagement in aesthetics (SACH).

The research begins with an extensive literature review (Section 1), covering the fields of aesthetics and arts in healthcare settings. This sets the context for the study, identifying gaps in the literature and developing the research question (Section 2). Mixed methodology design (sequential-exploratory) was chosen for this research and the theoretical framework used is Maslow's Triangle of Needs. The research has two parts: (1) a qualitative study of twenty older patients in acute hospital (Section 3), using in-depth interviews following Van Manen's phenomenological approach; (2) a quantitative study (Section 4) presenting the process of developing and implementing SACH. The survey was conducted with 150 older patients and it explored the aesthetic interests of patients before, during and after hospital stay. The quantitative study was directly developed from findings from the qualitative study.

The results of the qualitative study are seven key themes: (1) the interests and passions of patients (2) loss of aesthetic and leisure interests (3) low expectation of arts in hospital (4) the aesthetics of hospital stay (5) positive experiences of the benefits of arts in hospital (6) different needs for arts interventions depending on stay of hospital stay and recovery and (7) recommendations for improvements in hospital aesthetics. The quantitative study provides data on various aspects of

aesthetics and hospital, notably that (1) film, music and dance are the most popular art forms in this sample (2) a large drop in attendance and participation in arts activities is noted after discharge from hospital, due mainly to physical difficulties, loss of confidence and loss of motivation (3) lack of choice and control over aesthetic activities and noise pollution in hospital and (4) the neglected attention given to receptive arts in hospital.

The mixed methodology analysis allows for findings from the exploratory qualitative study to influence the development of the confirmatory quantitative study. Results from the two arms of the research were compared and confirmed, with reference to international literature.

This research makes an original contribution by understanding the aesthetic needs of older people before, during and after hospital stay, providing information regarding how patients perceive the aesthetic environment of hospital and creating a survey that could be shared and used for this purpose. This is one of the first international studies to catalogue the aesthetic interests of patients in hospital, to assess patients' satisfaction with their aesthetic environment, to review rigorously which qualitative methodology is best used for arts and health studies and to set out a replicable process for in-depth patient interviews regarding the aesthetic environment of hospital.

The research contributes knowledge to the field – specifically, by providing baseline information on patients' aesthetic interests pre-hospital and their views regarding the aesthetic environment of hospital. Originality appears in the concept of aesthetic deprivation as an issue of relevance to health and well-being as well as highlighting the importance of receptive arts and noise pollution, aspects of aesthetic engagement rarely explored in the healthcare literature.

This research points to the possibility of aesthetic deprivation in hospital and begins to provide a template for assessing this for patients. It is hoped this survey, in particular, might be the beginnings of a more robust tool to assess aesthetic needs, interests and deficits as there are very few available to use at present in the health sector. There is a relatively limited amount of evidence-based research undertaken as to the nature of, and potential benefit from, aesthetics in health care and a limited number of studies with rigorous methodology. This research has contributed peer-reviewed papers in this area of work and has contributed knowledge in this field of the role of aesthetics for older people in hospitals.

## **Publications arising directly from this PhD research**

### **Peer reviewed papers**

- MOSS, H. & O'NEILL, D. 2014b. Perspectives: Aesthetic Deprivation Disorder. *The Lancet*, 383, 1032 - 1033.
- MOSS, H. & O'NEILL, D. 2014. The aesthetic and cultural interests of patients attending an acute hospital – a phenomenological study. *Journal of Advanced Nursing*, 70, 121 - 129.
- MOSS, H., DONNELLAN, C. & O'NEILL, D. 2012. A review of qualitative methodologies used to explore patient perceptions of arts and healthcare. *J Med Ethics; Medical Humanities* 38, 106 - 109.
- MOSS, H. & O'NEILL, D. 2012. Medical Humanities - Serious Academic Pursuit or Doorway to Dilettantism? *Irish Medical Journal*, 105, 261 - 2.
- MOSS, H. 2012. Media Review: The King's Speech. *Arts and Health: International Journal for Research, Policy & Practice*, 4 183-185.
- O'CONNELL, C., CASSIDY, A., O'NEILL, D. & MOSS, H. 2013. The Aesthetic and Cultural Pursuits of Patients with Stroke. *Journal of Stroke and Cerebrovascular Diseases*, 22, e404-e418.

### **Conference Paper presentations**

- MOSS, H. 2013. Benefits of the arts for patients in hospital. *The Meath Foundation Research Symposium*. Dublin.
- MOSS, H. 2012a. How do patients perceive arts in hospital? Aesthetic deprivation and the role of the arts in an acute hospital. *UK Association of Medical Humanities*. University of Cork.
- MOSS, H. 2012b. The music and health landscape in Ireland. *Music Network National Music and Health Conference*. Dublin Castle.
- MOSS, H. 2012c. A phenomenological study of the role of arts and culture for patients in an acute hospital. *Medical Gerontology Study Day*. Trinity College Dublin.
- MOSS, H. 2012d. Why not ask the patient? Service users perception of the role of arts in an acute hospital: research and innovation. *ArtsCare 21st Anniversary International Arts in Health Conference*. Belfast.
- MOSS, H. 2011. Aesthetic Deprivation Disorder - the role of the arts in acute hospital. *Narratives of Health and Illness Across the Lifespan*. Dublin.

O'CONNELL, C., CASSIDY, A., MOSS, H. & O'NEILL, D. 2011a. Aesthetic and cultural pursuits of patients with stroke. *Irish Gerontological Society*. Dublin: Irish Journal of Medical Science.

O'CONNELL, C., CASSIDY, A., MOSS, H. & O'NEILL, D. 2011b. Aesthetic and cultural pursuits of patients with stroke. *European Geriatric Medicine Society*. Malaga, Spain.

## **Poster presentations**

JENKINS, E., MAWHINNEY, R., MOSS, H. & O'NEILL, D. 2012. Designing medical humanities curricula: What are the cultural, artistic and leisure pursuits of medical students? 2nd year Research Study Day: School of Medicine Trinity College Dublin.

MOSS, H. 2011. Aesthetic deprivation disorder? The role of the arts in hospital. 4th School Of Medicine Postgraduate Research Day: Trinity College Dublin. 19<sup>th</sup> September.

O'CONNELL, C., CASSIDY, A., MOSS, H. & O'NEILL, D. 2011. Aesthetic and Cultural Pursuits of Patients living with Stroke Trinity Medical School Conference. July.



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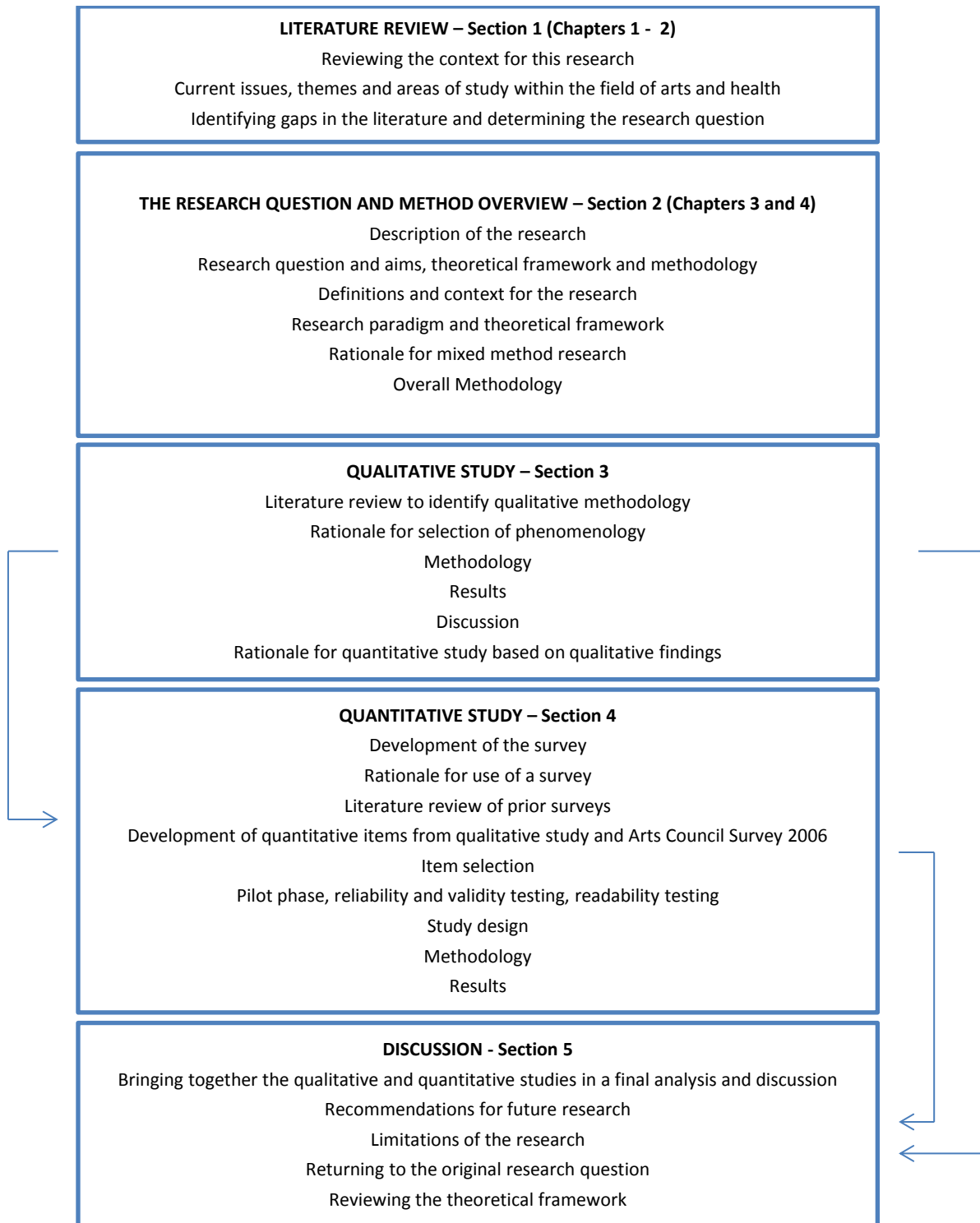


## ***Introduction to the thesis***

This thesis is divided into five sections. In order to explore the role of aesthetics for patients in hospital, a literature review was conducted in Section One, which thoroughly examines the fields of aesthetics and aesthetics in healthcare, to set the context for this study and to identify gaps in current research. In Section Two, the research question is formulated and presented, along with methodology for the overall study and theoretical framework.

Section Three and Section Four present the two arms of the mixed methodology research – a qualitative study (Section Three) followed by a quantitative study (Section Four).

Section Five presents the discussion of the whole research, bringing together the results of the two studies which together form the mixed method research. A final analysis and discussion is given in this section, as well as recommendations for further research. Figure 1.1 outlines the overall thesis design.



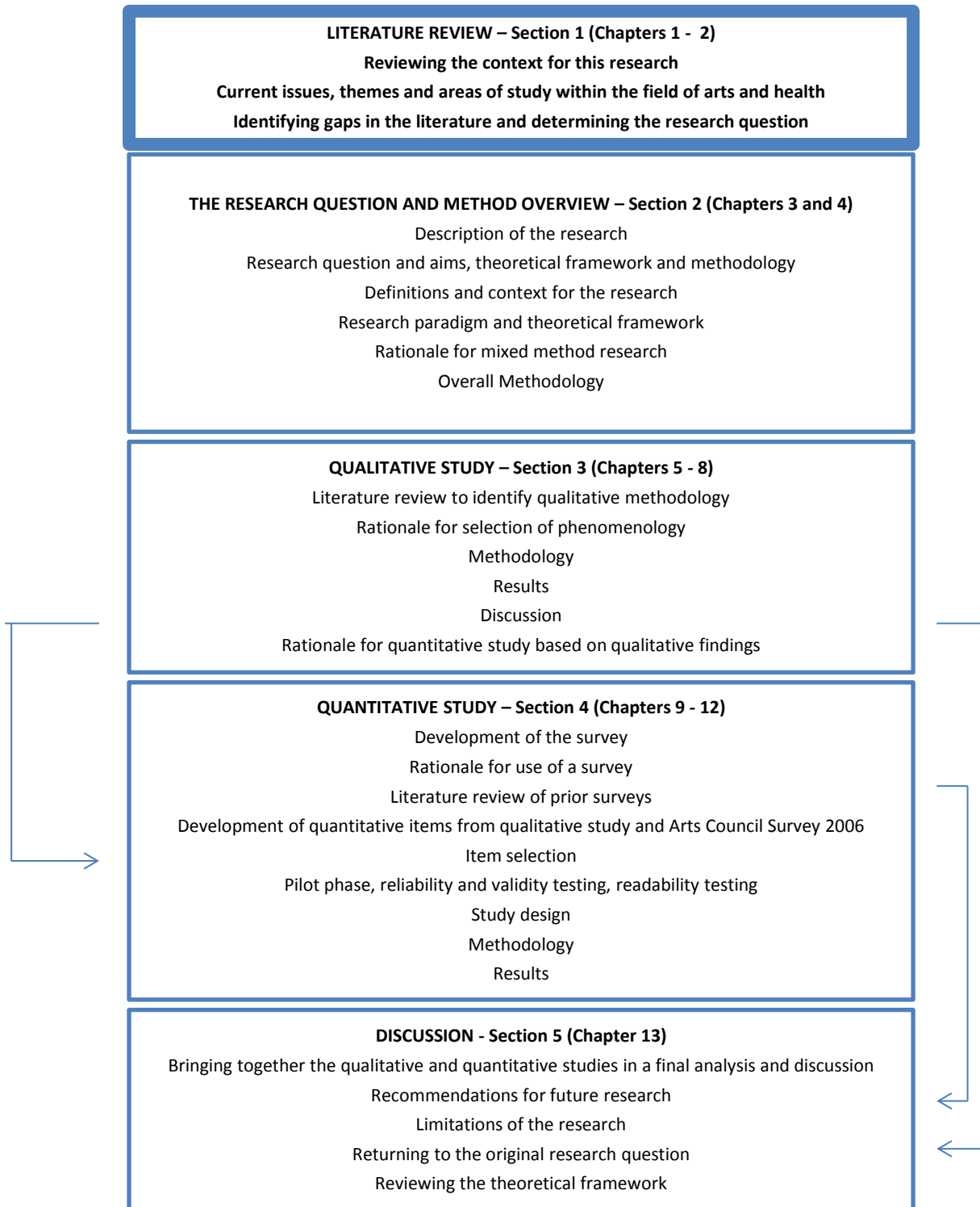
**Figure 1.1 Overall thesis design**

## ***Section One Literature Review – Overview***

This section presents the literature review which is the first stage of this research (See Figure 1.2).

The review of relevant literature aims to provide the reader with a framework for the research, to set the context of the international field of aesthetics and health and to position this research within the current status of arts and health research and findings of relevant research in the area. The literature review also identifies key findings in the literature to date and gaps in current research. The research question and methodology for the research were formulated arising from this review (Section Two).

The literature review is presented in the format of orientating the reader to the broad field of aesthetics (Section 1, Chapter 1) followed by a comprehensive overview of the literature concerning aesthetics in healthcare, with a section specifically reviewing arts and older people (Section 1, Chapter 2). Following this literature review, the research question is then presented (Section 2, Chapter 3), including aims and theoretical framework, followed by the overall methodology for this research (Section 2, Chapter 4).



**Figure 1.2 Overall thesis design highlighting literature review**



# **Chapter 1 Literature Review - Aesthetics**

## **1.1 Introduction**

This purpose of this chapter is to give an overview of the field of aesthetics and to outline the definition and understanding of aesthetics underpinning this research. The role of aesthetics in healthcare can only be understood within the broader context of aesthetics and its many applications in different areas of society. The chapter gives an overview of the following topics:

- Introduction to the philosophy of aesthetics and four significant topics discussed in the literature – art and pleasure, art and emotion, art and human understanding and art as a relief from suffering.
- Definitions of art and beauty, including, the value of art, high and low art and the concept of beauty
- Aesthetics in contexts – arts and sociological theory, changing notions of culture and curatorship and environmental aesthetics
- Aesthetic deprivation and the neglect of everyday aesthetics

The chapter ends with a summary of key themes and issues surrounding the field of aesthetics. The following chapter (Chapter 2) presents the role of aesthetics in healthcare settings and more specifically in the context of older people.

## **1.2 The philosophy of aesthetics**

The arts are an important part of human life and culture and attract a significant amount of private and public funding, attention and support. Philosophers have engaged with the role and significance of arts in society for thousands of years

and there are many different views as to the value and meaning of the arts in society and many definitions of aesthetics (Eggenberger et al., 2004). Studies confirm that attendance at arts events and participation in arts activities is popular and can have some health gains (Bygren et al., 2009a, Bygren et al., 2009b, Bygren et al., 1996, Hill, 2010, Konlaan et al., 2000, Lunn and Kelly, 2008, The Arts Council, 2006).

The word *aesthetics* is derived from the Greek noun *aesthesis* meaning sensation (Eggenberger et al., 2004). The definition chosen for this research is as follows:

*Aesthetics is an attempt to theorize about art, to explain what it is and why it matters (Graham, 1997) p. 2.*

There is a number of perspectives and a diverse range of definitions regarding the role of arts in society (aesthetics), stemming from the earliest philosophers to current writers. In reviewing the literature, three broad outlooks appear to dominate – art as pleasure (the arts as a form of recreational activity, for diversion or pleasure), art as emotion (the expression of emotions through the arts) and art as a channel through which one can deepen one's understanding of what it is to be human (O'Hear, 2008). To begin this study of aesthetics in healthcare, and to reach the definition of aesthetics used above, a brief review of the earliest philosophies of aesthetics was undertaken.

Plato viewed the arts as an activity that must be regulated so that impressionable young people could be moulded towards an ideal state.

*The arts can only have true worth if they correctly represent (a metaphysical and ethical) order or help in aligning us with it (Janaway, 2005) p.3.*

Plato (428/427 – 348/347 BC) held that art imitates life, in that it is always a copy of the original physical things. The arts can lead us away from truth and towards illusion and must be carefully utilised. Plato believed that self-control, especially control of the passions, was critical to the soul's purity. Art was therefore seen by Plato as, at best, imitation and entertainment and at worst, a dangerous delusion. Thus, Plato severely censored the arts. Plato also developed the theory that artists are divinely inspired, a theory which persists to the present day (Clowney, 2011, Stock, 1909, Richards, 1948).

Aristotle (384 BC - 322 BC) however, identified that arts could arouse passions and was less censorial of the arts. He noted the idea of *catharsis* (the venting, clarifying and training of emotions) as well as the understanding of these emotions as ground work for ethical behaviour. Aristotle argued that catharsis, through the arts, could benefit ethical action rather than subverting or overpowering the capacity to reason. In short, Aristotle viewed art as a learning tool not just a pleasurable activity. His work focused mainly on drama and tragedy, giving strong guidelines for plot, characters and form of drama. Many of the elements of his work are still an influence today, such as the idea that man's propensity to engage in mimetic activity (representation, imitation) and to take inherent pleasure from these, are what distinguishes man from other creatures (Halliwell, 1987). However, some of his early ideas about aesthetics are quite controversial. For example, comedy was viewed as a mimesis by men who are inferior beings and women were only allowed to adopt certain characteristics when playing theatre parts and he also refers to the weakness of audiences (in other words, doubting their ability to think and process for themselves) and viewed some arts as clearly superior to others (Halliwell, 1987).

A notable thought in Aristotle's theory is that a good tragedy speaks of what might occur, whereas a good historical account speaks of what did occur. It is

this 'what might occur' which makes it art and changes ignorance to knowledge. Certainly, during Aristotle's time we see a shift from Plato's censorship of the arts to an acceptance of the emotion and value of arts, as well as recognition of the value of the pleasure people gain from viewing arts and the understanding and mirroring of oneself which is seen in the arts.

Moving through history, the medieval philosophers such as Aquinas (1225-1274) view aesthetics as purely what is beautiful and pleases the soul, the soul's natural aspiration (Margolis, 2005). Discourse on aesthetics dwindled in importance during this period and was confined mainly to concerns with Christian art. The eighteenth century saw the 'modern system of the arts' emerge with the work of Hutcheson (1694-1746) and Hume (1711 - 1776). It is Kant (1724-1804) who is generally regarded as writing the foundational treatise on modern philosophical aesthetics (Crawford, 2005).

Kant denied that art was purely about pleasure and discussed sensibility (the passive ability to be affected by things by receiving sensations) and understanding (the active faculty of producing thoughts) as core components of the arts. Immanuel Kant's Critique of Judgement is considered one of the greatest works on aesthetics and he is largely considered the founder of the philosophy of aesthetics (Creed Meredith and Walker, 2008). His great advance was to see aesthetic taste as having three elements - firstly, that it is not a purely subjective matter but something which claims universal assent; second, that it arises not from any concept of the understanding but from the free play of imagination; and third, that the ability to play freely is the peculiarity of artistic genius (Graham, 1997).

Kant's position is that something is beautiful if it is disinterested, universal and non-cognitive (O'Hear, 2008). In other words, something is beautiful for what it is, not for some other purpose that it serves. Aesthetic judgement is

distinguished from a mere preference of taste – when we call something beautiful we presuppose that anyone else who looks at the object will come to the same conclusion. For example, we might read a text by Oscar Wilde multiple times and still appreciate it, but the same cannot be said for re-reading a text book or newspaper. The beauty of an object is also based on personal direct experience and not simply by our cognition (for example, we might appreciate, cognitively, a Bach fugue, but this in itself does not make it beautiful and one does not need to understand fugue to appreciate Bach's music as beautiful). Some art is, of course, primarily political or instrumental and is therefore (in Kantian terms) interested and particular. It might, for example, aim to disturb or challenge. Kant argues that this art may not actually be beautiful or of the highest quality.

Hegel (1770 – 1831) took this thinking even further, believing that humans acquire their grasp of the world through art and religion as well as through cognition. This placed the arts as equal in importance to religion and rational thought. Hegel was convinced that we are informed by all three of these elements (art, religion and rational thought) when making sense of the world (Inwood, 2005).

A review of the philosophy of aesthetics reveals four key perspectives that reappear throughout history and emerge as central to the role of arts in society. These are art as a form of pleasure, entertainment and diversion; art as a form of expression of emotion; art as a vessel through which we deepen our understanding of what it is to be human and art as a relief from the suffering and striving of life. These four key outlooks are presented below, followed by a discussion of concepts of art, beauty and the value of art.

This brief review of the ancient philosophies of aesthetics indicates how important context is on the acceptance of art, art forms and artistic practices.

### **1.2.1 Art and pleasure**

Hume (1711-1776) is one of the foremost philosophers to hold the view that art is primarily connected with pleasure or enjoyment. To Hume, to state that a work of art is good is the same as saying that it is pleasant or agreeable (Graham, 1997). He also proposes that there are some universal qualities to this view of art as enjoyable, so that particular forms are calculated to please and others to displease. For example, many people find Mozart enjoyable to listen to and agree that Jane Austen is a fabulous writer. The argument against this simple theory of art as pleasure and recreational activity is the value societies place on art in education and public spending. There might be objections if the only reason for government arts spending was to amuse people and this acceptance of arts as part of civic society implies that the arts must have a deeper purpose than purely entertainment. If art was purely for pleasure, it would be appropriate to transfer spending on classical music and opera, which is currently a minority interest, to major sporting events which are popular recreational activities. There are many cheaper and less taxing forms of amusement than the arts! Gadamer (1900 – 2002) advanced previous philosophical theories about art as pleasure, arguing that art is an especially valuable form of play. However, an undue emphasis on perception of the arts as recreation might explain why artists and aesthetics often struggle to have a serious role in society.

### **1.2.2 Art and emotion**

Art as pleasure is quite a limited concept. The emotional and communicative aspects of arts are significant when compared to other entertainments and pleasures. This was the view shared by the Expressionist school of art, which held that painting ought to contain emotion. Tolstoy (1828 – 1910) states that

*Art is a human activity consisting in this, that one man consciously by means of certain external signs, hands on to others feelings he has lived through, and that others are affected by these feelings and also experience them (Tolstoy, 1930) p 123.*

The ability of artists and poets to arouse dangerous emotions was one of the factors that led Plato to ban them from the Republic. However, the outpouring of emotion may not be enough, in its own right, to constitute a work of art.

It is possible that one can never really separate the aesthetic experience from personal experience, for example the memories and emotions associated with experiencing a song can colour our judgement of its aesthetic quality. A song heard at a funeral of someone we love, for example, takes on a totally different role in our lives and is appreciated in a different way to the same song heard prior to this event. We evaluate a physical environment, for example a hospital, from our own role in that place and our purpose being there, and that influences our judgement of its aesthetics (Cold, 2001).

### **1.2.3 Art and human understanding**

The two views of art as pleasure or art as emotion are key aesthetic theories. A third view of art is that its content enables us to understand the deeper mysteries of the human condition, which may explain the high value placed on arts by all societies.

*The arts must be taken no less seriously than the sciences as modes of discovery, creation and enlargement of knowledge in the broad sense of advancement of the understanding (Graham, 1997) p.42.*

Knowledge gained through art, however, cannot be the only reason for it. Graham (1997) purports that although the arts can, and do, give us knowledge of many kinds, knowledge cannot surely be the key to, and limit of, the love of art (Graham, 1997)? Aristotle spoke of the view that the primary value of art concerns the way in which it enriches how we understand ourselves and the world. Aristotle was reacting to the notorious condemnation of art by Plato. Plato held that art cultivated the baser affective aspects of our souls, overriding the proper control of reason and thus leading us away from what is true and good. Aristotle argued that art was to be highly valued as a craft and can realise certain cognitive affective ends particularly well (Kieran, 2005). The standard cognitivist presumption is that art is a communicative act and what is distinctive about art as opposed to philosophy is the means by which it seeks to do this. This view of art is deeply tied to our capacity, and need, to understand ourselves, others and the world.

#### **1.2.4 Art as respite from everyday life**

Schopenhauer (1778-1860) identified the ability of the arts to provide escapism or respite from the trials of everyday life. He proposes that every human being experiences suffering as a keynote of life due to unfulfilled desires and frustration. Art and artistic genius play a pivotal role in life by allowing us a temporary respite from the cares of daily life; a transcendence of practical desire and a breaking free from the servitude of the will and the suffering of life (Graham, 1997).



### 1.3 What is art?

Despite the many philosophical perspectives about the role of art in society, there continues to be difficulty in defining art. Art has variously been described as imitation or representation, as a medium for the transmission of feelings, as intuitive expression and as significant form (Davies, 2005). Davies (2005), however, believes that even these various definitions are inadequate and describes two approaches to the question of 'what is art?' Firstly *functionalism*, whereby art is designed to service a purpose, to provide a pleasurable aesthetic experience and secondly, *proceduralism*, whereby something is art if it is made according to the appropriate process or formula, regardless of how well it serves the point of art. Davies argues that the function of art changes through time and the definition of art is subjective. Combining the functional and procedural definitions produces a hybrid definition of art, which may produce a more useful definition. The definition of art taken for the purpose of this research is as follows:

*A work of art is one, about something and two, to embody its meaning (Davies, 2005) p. 235.*

Alexander (2003) attempts to define some elements that form the notion of 'the arts'. These include the need for an artistic product (e.g. CD, performance, poem), a public communication, an enjoyable experience and an expressive form (Alexander, 2003). However, such a definition raises as many questions as answers. Can art not be a private performance? What about art which is not necessarily enjoyable? Is haute couture art? Is French gastronomy an art form or a food? Why is ballet defined as 'art' but World Federation wrestling not? Alexander queries whether art must have aesthetical value and a defensible and coherent aesthetic to be called an artwork, or is something an artwork just because people say it is? For example, we tend to call a work 'art' if it is housed

in a museum, but this may just be because the context tells us it is art rather than because the piece has a special attribute which makes it art (Alexander, 2003).

Mandoki (2007) also questions the link between art and aesthetics, proposing that other forms such as landscapes and gardens are aesthetic, not just art. Art might in fact be economic, political, therapeutic or public relational and not actually aesthetic at all (Mandoki, 2007). The polemical writer John Carey controversially defines a work of art:

*Anything that anyone has ever considered a work of art, though it may be a work of art only for that one person (Carey, 2005) p. 29.*

In ancient civilizations art was made by the whole community and was not the elitist activity it is today. Art in ancient Greece and Rome was not created by a specialist caste of people. Carey argues that defining art is a modern twentieth century problem and aesthetics only arose as a definition from about 1750. However, many societies throughout the history of humanity took pains to make special things. People in the Inuit and Stone Age cultures, for example, made items that were not just decorative or competitive; there was a sense of excellence and of 'making special', with social importance. A more recent study identified music, literature and painting as some of the transcendental, special, ecstatic experiences identified by a sample of the population. Natural beauty, sex and childbirth were the only experiences rated more highly than these art forms (Laski, 1961).

Carey concludes that there are no absolute values in art and we can't call others opinions invalid or incorrect. The tastes of certain periods and the fashion of a particular culture often lead to definitions of 'greatness' from that period. There is a belief in the truth of 'great' art. Carey's polemical writing claims that anyone

can be an art expert, in other words, none of us really know much about art, but we know what we like (Carey, 2005).

In conclusion, it is very challenging to define aesthetics and art. The origin of aesthetics comes from Greek etymology as the subject of sensibility or perception (Mandoki, 2007). This definition does not relate specifically to any particular category of objects or their relation to beauty. Mandoki's definition seems useful in understanding aesthetics as a spectrum from basic bio-aesthetic condition of live creatures (feeling pain, undergoing enjoyment) to the everyday aesthetics to aesthetics in high art forms such as literary, musical or visual artefacts.

## **1.4 High art versus low art**

When defining arts and aesthetics there can be controversy regarding perceived divisions between high art and low art. For example, in hospitals there is often disagreement about which kind of art is most appropriate, with popular culture often prevailing over more challenging modern art. Alternatively, sometimes the popular arts are not considered 'proper' arts, with bodies such as The Arts Council of Ireland, for example, funding only what they consider to be high art.

Societies have always tended to rank and divide arts, but there is not necessarily a distinct difference in aesthetic value between 'high' and 'low' art. Some people think of high art as 'good' and low art as 'bad', whereas some writers suggest that each appeal to different audiences which are no more or less important than each other (Fisher, 2005). Are literary classics or Jackie Collins novels more valid literature for a library to acquire? Is country music or classical more appropriate for a publicly funded music venue? Kant defined art and beauty as a specific entity, stating that beauty lifts us to good behaviour.

Other writers suggest that what one person finds beautiful is, in fact, all that matters (Carey, 2005, Commission for Architecture and the Built Environment, 2010b). There are many attempts to place art in a special category, for example better or higher than other activities but Carey's controversial definition of arts does provoke one to consider what makes anyone claim to be an art expert.

Fisher defines popular art as follows:

*Dominated by a need for familiar forms, an intolerance of ambiguity, a tendency toward easiness and emotional indulgence*  
(Fisher, 2005) p. 529.

It can be argued that high and low arts meet distinct aesthetic needs and that only social convention differentiates between high and low art, making this an artificial distinction (Fisher, 2005). For example, opera was enjoyed by the masses in the nineteenth century and is less widely accessed in modern society due to attitudes within society and current music education. Other distinctions include mass art vs. high art (Fisher, 2005). Mass art is characterised as appealing to the masses, being safe, easy and undemanding, formulaic, not original and lacking the critical perspective required of real art due to its commercial value. Another proposed distinction is 'serious' art vs. 'entertainment' art, but again it is contentious to see entertainment as negative, and less intrinsically valuable, than the 'serious' art world.

The elite art world of modern times may have created their world of galleries and concert halls from which the 'masses' are excluded. However, it is arguable that this excluded group has simply carried on creating their own art which is popular and has mass appeal (Carey, 2005, Mandoki, 2007)! Andy Warhol's *Brillo Soap Pad Box 1964* is a prime example of the debate about what is art. In this work, Warhol employed carpenters to construct numerous plywood boxes identical in size and shape to supermarket cartons. He painted and silkscreened

the boxes with logos of different consumer products: Kellogg's corn flakes, Brillo soap pads, Mott's apple juice, Del Monte peaches, and Heinz ketchup. The finished sculptures were virtually indistinguishable from their cardboard supermarket counterparts. Warhol first exhibited these at the Stable Gallery in 1964, and though they did not sell well, the boxes caused much controversy (see Figure 1.3).



**Figure 1.3 Photograph of artwork by Andy Warhol, entitled Brillo Soap Pads Box, 1964<sup>1</sup>**

Art has been mystified by many and this can limit our understanding or confidence regarding what art is, what it can be and also what aesthetic experience might be (Gaut and McIver Lopes, 2005). Fear of the immoral also affects what a society will consider as art and show in their film and exhibition venues. For example, is some pornography art? Is an art exhibition depicting Nazi death camps an aesthetic experience or inappropriate due to political

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<sup>1</sup> © 2014 Andy Warhol Foundation for the Visual Arts/Artists Rights Society (ARS), New York

concerns? Mandoki argues that there is an art for every public and taste, whatever the level of sophistication and technique, audacity or creativity, talent or acumen may be. While museums might be quiet and underused

*... The public has no difficulty in finding alternative aesthetic delight through many other phenomena, like movies, video-games... weekend hobbies, pets and sport (Mandoki, 2007) p. 34.*

Controversy and debate seem set to continue regarding definitions of art, its value and the high/low art debate. For example, are soap operas art? They offer discussion and reflection through unpretentious drama but are seen by many as far from an artistic experience. Is high art sacred and unassailably valuable or is it just a creation by the elite to make the art specialist feel unique, special and better than mere mortals (Fisher, 2005, Mandoki, 2007, Carey, 2005)? Is any art universally admired? Even Shakespeare and Mozart are criticised by some. Fisher's (2005) argument that there is no specific difference in aesthetic value between high and low art, and that any such distinction is an artificially constructed view by society, sits well with the experience of programming arts for patients in a hospital. Neither can be argued to be more important and neither has been proven to have greater effect. A patient-centred approach would indicate that all arts are equally salient if viewed as an expression of the individual preference of the patient.

## 1.5 The value of art

The arts can be defined in many ways, with attempts to define the value of art being equally elusive. The arts can be instrumentally valuable (as a means to an end, for example an artwork is valuable because it cheers me up) or intrinsically valuable. The intrinsic value of art has been described as an appreciation of the imaginative experiences provided by arts, which may be beautiful, moving, uplifting, pleasurable, insightful or profound (Kieran, 2005). The value placed on a work of art is often a result of our active mental engagement and its value is relative to whether, or how, it affords us a valuable experience.

*We do not value works for their own sake but because they enable us to realise certain ends such as pleasurable experiences (Kieran, 2005) p. 294.*

Kant (1724–1804) stated that art is a cultural practice geared towards the intentional production of artefacts that are graceful, elegant and beautiful thus giving rise to pleasure in our contemplation of them. However, not all art has aesthetic appeal yet can still have value, for example conceptual art. Mandoki argues that art has always been a social product linked to society. Even those who argue that art is for 'art's sake' and not for any other reason, for example, are actually committed to a certain social group with certain political views (Mandoki, 2007).

While aesthetic cognitivism can explain, to some extent, why we attribute such value to great artworks, it is also valid to value the arts as important not only because they bring a greater understanding of the human condition, but because we find pleasure, beauty, emotion and communication in them.

*Perhaps art is needed to gesture towards mysteries left by science (Inwood, 2005) p. 78.*

Thus, art may be both an end in itself and of service to morality or ethical life (Inwood, 2005).

*Great nations write their autobiographies in three manuscripts – the book of their deeds, the book of their words and the book of their art. Not one of these books can be understood unless we read the two others, but of the three the only trustworthy one is the last (O'Hear, 2008) p. 48.*

The predominant role(s) given to arts, and the value (or not) placed on it, often reflects the social, political and economic context as well as the value of the arts in society. This is certainly reflected in the role of arts in modern healthcare environments. For example, funding for arts in health settings is affected by the government budget available for the arts in general and national policy (or lack therefore) regarding funding the arts in healthcare settings.

## **1.6 Aesthetics and the concept of beauty**

In any study of aesthetics it is important to mention the concept of beauty. Attempts to capture the value and nature of beauty are found throughout human history, from Plato and Aristotle to the present day. For example, Aristotle (384 BC - 322 BC) defined beauty in terms of specific aesthetic qualities, in his case order, symmetry and definiteness (Bakhshi, 2010). In ancient Greece, beauty was construed in a mathematical fashion, in other words certain proportions produced a beautiful form. Column lengths in architecture and lengths of human limbs in sculpture, for example, were defined as having perfect proportions (Parsons, 2010). In modern times beauty is quite an unfashionable word and a concept rarely mentioned, with a stronger focus on



culture and the arts than beauty. The importance of beauty in today may indeed be most apparent in its absence (Bakhshi, 2010).

Definitions of beauty are highly elusive. Questions such as whether beauty matters and what beauty is are very subjective concepts. Nature is the most commonly identified beauty in our world. However, as early as cavemen, art was identified as an important way of preserving memorable and important events and often viewed as a potential source of beauty.

*Paintings, pieces of music and buildings ... can flood a beholder with life-love, but many others stimulate in different ways, inspiring awe, astonishment, grief, shock (Athill, 2010) p. 6.*

It is common to link beauty with 'safe' art, for example the elegance of a cathedral or Georgian architecture. Unfamiliar art forms or expressions can be harder to accept as beautiful. The commissioning of public buildings can be controversial due to the subjective nature of what makes a building beautiful. Often, public buildings, including hospitals, are about the usefulness of the building first and beauty is seen as a secondary benefit (Athill, 2010). Research by the UK Commission for Architecture and the Built Environment (CABE) in 2010 involved conducting a major nationwide survey in the UK, asking people about beauty and the built environment, including what beauty meant to them, where they experience it most often, who they think is responsible for it and whether there is enough beauty in their area. 80% of those surveyed thought everyone should be able to experience beauty and only 18% thought that beauty matters less if you are poor.

*It feels as though discussing beauty has been a taboo...but beauty is closely linked to our individual sense of well-being: our personal worth, collective pride and appetite for making things*

*better (Commission for Architecture and the Built Environment, 2010a) p. 1.*

What does it mean when we say something is beautiful? Parsons (2010) stresses that sometimes we simply mean we like something (e.g. 'That dress is beautiful' really means 'I like that dress'). Some writers believe that beauty is simply a personal preference and falls beyond the concern of the state (Parsons, 2010). However, it is arguable that beauty is integral to our survival – if we didn't find babies beautiful we would leave them to die (Greer, 2010). There is great diversity in what people find beautiful (for example, dresses, faces, sunsets, cars, paintings) and for some beauty is simply a reason for pleasure. The same arguments surrounding the definitions of aesthetics are found in discussions of definitions of beauty and the two areas overlap greatly. For example, it can be argued that pleasure is an insufficient explanation of beauty, because we might find our new drain pipes pleasing but they are not beautiful. Another definition of beauty is that it is pleasing for its own sake, and not for some other reason such as usefulness or durability. Again, this might be a limited theory, for example roller coasters are enjoyed for their own sake, as are good jokes, but neither is beautiful. Beauty is defined, for the purpose of this research, as:

*That which pleases in virtue of its perfection... to find something beautiful is to see it as something of supreme quality that cannot be improved (Parsons, 2010) p. 13.*

Beauty is a glimpse of the ideal, which we need psychologically as a reminder that it exists, despite the imperfections of the world. This may be why beauty has been classed among the great goods of human life.

*To live with beauty is to live in the world we want, a world where, despite the obstacles, at least some good thing has*

*flourished beyond our imagination. It is not difficult to see the deep psychological satisfaction that this kind of experience can offer (Parsons, 2010) p.16.*

It would appear that in modern society we have lost the articulacy to talk about beauty. For example it has become unfashionable to discuss the need for beautiful places to be available to people in hospital. The concept of beauty appears to have little attention or importance in modern society. Some writers view beauty as being purely subjective, or linked to moral values, or only understood and appreciated as a cultural or communal phenomenon. As a result, precise definitions of beauty are hard to find, and there are a lack of agreed definitions as to what makes an aesthetically pleasing environment.

*It is tempting to drop the talk about beauty altogether, and steer the discussion toward more quantifiable matters: cost, sustainability, economic benefits, and so forth (Parsons, 2010) p. 19 - 20.*

Beauty is about transcending the everyday and finding meaning and our spiritual core. Life with beauty becomes more than politics, moral values, science, materialism or functionalism. Positive aesthetic experiences can be seen as a pointer to the existence of a higher reality and meaning. Art, then, is seen as a quest for universal and disinterested experiences of beauty (O'Hear, 2008). Umberto Eco (2007) wrote one of the few accounts of ugliness in art throughout the ages. Concepts of beauty and ugliness are relative to historical periods and cultures, for example in music the interval of the augmented fourth was always seen as the classical example of ugliness but in modern times atonal music has become accepted and appreciated. Similarly the Eiffel Tower was seen as ugly when it was designed but now is appreciated as beautiful by many people. Eco argues that assumptions of beauty or ugliness are often due not to aesthetic but

to socio-political criteria and that the concept of beauty and ugliness is purely a construct of a particular society (for example, the idea of witchcraft in early Christian times).

*Ask the devil, he will tell you that beauty is a pair of horns, four claws and a tail. (Eco, 2007) p. 12.*

Mandoki (2007) agrees with Eco and argues that beauty does not have a power of its own, nor does it exist independently of a subject. For example, in some African countries a deformed lower lip is a sign of beauty, in other cultures tattoos are viewed as beautiful – beauty is, according to Mandoki, a linguistic effect to describe personal experiences and social conventions. Beauty exists only in the subjects who experience it. She contends that arts can be viewed sociologically, philosophically, economically or aesthetically and context, such as a hospital building and the current political stance, becomes crucial here in deciding what might be considered beautiful and whether investment is made in beautiful objects (Mandoki, 2007).

Whilst a unified concept of beauty seems elusive, there is a growing body of knowledge about how people value beauty in their everyday life. In modern times, we are increasingly drawn to only value things that can be measured (Bauman, 2010). The instrumental value of beauty may matter more to policy makers than the intrinsic value.

*In an age of financial austerity it is tempting to think of beauty as a needless decorative expense. It is not merely that decorative beauty has an important role to play in our lives – far more often beauty is the upshot of serving our practical needs with elegance, integrity and imagination (Kieran, 2010) p. 15 - 16.*

Freud (1856 – 1939) reasoned that beauty had no obvious use: a wider adoption of this line of thought may lead to it being undervalued by public policy makers. The importance of beauty, perhaps, lies in its absence, and it may not be noticeable to policy makers until it is not there. Beauty often competes poorly with utilitarian demands, yet the love of beauty is a deep seated need in human experience and the pursuit of beauty is a major drive in humans in their search for happiness (De Botton, 2006, Bauman, 2010).

## **1.7 Art and sociological theory**

In reviewing the various perspectives on aesthetics, beauty and art, and their value, it is important to consider the effect of context and how this context affects how arts are viewed. The next sections (Chapter 2, sections 1.7 – 1.9) review the role of aesthetics in contexts, namely sociological theory, environmental aesthetics and everyday aesthetics. This will lead to a focus in Chapter 2 on arts within healthcare contexts and with older people.

Sociological thought centres on the value of arts in terms of the specific function it holds in cultures. The presence of art in every culture suggests that the arts have an abiding value. Dutton describes art as a cultural universal; there are no known human cultures in which there cannot be found some form of what we reasonably might term aesthetic or artistic interest, performance or artefact production. Tolstoy (1828 – 1910) defined art's universal essence as its communicative capacity to tie people to one another (Dutton, 2005).

Aesthetics have always played an important role in society. A study by the Economic and Social Research Institute (ESRI) of the Irish Population in 2006 indicated that 90% of the population believe the arts play an important and valuable role in a modern society and 85% of people had attended at least one

arts event in the last 12 months. Film was the most popular art form followed by rock/pop music. Consumer and government spending in arts is also revealing, totalling 4% in Canadian surveys, for example, and being greater than the spend on alcohol and tobacco (Hill, 2010).

Society is both reflected in the arts and affects how art is created. For example, Turner's art work shows aspects of the political and economic climate of Britain at the time; in the nineteenth century art was believed to have an uplifting effect and this led to a cultural highbrow that believed that high art was beneficial and mass art was harmful. Similarly the compositions of women in the eighteenth and nineteenth centuries were ignored and/or undervalued and only in recent times have music historians begun to piece together the compositions of women in those centuries.

The arts in modern society are shaped and affected by a number of stakeholders, from the artists themselves to the tour agents, promoters and audiences. Some of these people act as gatekeepers, making some cultural activities more accessible than others (for example, high ticket prices for opera making this less accessible; huge promotion budgets and advertising for major pop stars). Similarly non-profit arts organisations, whilst not motivated by profit, might be conservative in their programming in order to guarantee revenue streams as they depend on ticket sales to survive.

In all contexts, from art in galleries to public spaces to healthcare settings, there are conventions that can either constrain art or make art possible. Rather than art being the work of a genius, the creation of art can be greatly affected by the social positioning of gatekeepers. In healthcare settings the dominant focus of the institution is not engagement in arts and therefore high levels of concern about risk, infection control and health and safety can affect what art is possible in this setting (Alexander, 2003).

Sociological perspectives explore how cultural backgrounds affect the decisions people make regarding arts consumption. For example, the social class, age and gender of an audience affect the modes of reception, so that some ages and genders will listen to a band in a pub while other sectors of society are more likely to attend a gallery or concert hall. Sociologists arguably share a core assumption that art is a mirror held up to society (Alexander, 2003). New works of art may reflect the politics of the day as much as any genius or genuine free creativity. For example, curators of art galleries and museums may be involved in preserving the community's cultural heritage, concerned about the spiritual life of its citizens and preserving achievements of a society's past (Duncan, 1990). However, they can also be selective about what they collect, retain and commission. Art is situated in social systems and is embedded in society. The artist, creator, consumer and society cannot entirely be separated out and they all influence each other. Thus in a health service context, the artist creating work cannot entirely be separated from the health service culture, priorities, staff and patients when creating work in this specialised environment. The context of any society or time affects the role and value of the arts in that setting.

## **1.8 Changing notions of culture and curatorship**

The way arts are received and perceived is always driven by social, political and economic contexts and decisions regarding selection and commissioning of arts is often affected by prevailing fashions of the time. A timely example is seen in the literature on museum curatorship in the UK. In the 18<sup>th</sup> century, museums

emerged in England in order to meet the need to provide a general education for large numbers of people. This grew from the ideals of the Age of Enlightenment (a cultural movement of intellectuals beginning in late 17th- and 18th-century Europe emphasizing reason and individualism over faith and tradition). Collections which had previously been in private possession of monarchs became public. In the 1970s the education role of the museum was particularly seen as important and changed the focus expected of national museums, increasing outreach and educational programmes at museums and galleries. In the 1990s in the UK, however, there was a significant move to identify why museums and art galleries seemed to have become so elite and isolated from the people they served and to identify what role they should and could play in society. Managers and marketing specialists were introduced to cultural institutions to try to bring them closer to the people and this was greeted by some art specialists with suspicion. Curatorial departments often reflected the class system in Britain and free access for all was an attempt to reverse this position. In more recent years, debate has arisen again about whether visitors should be charged to visit British galleries and museums or whether free access for all is an important value to uphold (Anderson and Karczmar, 1990).

It can be seen from this brief example that the role of galleries and museums throughout history range from scholarly and academic specialist centres to centres of 'education and fun for all'. Deciding what to curate and what objects are valuable is a changing business, dependent on the politics and context of the day.

*What obligations, if any, do museums have in relation to inequalities in the consumption of culture, or to inequalities in other domains of social life? (O'Neill, 2008) p. 290.*



The debate about the value of arts can be seen as a split between politicians and policy makers who value the 'instrumental value' of the arts and cultural professionals who are dedicated to the 'intrinsic value' of the particular medium. This debate has been seen throughout the history of aesthetics. O'Neill proposes a solution for artists

*...the key issue is ... not a conflict between instrumental versus intrinsic values, but how expert institutions make their specialist contribution and at the same time foster the wellbeing of society as a whole (O'Neill, 2008) p. 291.*

This debate can also be seen in the curatorial aspects of arts in healthcare settings. Are the arts provided to meet certain health promotion or clinical aims or are they intrinsically valuable in healthcare contexts? Curators often act as guardians of our artistic heritage and make decisions which may not always serve the wider population. A recent move has been for art galleries to create outreach programmes to bring our national cultural heritage into hospitals and other health settings. Some commentators welcome this sort of change and argue that museums should clearly articulate their terms of contract with society.

*Society has continued to fund museums, though with growing reluctance and increasing uncertainty about the benefits it could expect from its share of the contract. Curatorial knowledge does not exist in a vacuum; it is a social construct (Anderson and Karczmar, 1990) p. 200.*

Museums and galleries are taking an increasing interest in the health and wellbeing aspects of visiting museums and handling objects and artefacts. The rationale for this is an increased awareness of the importance of building social

resilience and enabling people to tackle negative aspects of ill health through positive cultural experiences. Examples such as New York's Museum of Modern Art *Meet Me* programme (offering guided tours for small groups of people with dementia) are at the foreground of this new area of work. Similarly, historical collections such as the Wellcome Collection in London serve both as places to contemplate health-related information and somewhere to tackle current public health challenges such as obesity (Chatterjee, 2012).

Museums and their collections are also increasingly being used by medical humanities programmes in medical schools as places to educate their students. Some of the benefits for patients of handling objects and visiting museums have been identified as providing positive social experiences, opportunities for learning, environments which are calming and reduce anxiety and promoting a sense of identity and community. However, a limitation of these programmes is the lack of an agreed framework for measuring and evaluating the impact of museum encounters on health and wellbeing and economic restrictions which hamper growth and research in this area (Chatterjee, 2012).

Curators both inside and outside healthcare contexts have a delicate role in balancing support for the intrinsic value of the arts with meeting patients' preferences and health service aims for improved well-being through the arts. Clearly articulated aims are paramount in this emerging field.

## **1.9 Environmental aesthetics**

Aesthetics, art and beauty must be considered within both the societal and environmental contexts in which they reside or are created. Analysing the arts demands closer attention to the wider social setting in which art is produced and received and a greater sensitivity to the variety of such settings, many of which

fall outside the ambit of the art world of 'high' Western art (Davies, 2005). Environmental aesthetics extends beyond the narrow confines of the art world and our appreciation of works of high art, to the aesthetic appreciation of environments, not only natural ones but also human influenced and human constructed environments. It has its historical root in early work on the aesthetics of nature (Carlson, 2005).

In the 18<sup>th</sup> century, works of art became more important and landscapes became less important as objects of aesthetic appreciation. The aesthetic appreciation of the world beyond the art world was neglected even in the early 20<sup>th</sup> century. In the second half of the 20<sup>th</sup> century philosophical aesthetics was virtually equated with philosophy of art (Carlson, 2005). This development reached the extreme in the idea that aesthetic appreciation itself is limited to art. However, a new public awareness of the aesthetic qualities of the environment began to evolve in the second half of the 20<sup>th</sup> century and this led to the modern study of environmental aesthetics.

Environmental aesthetics concerns itself with the aesthetic state of the environment such as landscape architects, environmental planners and landscape planning and design, as well as the aesthetic appreciation of the natural world. The aesthetic experience in the natural world is arguably as emotionally and cognitively rich as that which we can have with art. Perhaps art has been placed on a pedestal by the 'art world', separating it from the world at large (Carlson, 2005)? Environmental aesthetics is not simply focusing on natural environments but encompassing our aesthetic appreciation of the world at large. Those engaged with the arts need to be aware of the sense of place and ordinary scenery and our day to day experiences as important objects of aesthetic appreciation (Carlson, 2005).

*Environmental aesthetics is the aesthetics of everyday life*  
(Carlson, 2005) p. 552.

Aesthetic appreciation has been divided, by theorists, into three components - biological, cultural and individual. All three need to be taken into account when considering the human experience of aesthetics. We are often overly concerned with the visual impact of buildings and do not consider the other senses when concerned with environmental aesthetics, such as the smell and sounds of the building (Lawrence, 2001). For example, a bakery and a pharmacy give us a different aesthetic experience, one of the main elements being the smells in both places. Strumse writes:

*I have never been enthralled by the idea that the quality of the physical environment should be of only minor importance to people, implying that people can learn to thrive anywhere, even in settings such as windowless offices or surroundings devoid of nature... on the contrary, personal experience tells me that certain qualities in my physical surroundings, such as air quality, the absence of noise, an open view from my window... are crucial to my well-being. I do believe in being serious about the quality of our everyday surroundings, something we too often fail to be. It seems the only way to convince employers, designers and environmental decision-makers to take these aspects of life seriously is to provide scientific documentation of the rather obvious fact that environmental aesthetics does matter. (Strumse, 2001) p. 260.*

Planning and design is more often influenced by fashion and cost than aesthetic concerns. It is also very difficult to gain agreement on aesthetics and to please a wide audience or reach consensus when making aesthetic choices. Environmental aesthetics in healthcare is important for a number of reasons, including helping people to enter a building, helping people feel welcome and to find their way around. A strong argument from some writers on environmental

aesthetics is for user involvement and consultation in order to reach decisions on aesthetics. A concern for the aesthetic environment, and indeed consideration of all the senses, seems important in healthcare settings, for example noise pollution and smells, as well as the more obvious physical look of the building. Knowledge of people's preferences and the needs and wishes of users are the basis for creating and designing aesthetically pleasant and healthy environments (Cold, 2001)

### **1.10 The neglect of everyday aesthetics - aesthetic deprivation**

Very few writers address the importance of everyday aesthetics and the neglect of the aesthetic. Attention to everyday aesthetics (such as nature, popular arts, textures, food) might allow greater appreciation of the aesthetic concerns that influence and sometimes determine our basic the quality of life. Everyday aesthetics arguably have a much more direct connection and relevance to everyday life than high art. In Saito's definition, aesthetics are any reactions we form to the sensuous and/or design qualities of any object, phenomenon or activity. She argues that aesthetics are neither dispensable luxury nor inconsequential triviality (Saito, 2007).

Saito (2007) proposes that we have separated aesthetic experiences to mean only high art, but while it is possible to avoid theatre and ballet, never to visit museums or galleries and never to read poetry or literature, it is impossible to escape the everyday aesthetics of our lives. Whilst these everyday aesthetics are often trivialised and given less attention, they are probably more significant to most people and even more so for people living in healthcare settings such as nursing homes who have limited opportunities to access traditional settings to view high art.

The concept of beauty in everyday aesthetics is a growing field of interest and yet often missing from traditional considerations of aesthetics. Rautio (2009) describes the hanging of laundry in a small village in Finland as an example of beauty in everyday life. A young woman called Laura wrote letters as part of Rautio's research describing the significance of hanging laundry as an everyday aesthetic experience (Rautio, 2009). The beauty of this task occurred in the specific surroundings in which it took place (outside, with a view of nature) whereas in other cultures, such as the US, hanging laundry outside is considered an eyesore and is associated with poverty.

Saito argues that the aesthetic impression of everyday buildings even gives a sense of health and moral attitude. For example, the impression of a nursing home, from gardens to curtains and décor, give a clue as to whether the home is designed with the well-being of both the environment and people in mind. A clinic that has been designed in haste and carelessly (for example an untidy area, lacking in colour or attention to detail) can give an impression of insensitivity or indifference to the patients attending the clinic. There is a body of research about 'sick' buildings, which have poor ventilation, lighting and air quality and which can increase staff absenteeism and poorer recovery rates (Lawson and Phiri, 2003, Ulrich, 1984, Ulrich, 1992, Ulrich et al., 2010, Ulrich et al., 2008).

Modern day environmental aesthetics is affected strongly by Twentieth century functionalism which had an aesthetic theory underpinning it – that anything pertaining to the beautiful or to the taste of old-fashioned human beings was viewed as mere clutter, untidiness and should be ruthlessly eliminated (O'Hear, 2008). This approach is increasingly being challenged by designers. It can be difficult for planners and healthcare providers to try and create aesthetically pleasing environments for patients when the current healthcare culture is

dominated by the values of functionality, efficiency and health and safety. Saito argues for the cherishing of everyday and natural processes and a new view of beauty. For example, clothes that are not perfectly white, but use fewer chemicals to wash, can be seen as beautiful. In current society we tend to value only brand new, sparkling goods (Saito, 2007). Saito argues that cognition is a key part of this appreciation of beauty - for example, our enhanced knowledge of the natural life in bogs allows us to appreciate this seemingly ugly landscape.

The relationship between aesthetics, well-being and health is emerging as an important area of study (Cold, 2001, Cuypers et al., 2011b). It can be argued that planners, politicians, architects and builders regularly neglect the aesthetic, especially in public buildings and healthcare settings where the predominant concerns are health and safety concerns and efficiency. The result can be ugly, hostile, unpleasant and unhealthy environments.

*It would appear as if we are more focused on.... diseases than sick people's recovery, more on productivity than the well-being of employees, more of cars, comfort and speed than aesthetically pleasant places, more on quantity than quality, more on rational and intellectual matters than sensuous and emotional ones (Cold, 2001) p. 3.*

We might, therefore be focusing more on formal, rational and material matters than ethical or aesthetic values in our current environments. Although our day-to-day lives are influenced by the aesthetic quality of our physical and public surroundings, we seem to give more attention to aesthetics in our private sphere, for example our home, than in public spaces. Cold (2001) proposes various reasons why aesthetics are neglected in the public environment today. These include a lack of societal ideals, hopes or beliefs and thus no inspiration for creating beautiful environments; a system whereby those who are

aesthetically educated are rarely responsible for the public environment and a lack of the necessary skill or knowledge in planners to create beautiful places. As a society we may be more focus more on our own family and private sphere and give less attention than earlier societies to creating community and shared beautiful places. The growth of industrial mass production of goods has also created a focus on rational, cost-benefit views of life and generally has not focused on the high aesthetic quality of products. Cold (2001) also argues that architects, engineers and developers are poorly trained in aesthetics, with an over emphasis on environmental and health and safety issues over aesthetic values.

Aesthetic theory has traditionally ignored more commonplace expressions of everyday aesthetics, such as entertainment, textiles or food, to concentrate only on more specialised definitions of high art. The importance of everyday aesthetics is quite a revelatory and new stance taken by Mandoki (2007), Saito (2007) and others. Objects do not possess superhuman or magical properties that make them art. For example, the Brillo boxes that Warhol represented in wood can be viewed in three ways, as a utilitarian object (which depends on being put to use), as an artistic object (which depends on the institution such as an art gallery to classify it as such) and as an aesthetic object (which depends on the aptitude of a subject to enjoy, appreciate or endure it). In healthcare this includes the bed linen, the food and the crockery used by patients. The quality of these items can often be overlooked in the eagerness to buy in bulk and save money.

*Mainstream aesthetics will corroborate the privileged status of certain objects, artworks and, by contagion, of certain subjects who are in contact with them, namely aestheticians and art historians.... Aestheticians continue to work alone in the museums, libraries and art galleries with their coffee table books*



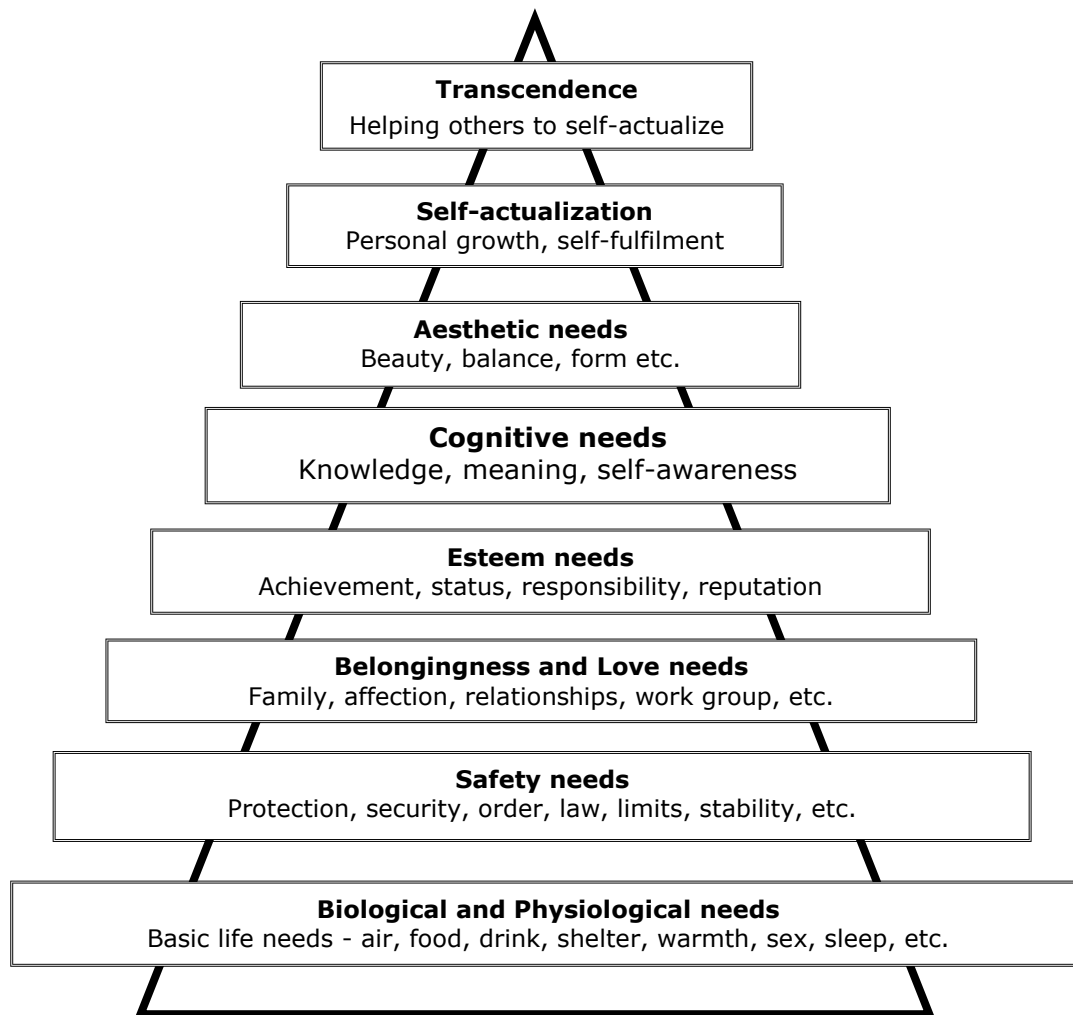
*and academic journals so as not to be disturbed by the smell, heat and sweat of everyday aesthetics (Mandoki, 2007) p. 13.*

The argument against everyday aesthetics is that if aesthetics is not art or beauty then everything becomes aesthetic and it loses its value. In *Undoing Aesthetics*, Welsch (1997) comments on the aestheticization of everyday urban spaces, such as shopping centres, clinics and everyday objects such as door handles and gates. These can be seen as superficial aesthetics with the only aim being pleasure and amusement. Aesthetic fashions can be short-lived but it is certainly arguable that the aesthetics of an item (for example a phone, watch or a computer) is often more important than the actual use of the product. Welsch argues that our public spaces have been 'aestheticized', from erecting spectacular pieces of art in public parks, to the corporate identity branding and visual imagery that is found all over our cities, to 'beautiful people' being idolised (such as Hollywood stars). The many new definitions of aesthetics might contribute to confusion about the concept – does the ambiguity of the term make it a fake concept?

*The actual task of art in public places today would be to interrupt the 'beauteous aestheticization' of a place... (to offer) strangeness, disruption, interruption... art must do this to differentiate from everyday aesthetics (Welsch, 1997) p.121-122.*

Although a uniform definition of aesthetics does not exist, Welsch offers an interesting one. Aesthetic means a sensuous cognitive faculty, (from the Greek origin *aie thetos* meaning sensuous, perceptible), something beautiful, reforming, cultivating and refining. An aesthetic attitude considers evaluates and shapes everything in accordance with aesthetic criteria (Welsch, 1997).

Maslow's hierarchy of needs is a fruitful approach to identifying aesthetic needs and includes aesthetic needs in a fully functioning healthy human being. The five basic needs (physiological, safety, belonging, esteem needs and self-actualisation) are all identified as important needs by Maslow and he purports that full psychological health is achieved only when all these needs are met. A need to be creative and to engage with aesthetics is listed as a need within the self-actualisation category (see Figure 1.4). It follows that neglect of aesthetic considerations in modern society may actually represent a deprivation of one of our basic psychological needs. In a hospital setting, the aesthetic needs of patients may be less important than the other basic needs such as health and pain control. However, Maslow's theory purports that the need to be creative is still important. It is interesting to note that Maslow believes that society has a responsibility to provide for all these needs, as rights for citizens, rather than focus on basic needs and neglect the higher needs. Maslow added aesthetic needs as a category in a later version of his original pyramid, perhaps indicating that he identified this as a need that was missing from the original list of basic needs (Maslow, 1970, Maslow, 1969).



**Figure 1.4 Maslow's Hierarchy of Needs<sup>2</sup>**

<sup>2</sup> © Design Alan Chapman [www.businessballs.com](http://www.businessballs.com). Adapted by persons unknown based on Maslow's Hierarchy of Needs MASLOW, A. 1970. *Motivation and Personality*, New York, Harper & Row.

## 1.11 Conclusion

This chapter has given a detailed overview of the broad context regarding the role of aesthetics in society and definitions of art, aesthetics and beauty, as well as a discussion of the economic, social and political contexts which shape our involvement in the arts.

It is clear that the number of different definitions and varieties of meanings attached to the term *aesthetics* and *arts* mean that categorical definitions are difficult to determine. This chapter establishes the undeniable importance of the arts in our lives and the variety of roles played by the arts. The effect of environment, social status and demographics on engagement and participation in the arts was explored. It seems unreasonable to limit arts in hospitals to just 'high' arts and a broad definition of aesthetics is needed to capture the variety of arts approaches and activities available in hospitals (from environmental aesthetics to everyday aesthetics to high art).

This initial review gave a broad baseline from which to examine, in the next chapter, aesthetics in the healthcare environment and for older people specifically. This chapter confirms that aesthetics and the arts have always been important in society, from the earliest times. This review identified the myriad of definitions of arts and aesthetics and one important conclusion was the need to explore the aesthetic experience of patients in our hospital without pre-determining how they understand aesthetics and arts.

The first aim of the research, arising from this review, is to explore and map patients' aesthetics and arts interest. The variety of definitions of aesthetics, art and beauty mean that no particular definition can be attached to participants being researched and thus an open approach was taken to their understanding of art and aesthetics. Mandoki purports that the task is not to define what is

aesthetic but to establish the conditions for the possibility of aesthesis (Mandoki, 2007).

In summary, this chapter has presented in detail the following points:

- All societies and people throughout history have shown the impulse to create. The understanding and role of arts and aesthetics in societies has varied greatly. However, it is indisputable that the arts and aesthetics are an important part of our society, as much as religion or science and thus warrant further attention in hospitals, where it appears that aesthetics are often neglected or undervalued.
- The most convincing theories in the philosophical literature are that the arts are a form of entertainment/recreation; an opportunity for self-expression; an aid to deeper understanding of human nature and art as a relief from suffering of everyday life. There is no conclusive definition of what art is, but these four strands are convincing for the purposes of this research and are explored further in healthcare contexts in the next chapter.
- The idea that the arts may simply be about entertainment is important and often overlooked as an important facet of human experience – enjoyment is rarely associated with hospital experience!
- Context is seen throughout history as strongly affecting the acceptance of different art forms, the predominance of some creative expressions and views of aesthetics. Thus, the context of hospital is important and worthy of exploration in terms of arts programming and the curatorship of same.
- Controversy and debate seem set to continue regarding definitions of art, its value and the high/low art debate. It is important to recognize both the low and high arts. Attempts to only recognize the high arts are unconvincing and in a hospital context it is important to ask patients what

arts they enjoy, and indeed how they define arts, rather than to impose pre-conceived notions onto them.

- The arts in modern society have become an elitist activity enjoyed by the minority. It is noticeable that the desire to create has prevailed in 'common' people and these alternative modes of artistic self-expression are also important.
- Aesthetics is a very broad term which includes every day and environmental aesthetics as well as mass arts, high and low arts. In a hospital context, aesthetics includes issues such as noise pollution, the texture of bed linen and crockery. Given the broad range of definitions of aesthetics, this research seeks to be a broad exploration of patients' own experience of hospital aesthetics.
- The concept of beauty has received little attention or importance in modern society and has certainly been neglected as a triviality in hospitals and health care services. Quantifiable, objective measures (such as cost and length of stay) have pre-dominance in our health service and the place for subjective quality of life 'extras' is hard to justify. There is a need for a conversation about the role of beauty and aesthetics in healthcare.
- Curators both inside and outside healthcare contexts have a delicate role, to balance the intrinsic value of the arts with some patients' preferences for popular art forms and management aims for improved well-being through the arts. Clearly articulated aims are paramount in this emerging field, as well as a nuanced approach to curatorship.
- Increased knowledge and education about the importance of aesthetics in healthcare is important, as well as debate about everyday aesthetics and how these might impact on patients' recovery and progress in hospital.

The context of healthcare is important to the provision of appropriate aesthetic and cultural pursuits for patients and it is important to explore the role arts can play in healthcare in more detail. This is the focus of the next chapter.

## **Chapter 2 Literature review - Role of aesthetics in the healthcare environment.**

### **2.1 Introduction**

The purpose of this chapter is to set out the specific role of aesthetics in the healthcare environment and in particular in hospital. While arts have been integral to all cultures, it is a relatively recent research phenomenon to explore and examine the association between arts and health and well-being (Johnson and Stanley, 2007). Activities within the 'arts and health' term range from receptive involvement (such as reading, listening to music) to active involvement (such as performance, painting and dancing). The purpose of aesthetic activities in healthcare varies widely, from environmental enhancement to contributing to clinical interventions to health promotion and staff education.

There is increasing acceptance in current times that health, wellbeing and quality of life are reliant upon interconnections between physical, psychological and social functioning (Thomson et al., 2012). These elements are in keeping with the World Health Organisation (1946) definition of health whereby health is a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity (World Health Organisation, 1946).

This chapter will give an overview of aesthetics in healthcare environments through discussion of three themes: Arts and the aesthetic environment, Arts as a clinical and/or therapeutic intervention, and Arts for staff (Medical Humanities). The aim of this chapter is to give a thorough overview of current



research in the arts and healthcare field and to indicate how this particular research question emerged from a review of the current literature.

## **2.2 Arts in Healthcare Settings – Overview of the literature**

The field of arts in healthcare embraces a wide range of practices including medical humanities, design aspects of healthcare, arts in hospice/end of life care, arts therapies and arts and aging (Brener, 2003). The field of arts in healthcare intersects with a number of disciplines including medicine, architecture, arts therapies, medical education and gerontology (Dileo and Bradt, 2009). The 'arts' of arts practices also cover a very wide range of forms including visual arts, performing arts, technology, creative writing, horticulture, video arts and film. Arts in healthcare can also be defined by the healthcare contexts in which it takes place, again very diverse, from community health to educational settings to hospitals to drug rehabilitation centres to care homes. Participants in arts and healthcare programmes are also varied, from patients to carers to medical students and healthcare staff and there is no one designation or recognised qualification for arts practitioners in healthcare (Dileo and Bradt, 2009, Moss and O'Neill, 2009). It is therefore difficult to bring together these diverse strands of specific literature into a body of work of significance. However, the aim of this literature review was to explore the broad concept of arts in healthcare and to see what research currently exists in this broad field.

### **2.2.1 Search terms**

For this research, a narrative literature review was conducted over an extended period, from 2010 – 2014. Five computer databases were used: PsycINFO (1872 – November 2011), PubMed (1940 – November 2011), CINAHL (1981 – November 2011), AMED (1995 – 2011) and Web of Science.

Primary search terms used were as follows:

Music OR music therapy OR performing arts OR singing OR performing arts OR art OR visual art OR sensory art therapies OR art therapy OR Canadian art therapy association OR reading OR motion pictures OR medicine in art OR drama OR psychodrama OR dance therapy OR dancing OR dance OR literature OR literature modern OR aesthetics OR esthetics OR culture OR art and society

AND

Inpatients OR health OR psychological well-being OR health facilities OR hospital OR personal satisfaction OR patients OR social determinants of health OR well-being OR clinical settings

Cochrane reviews were searched using the same search terms and specific journals of interest were also reviewed, namely the British Journal of Medicine – Medical Humanities, Journal of Applied Arts and Health, Arts and Health, British Journal of Music Therapy, American Association of Art Therapy and the Journal of Psychology of aesthetics, creativity, and the arts

Grey literature was also searched, in particular key reports on arts and health from the Arts Council of Ireland, the Arts Councils of Scotland, England and Wales and Government reports on the arts in the USA, such as the National

Endowment for the Arts. The research listings from the Society for the Arts in Health in the USA were a useful resource.

A broad survey over four years, by this researcher, covering over 900 papers, books and other literature on arts and aesthetics in healthcare settings, from 2010 to the present day, led to the identification of four broad themes:

- Aesthetics and the healthcare environment, for example, way finding art, the role of arts on patients' perception of health service quality and engagement in arts as part of patients' control over their experience of hospital (Caspari et al., 2006, Caspari et al., 2007, Caspari et al., 2011, Frampton, 2001, Gates, 2008, Lawson, 2001, Lawson, 2003, Lawson and Phiri, 2003, McCabe, 2008, Scher, 1996, Ulrich, 1984, Ulrich, 1991),
- Clinical and therapeutic benefits of arts, including arts therapies and arts and health participatory practice
- Arts for staff - Medical Humanities, narrative medicine and the effect of aesthetically pleasing environments on improved staff performance (Louis-Courvoisier, 2003, Wikstrom, 2000, Charon, 2001, Kirlkin, 2003, Shapiro et al., 2009, Furniss and Motts, 2007, Konlaan et al., 2000, Shapiro and Rucker, 2003).

### **2.2.2 Summary of key findings**

A large number of small, qualitative studies have been written to date about the benefit of arts on health and wellbeing for patients in hospital (Berhman, 1997, Donnelly, 2007, Hume, 2010, Lane, 2005, Macduff and West, 2002, Reynolds and Vivat, 2010, Scher and Senior, 2000). However, in terms of medical research and randomised controlled trials, there is relatively scant empirical evidence on the benefit of arts in healthcare with fewer quantitative or larger studies.

A survey of Cochrane reviews, for example, indicates that currently there are only n=21 Cochrane reviews on arts (music therapy n=13, art therapy n=2, singing for health n=2, dance n=3, drama therapy n=1, the sensory environment n=1). None of these reviews show categorical empirical evidence of benefit and all indicate further research and a need for larger sample sizes. There are no such reviews on the role of aesthetics in healthcare (Bradt and Dileo, 2009, Bradt and Dileo, 2010, Bradt et al., 2010a, Bradt et al., 2011a, Bradt et al., 2011c, Dileo et al., 2008a, Dileo et al., 2008b, Drahota et al., 2012, Irons Jung et al., 2010, Laopaiboon et al., 2009, Maratos et al., 2008, Meekums et al., 2012, Ruddy and Milnes, 2009, Vink Annemiek et al., 2003).

It can be concluded that there is relatively little evidence, or indeed literature, on the role of aesthetics in hospital or healthcare facilities and an indication that much of the literature lacks rigour (Eades and Ager, 2008, Eades and O'Connor, 2008). For example, a significant study systematically reviewed 600 papers from 1985 – 2005 on arts, design and environment in mental health (Daykin et al., 2008a). The review found that while there is extensive literature in the area there is a need for further research that addresses the methodological challenges of evaluating complex interventions. Only 19 of the 600 papers met adequate methodological criteria and none of these 19 would have met the stringent selection criteria of Cochrane reviews. Another small randomised control trial found some evidence that tango dancing is effective in reducing symptoms of psychological stress, anxiety and depression but called for larger studies to verify these initial findings (Pinniger et al., 2012). It appears that arts and health research is an area which is not prioritised within medical research, perhaps due to more urgent priorities within healthcare and/or competing demands on time and financial resources. A lack of scientific evidence to support the role of the humanities in healthcare may also contribute to a seeming lack of interest in this area of research.

However, to counter the lack of evidence-based studies, it can be noted that there is a significant number of smaller and/or qualitative accounts of the subjective benefit of arts for patients attending health services and these together bring compelling qualitative evidence of benefit and high quality practice in this area.

The need to participate in cultural life and to enjoy the arts is identified as a basic human right covered in chapter 27 of the UN declaration (Bygren et al., 2009b). This enjoyment has been found to be conducive to prolonged survival (Bygren et al., 1996). Despite the limitations found in the medical literature, there is evidence to support the philosophical theories regarding the role of aesthetics in society and these are reflected clearly in the literature on aesthetics in healthcare. For example, the Platonic ideal that we should be governed by noble, rational, good-seeking parts of the soul is arguably reflected in the argument in some literature for conservative, pleasing landscapes in waiting rooms to create peaceful, happy, safe environments (Grehan, 2005). Aristotle's idea of catharsis, however, might be more clearly seen in the development of the arts therapies, where the arts are seen as a vehicle for expressing emotion (Janaway, 2005, Pappas, 2005). The idea of arts as a vehicle to gain greater understanding of the human condition is reflected in the growing literature on medical humanities, where humanities are used as a forum for trainee doctors to explore ethics and to enhance their reflective skills through arts activities.

Increasingly, there is a tension in the literature between the intrinsic value of art as part of our cultural heritage and the notion of arts being 'useful', for example meeting societal needs such as reducing social exclusion (Edwards, 2011). The utility of the arts may need to be balanced in healthcare with the human cultural experience afforded by the arts. Some literature focuses on discussions around the 'goodness' of music, how it creates social cohesion and calms the soul, but

these seem to be over-reaching claims and the possible negative effects of arts interventions are often overlooked by arts and health practitioners (Edwards, 2011). Beliefs about the inherent value of arts make it difficult to consider where the arts can be distressing or unhelpful in public spaces. Funding limitations can also lead to a desire by health policy makers to 'use' the arts as positive, useful interventions rather than engaging in a more sensitive application to meet the needs of individual patients (Edwards, 2011).

As far as arts and health practice is concerned, the predominant art forms in the literature are music (by far the most researched art form), visual art, drama and dance with some research relating to digital art, literature and other art forms. The predominant areas where the arts are reported, qualitatively, to have benefits for clients' wellbeing, are mental health, older age and paediatrics. The role of community arts and cultural consumption (for example, attending galleries and concerts as part of health and well-being) has also received some attention in the literature.

It is notable that nearly all the literature is on the participative arts (for example, engaging in arts activities such as painting or singing in a choir while in hospital or attending a health centre) as opposed to receptive arts (for example, listening to music, reading a book, watching a film).

The literature on the role of arts in healthcare settings could be summarised as suggesting that arts play a significant role in improving quality of life for patients in hospital and individualising the patient experience.

Overall, the research on arts and health is relatively limited, with relatively few significant quantitative studies. Rigour of methodology is questionable in many studies and sample sizes are generally small. However, there is a wealth of qualitative evidence of benefits in terms of arts participation for clients of health

services, especially in the areas of self-reported sense of well-being, self-esteem, confidence, mental health and reduced isolation. Current research indicates the need for more epidemiological and longitudinal studies with larger populations, more controlled studies, scientific evaluation of the effects on health of receptive and participative arts activities, as well as further qualitative studies to understand the processes underlying involvement in both receptive and participative arts and cultural activities (Cuypers et al., 2011a).

### **2.2.3 Themes arising from the review**

This chapter presents and explores the main themes emerging from this extensive literature review. This chapter is divided into the three main themes that arose from the review – the aesthetic environment of healthcare (section 2.3), arts as a clinical intervention (2.4) and medical humanities (2.5).

## **2.3 Aesthetic theory and the healthcare environment**

The role of aesthetics in healthcare facilities appears to be a neglected or undervalued field (Caspari et al., 2006, Caspari et al., 2007). A study of 86 hospitals in Norway indicated that very few concrete guidelines or directions for the aesthetic dimension of the hospital were included in written documents. A questionnaire was used with 400 patients to give their opinion on eleven aspects of the aesthetics of the hospital. Results indicated that the provision for choosing different kinds of aesthetic input was the area where patients were most dissatisfied.

The arts in healthcare environments, such as hospitals, have a different function to that of arts in other contexts. The reason for attending hospital is not to view

art, or to listen to a performance, but because of failing health. Thus, the arts are often seen as having a passive, distracting or healing function.

*To escape to, or be subdued by, landscapes other than the ones where (patients) are situated (Evans et al., 2009) p. 720.*

Environmental aesthetics is of relevance in a hospital context, where arts are viewed or experienced beyond the formal art galleries and concert halls. It can be argued that art has been placed on a pedestal by the 'art world', separating it from the world at large and that art in different contexts such as healthcare services is important (Carlson, 2005). Artwork viewed in hospitals is experienced very differently to galleries and can arouse emotions and strong responses (Grehan, 2005). Everyday aesthetics, such as food, crockery and bed linen are also arguably more important to patients than fine art (Saito, 2007). Fisher's argument that there is no specific difference in aesthetic value between high and low art, and that any such distinction is an artificially constructed view by society, would sit well with the experience of programming arts for patients in a hospital. When consulting patients about the arts programme in our hospital, it is clear that popular art (such as a pop band playing hits from the 1980's) is as valued and beneficial as a performance of classical masterpieces by an orchestra. Both have a value and both have therapeutic benefits for patients. The classical performance exposes patients to new art that they have never heard before, offering access to music performances of the highest calibre and stimulation by performances of masterpieces that can help patients' relax or possibly escape to another world. The popular music event, on the other hand, allows patients to dance, sing along, clap, laugh and enjoy themselves. These are activities which bring their own list of health benefits. Neither can be argued to be more important and neither have, to date, been proven to have greater effect (Moss et al., 2007).



Caspari et al provide robust evidence that hospitals give little attention to aesthetics and that patients are often dissatisfied with their choices in these areas (Caspari et al., 2006, Caspari et al., 2007). It is possible that our current health system, with its emphasis on efficiency and measurement, has difficulty in quantifying aesthetic values and there is limited current evidence to support its use in healthcare settings. It appears that the idea of beauty is rarely considered when planning healthcare services.

*Are such examples of art, and the arts more generally, merely window dressing or institutional vanity distracting us from the real concerns of service users? Do they take money and resources away from more deserving areas? Do the arts actually make a difference? Do they merely pander to the preferences of a select and intellectual elite? (Gallagher, 2007) p. 424.*

In some hospital programmes, the arts are seen as an important part of spiritual care (Bailey, 1997). However, Gallagher cites an interesting example of the tension that can arise when commissioning art for healthcare settings. In 2007 a new 'pebble' sculpture was installed outside University College Hospital, London (see Figure 2.1). The sculpture, and the funding allocated to it, caused outrage and the furore was captured in a number of newspapers (see Table 2.1).



**Figure 2.1 Photograph of a 'Pebble' sculpture unveiled at University College Hospital, London 2007<sup>3</sup>**

**Table 2.1 Excerpt from The Sun Newspaper reporting on the controversial pebble sculpture (Starkey and Morton, 2007)**

*Off their rockers*

JEROME STARKEY and EMMA MORTON

*Last Updated: 01st August 2007*

A HOSPITAL has blown £70,000 on a ROCK to decorate its front entrance. The six-ton lump of granite was excavated in Brazil and shipped to London, where University College Hospital had it polished at vast expense. Last night the rock, looking like a giant pebble, was blasted by patient groups and medical staff who believe the cash should have been spent on healing the sick. One doctor described it as an insult to 7/7 victims who are still having after-care treatment at UCH.

The hospital insists the rock enhances the healing environment of their futuristic building. *But bedridden patients in wards cannot see it.* And Joyce Robins, of pressure group Patient Concern, said: I don't see how a granite stone outside a building will be good for patient care. It will do more for passers-by than patients. London's hospitals are facing a £100MILLION cash shortfall this year.

The rock — a work called *Monolith and Shadow* — was paid for out of charitable donations. But GP Dr John Cormack, a spokesman for the British Medical Association, said: When most people donate to charity they want it to go to doctors, equipment, that sort of thing.

<sup>3</sup> Copyright for this image and report is held with News Group Newspapers Limited in England No. 679215  
Registered office: 3 Thomas More Square, London E98 1XY.

A contrasting example is of the 'Mind Arts Project' in Stockport, UK, which was evaluated during 1999 – 2000. The evaluation found that engagement in arts assisted mental health service users; benefits included offering vulnerable individuals social opportunity, support and creativity and a place of sanctuary and safety from a hard external environment. The project was considered by the evaluators as excellent value for money. These positive findings were not as contentious as the 'pebble' sculpture example. However, evaluating the role of the arts is a challenging activity and there are few recognised standards of practice in the arts and health field. Gallagher argues that we do not know whether arts engagement makes a difference, or whether the social support and inclusive atmosphere offered by the facilitators in the above example was actually more important than the arts intervention. Would engaging in cookery or sport have had the same outcomes? (Gallagher, 2007)

### **2.3.1 Aesthetic environment and design**

Whilst a significant body of work has been undertaken in the field of healthcare design and architecture, little appears evidence-based or systematic. A significant body of evidence focuses on the importance of design and architecture of hospitals on health and well-being. Ulrich (1984) provides one of the most definitive studies in this area, indicating that the view from a window for patients can help increase wellbeing and reduce the need for pain relief. Further studies focused on the benefits of viewing abstract pictures on patients recovering from open heart surgery; the need for control with respect to physical and social surroundings; the need for healthcare environments to promote access to social support and the importance of positive distractions (Ulrich, 1984, Ulrich, 1991, Ulrich, 1992, Ulrich, 2009, Ulrich et al., 1993, Ulrich et al., 2004, Ulrich et al., 1991, Ulrich et al., 2003).

*There is considerable evidence that an overall improved atmosphere and quality of life may be one of the benefits of*

*better places... patients in the kind of accommodation they prefer appear to do significantly better than those who are not... not only being comfortable but having personal control over their immediate environment is important (Lawson and Phiri, 2003) p.*

3.

Much of the literature focuses on individualising the environment (for example, giving the patient control over access to art and music in their environment), way finding art (to help guide patients through complex hospitals) and arts as a calming, relaxing environmental tool. The role of architecture and design in healthcare is indicated as being not only about building requirements but also the social and psychological experience of people using the space, including the need for stimulation, security and a sense of personal identity within the environment (Day, 1990, Frampton, 2001, Lawson, 2001).

There is evidence in the literature of art being included in design stages of hospitals (Francis et al., 2003, Lawson and Phiri, 2003, Redshaw, 2004). In Ireland the Per Cent for Art scheme allows art to be included and funded in all publicly funded buildings. There is a significant body of literature on the impact of positive distractions, such as visual art, on clinical and behavioural outcomes of patients in hospital settings (Nanda et al., 2011, Ulrich, 1991, Ulrich, 2009). For example, Diette et al found that adult patients in a procedure room reported better pain control when exposed to a nature scene and nature sounds than without these aesthetic supports. Schneider et al reported that breast cancer patients had reduced anxiety and fatigue when exposed to virtual reality images of underwater and art museum scenes (Diette et al., 2003, Schneider et al., 2003). Douglas et al report that access to views of nature were identified as one of the most important factors in designing a hospital environment and that aesthetic needs were important for patients' sense of health and well-being (Douglas et al., 2002).

There is, it appears, a growing recognition of the value and contribution of arts to enhancing healthcare environments, both in terms of design and clinical outcomes (Daykin et al., 2010). Some of the research indicating the benefits of arts in healthcare environments include the use of art to promote positive behavioural changes for people with dementia (Kincaid and Peacock, 2003) and the positive effects of arts on reducing the need for pain relief medication (Ulrich, 2009, Ulrich et al., 2003, Ulrich et al., 2008).

There is little research, however, regarding the effect of *aesthetic deprivation* or *aesthetic injury* for patients in hospital. In a literature search of *aesthetics*, *deprivation* and *hospital*, the only reference to deprivation was in relation to children without access to play in hospital (Save the Children, 1989). In this study, the stress and anxiety for children and parents visiting hospital was recognised and play activities (including arts) were seen to aid normality, reduce anxiety, speed recovery, facilitate communication and help to prepare children for hospitalisation or surgery. Turner argues that the physical hospital environment is significant in giving messages about whether people are valued (Turner, 2002). Architecture, interior design and social activities can convey the message that people are respected.

*The idea of a respectful, as opposed to a disrespectful, environment should be taken seriously within healthcare (Gallagher, 2007) p. 427.*

The reason for attending hospital is not to view art, or to listen to a performance, but because of failing health. Thus, the arts are often seen as either irrelevant or at best to have a passive or distracting function in healthcare settings.

*The humanities appear to have little instrumental purpose, thus it is difficult to justify their purpose in life in general, let alone in healthcare (Edgar and Pattison, 2006) p. 93.*

The arts can seem to have little direct relevance in life and can be seen as an indulgent luxury, especially in the medical world. Edgar et al propose that the humanities are important because they allow a community to scrutinize its own values and meanings, to make those values and meanings explicit and attractive and to challenge perspectives (Edgar and Pattison, 2006).

### **2.3.2 Choice of aesthetic environment**

Studies have attempted to determine what art specifically assists in creating a therapeutic space (Eisen et al., 2008, Ulrich et al., 1993). Eisen et al (2008) showed children six art images and carried out a range of tests and semi-structured interviews to determine which might be less stress inducing. This was then tested with children in hospital. The researchers found that representational art was clearly indicated as the most preferred art image for all age groups. Another study indicated that patients frequently expressed a preference for landscape and nature scenes that patients who are ill or stressed about their health may not always be comforted by abstract art, preferring the positive distraction and state of calm created by the blues and greens of landscape and nature scenes (Lankston et al., 2010). However, this is a controversial area, as the subjective nature of individual art preferences makes it impossible to select a specific type of art or music to provide relaxing environments or peaceful atmospheres. An evaluation of the benefit of live music in our own hospital revealed that when patients were asked what music they found most relaxing, every type of genre of music was cited, indicating that one cannot determine a type of music or art that is universally relaxing (Grehan, 2005, Moss et al., 2007). Eisen et al's study indicated complex responses and the authors recommend that a choice of art be placed in children's hospital rooms to aid distraction and possible pain control rather than adopting a 'one size fits all' approach (Eisen et al., 2008).

A significant study identified more than 600 studies, most in top peer-reviewed journals, that establish how hospital design can impact clinical outcomes (Ulrich et al., 2004). The team found studies that documented the impact of single-rooms versus multi-bed rooms, reduced noise, improved lighting, better ventilation, better ergonomic designs, supportive workplaces and improved ward lay out, and noted how these helped to reduce errors, patient stress, improved sleep, reduced pain and need for drugs. The study indicates a strong body of evidence to guide hospital design (Ulrich et al., 2004). Humans who find their environment congenial or even beautiful flourish while those who find their environment stressful or ugly might do less well (Rolston, 1995).

In looking at the role of aesthetics in the environment of a hospital it is important to note that the value of any work of art will change when placed in different societies and contexts (Sorrell and Halpin, 1991). When asked what music patients preferred in an acute hospital, patients indicated that although their preferences ranged widely they felt that when in hospital one needs light, 'easy listening' popular or light classical music and nothing too challenging (Moss et al., 2007). In the same way, people tend to read light books rather than challenging literary works when acutely ill. However, nuanced selection of arts and their presence in healthcare settings is important. Where functional aspects are allowed to overshadow the visual and sensory effects, hospitals can become uninviting at best (Ulrich, 1992).

### **2.3.3 Aesthetics and control over the environment**

*According to evolutionary theory humans rebuild their environments to suit their preferences. In healthcare settings patients often have little control over their environment. For example, in hospital patients are rarely encouraged to decorate*

*their room or bed space in their own way, to bring in images or photos that they enjoy. The subjective nature of the benefit of the arts means that this issue is still often overlooked by health service managers. The Open Window project at St James' Hospital (Hegarty et al., 2009) is a project which consisted of virtual windows in patients rooms which allowed them to connect with works of art, film and music on the outside world. This was an art project where the artist created images to be shown on a DVD screen in the patient's room where they were in isolation for very long periods of time, but it also served the important purpose for patients of being able to view images of their families. A striking example was a man in isolation who was able to connect to images of his wife and their new baby very soon after its birth. Patients were able to experience much greater control over their environment and to view scenes of art or nature at their own selection Environmental aesthetics is...the landscape as a place of satisfactory, satisfying adapted fit, on which we live and move, and have our being (Rolston, 1995) p. 384.*

An environment can be defined as the current field of significance for a living being, usually its home, though not always. Environments are settings under which life takes place, for people, animals, plants (Rolston, 1995). In hospitals, patients commonly describe many aspects of their life being put 'on hold' and often these environments do not encourage life to take place as normally as possible (Moss and Granier, 2006). The tension within healthcare settings is often between the model of evidence-based medicine (i.e. being required to prove all treatment options) and the more subjective experience of providing arts and the aesthetic environment. Sorrell and Halpin ask



*...whether the sense of truth which art gives to so many people has to do, as this is very commonly held, with an inspiration which is entirely spiritual (for want of another word) or whether it can be accurately mapped in terms of neurological needs or whether spiritual and neurological drug mechanistic phenomena are indeed separable. Ultimately, it is a question of interpretation and belief (Sorrell and Halpin, 1991) p. 247.*

Gottlieb (2000) found that patients with control over their own environment in hospital had better mood and reduced length of stay. Interestingly, a positive physical environment was also found to encourage nurses to provide a higher level of service (Gottlieb, 2000). Kirklin and Richardson argue that everything in hospital is decided for us - when we are woken, when the light goes out, when we eat and what we are offered to eat. The hospital environment is not homely and not intended to be homely (Kirklin and Richardson, 2003).

An interesting 2001 study concluded that although being in a single room or a multiple bed ward did not make a significant difference to the recovery rate of patients, those patients who were in the type of accommodation of their own choice felt more satisfied with their treatment and made better progress than those who were not (Lawson, 2001).

Studies of the negative effect of the arts in healthcare settings are few. However, there has been increasing concern over the use of music in the operating room as a distraction to staff, although it is also recognized that sometimes music can reduce anxiety and discomfort. In one interesting study, it was found that music may contribute to overall level of background noise and impair effective communication among members of the surgical team. (Cruise et al., 1997).

### **2.3.4 Aesthetic environment and a sense of security**

Hospitals usually aim to offer security and a sense of safety and reassurance rather than stimulation, but for long term patients retaining a sense of identity is also very important. Lawson writes about the three psychological needs we have in any space, namely stimulation, a sense of security and a sense of identity. In hospital spaces, it can be noted that often people will sit in cold corridors waiting for an appointment rather than go for coffee because they need the security of knowing that they will not miss their appointment. The need for security in this instance overcomes the need for comfort. Lawson states that hospital spaces need to do what they seldom do; they need to counteract the loss of independence and identity the patient feels. A common mistake is to concentrate too much on the central purpose of the space and thus to forget the rest of the human condition. Such a way of thinking leads to the wonderfully efficient and clinically sterile hospital that treats the body and yet numbs the spirit (Lawson, 2001).

Lawson also discusses how seating and waiting arrangements can reduce patient anxiety. He stresses the need to acknowledge psychological needs such as a need for home and territory in hospital. Every person in hospital has different needs regarding their own territory or space. For example, for some people social life is of utmost importance and a shared ward is ideal. For others a single room is a paramount need. Lawson argues that sometimes bad design results from an uncertainty arising from the complexity of individual patient needs.

### **2.3.5 Aesthetic environment: making the intangible tangible**

Goldman et al (2010) propose that non clinical amenities matter to patients perhaps because they don't understand clinical quality and thus judge the organisation on the tangibles such as physical impression and other amenities (Goldman et al., 2010). Arts in hospital seem to play a part in improving the

impression of quality of care in hospital, through judgement of tangible signs of care.

*The arts may be a key indicator of a caring organisation and of a changing hospital culture (Redshaw, 2004) p. 8.*

The Planetree model of hospital care is an interesting development and has been embraced by over fifty hospitals in the US. In these hospitals, the art programme is articulated as 'nutrition for the soul'. (Frampton, 2001).

*Art serves as a significant diversion from pain and discomfort. At a deeper level, the arts have the ability to link people to inner spiritual resources needed to promote their own healing. (Frampton, 2001) p. 19.*

A study of two hospitals, a psychiatric and an acute hospital, indicated that patients rated the newly designed buildings better in terms of space, colour, privacy and facilitating a sense of community. However, the results also indicated that patients generalised their satisfaction with the building design to the whole medical treatment they received and as such the design was a tangible marker for patients of their overall care (Lawson, 2001). Aesthetics play a part in how the doctor looks and dresses, how the clinic is designed and choice of colours on the wall. It might even affect whether we choose one doctor over another. How a patient views their institution affects how they engage in treatment and sometimes how willing they are to stay and engage in treatment. When we lack sufficient knowledge about the precision of a diagnosis or treatment option we turn to aesthetic intuition to make decisions regarding our trust of a doctor (Mandoki, 2007). Mandoki makes controversial claims that the hospital is made up of a variety of aesthetic costumes, arguably to distinguish personnel and perhaps distance them from patients and relatives. Exhibiting

diplomas on the wall is also argued as an aesthetisization of the skill and identity of a doctor!

Caspari et al carried out interviews with sixteen experts on aesthetics (who had also been hospital patients). They identified the following areas as important – nature, view and light, sounds and smells, architecture and rooms, design and aesthetics, food, hygiene and maintenance, art colour and water, variation and atmosphere and finally, harmony, humour and play. Further research is recommended with other categories of patients (other than patients who are also experts in aesthetics) as well as in other healthcare settings.

*The goal is to create aesthetic environments in the hospitals, where the patient is the primary figure, an environment where aesthetics can contribute to recovery of health and well-being and can serve to make both daily existence and the entire stay in hospital more pleasant. (Caspari et al., 2011) p. 141.*

### **2.3.6 Aesthetic environment of hospital - summary**

Dose suggests that no-one, given the choice, would actively prefer medical treatment in a setting devoid of the arts, or life in a community with no arts provision (Dose, 2006). Two key papers give evidence of the importance of the aesthetic environment for patients (1) Sarkamo et al (2008) who provide one of few studies looking at the very normal, non-clinical aesthetic experience of listening to CDs (Sarkamo et al., 2008) and Ulrich et al (1984) who studied the effects of nature and art on patients recovering from open heart surgery (Ulrich, 1984). Daykin et al (2010) carried out an extensive qualitative study of the role of arts to enhance mental healthcare environments and found that arts were found to help shape healing environments, in particular by modernising the environment, enhancing valued features, diminishing negative aspects and creating opportunities for service users and staff. The authors conclude that

their research points towards the benefits of mixed method studies, allowing triangulation and helping to overcome some of the drawbacks of single methods (Daykin et al., 2010).

*The arts are not about this being right or wrong. It's much more flexible than that. It is about weaving arts and creativity into the rigidness of the hospital environment and this I think softens the institution ... and it makes space for people's feelings and expression and fears, allowing them to think beyond what is happening to them. (Kilroy et al., 2007) p. 27.*

In summary, the literature suggests that arts in healthcare settings can contribute to a sense of wellbeing and quality of care, as well as achieve benefits in terms of patients' experience of the service. It also suggests that hospitals neglect aesthetics and that there is a large body of qualitative evidence to suggest that improving aesthetics and access to art is important to patients. Evidence is weak, however, as to the actual benefits of arts in hospital. Rather than try to prove the benefit of arts and to make them fit into a scientific model, it may be better to concentrate on the stress and ill health associated with aesthetically deprived environments and to normalize healthcare environments by ensuring that arts are available to patients who want them.

*Environmental aesthetics are important in making a place more of a place you want to live. It is not just about arts and music. It is about thinking about the environment in all its ways. There are things in a hospital such as communal televisions and noise pollution. What if you want to turn off the TV and someone else wants it on? (Kirklin and Richardson, 2003) p. 3.*

## **2.4 Arts as a clinical, therapeutic intervention**

### **2.4.1 Introduction to arts as a clinical and/or therapeutic intervention**

Throughout recorded history, people have used pictures, stories, chants and dances as part of healing rituals and there has been philosophical discussion about the benefits of arts on health and wellbeing. However there has always been less empirical research in the area than in other areas of medicine and healthcare. Although arts therapies have been used for more than a century, and been recognised as a profession in the UK and USA since the early 1990s, only in recent years have systematic and controlled studies been conducted to examine the therapeutic effects and benefits of the arts (Stuckey and Nobel, 2010). 'Arts in health' and 'arts and health' are terms which have been defined as:

*Arts based activities that aim to improve individual and community health and healthcare delivery and which enhance the environment by providing artwork or performances (The Arts Council England, 2007) p. 5.*

A large number of academic papers fall within this broad umbrella term, including arts therapies, environmental effects of the arts on health and wellbeing, community arts and health practice and medical humanities programmes. This section presents a review of the literature which deals with the role of arts as a treatment or supportive activity for people with various clinical conditions. Reported benefits in the literature are predominantly improved quality of life, relaxation and distraction from worries, improvements in self-esteem and some other health benefits. This section has reviews of some of the primary themes coming through the literature – cultural participation and

well-being, arts and mental health, arts and older age and community arts and health practice. Psychological benefits are more often reported in the literature than physical benefits, although a notable exception is the role of music as part of physiotherapy and gait training.

Some examples of the therapeutic and/or clinical benefits of arts in healthcare settings follow, to give a flavour of the diverse patient groups and art forms being studied, as well as the limited number of significant evidence based studies available.

A body of research exists on the benefit of choral singing, which is associated with positive self-mood, increased self-esteem and enhancement of immune system functioning (Davidson and Faulkner, 2010). Singing has been the subject of extensive study, with a randomised control trial of a singing group for older people with dementia. Members of the singing group became more actively involved and engaged with others than those in a reading group (Harrison et al., 2010). Other studies include the role of expressive arts based work with children in foster care, describing benefits such as improved self-understanding, understanding relationships, exploring issues around death and spirituality and self-esteem work (Coholic et al., 2009) and the relaxing benefits of music played in the operating theatre (Oliver, 1999). Szeto and Yung report significant findings in a study of patients who listen to music while waiting for elective in-patient treatment in the theatre holding area. Patients in the control group had higher anxiety levels and higher blood pressure than those who listened to their own choice of music while waiting to go into theatre (Szeto and Yung, 1999). These sample studies reflect the wider literature, concluding that further research is needed and larger sample sizes to verify these findings.

Overall, the literature on aesthetics in healthcare is relatively sparse. However, a common theme in much of the existing literature is the role of the humanities

in supporting the psychological, social and emotional needs of the patient (Berhman, 1997, Donnelly, 2007, Engel, 1977, Miles, 1992). For example, three studies have shown that where individuals wrote about their own traumatic experiences, they exhibited significant improvements in various measures of physical health, reduction in visits to doctors and better immune functioning systems than a control group (Esterling et al., 1999, McArdle and Byrt, 2001, Pennebaker, 1997). A number of papers also suggest the benefit of arts therapies on various health issues such as pain control, gait improvement and speech development (Aldridge, 2005, Loewy et al., 2005, Mitchell and al, 2008).

However, a review of the Cochrane studies illustrates the limits of the current literature on arts in healthcare. None of the 21 Cochrane reviews concerned with the arts showed categorical empirical evidence of benefit and all indicated further study and a need for larger sample sizes. The most significant study was a Cochrane review of music therapy after brain injury which examined 184 patients from seven studies. The combined results of these studies suggest that music therapy can be effective in treating walking difficulties of stroke patients. However, its effectiveness in other problem areas and in treating other types of brain injury was inconclusive and therefore further research was recommended (Bradt et al., 2010b). A review on music and pain indicates that listening to music reduces pain intensity levels and pain relief requirements, but these benefits are small and, therefore, its clinical importance remains unclear (Cepeda et al., 2006). The Cochrane study exploring the effect of the sensory environment of hospital on health related outcomes for adults involved a review of 102 relevant studies. Interventions explored were 'positive distracters', to include aromas (two studies), audio-visual distractions (five studies), decoration (one study), and music (85 studies), interventions to reduce environmental stressors through physical changes, to include air quality (three studies), bedroom type (one study), flooring (two studies), furniture and furnishings (one study), lighting (one study), temperature (one study) and multifaceted



interventions (two studies). No studies meeting the inclusion criteria were found under the headings of art, access to nature, atriiums, flowers, plants, ceilings, hospital noise, patient controls, technologies, or views through windows. The authors propose that music may improve patient-reported outcomes in certain circumstances, so support for this relatively inexpensive intervention may be justified. They also recommended further well designed research studies in this area but find few other benefits. The one Cochrane review concerned with art therapy found only two randomized controlled trials of art therapy for people with schizophrenia or schizophrenia-like symptoms and found no strong evidence of on-going benefit from art therapy (Ruddy and Milnes, 2005). Of the three dance and drama related interventions there was no evidence of any benefit and too few studies to consider (Bradt et al., 2011b, Meekums et al., 2012, Xia and Grant Tessa, 2009).

A small number of clinical trials indicate results in terms of arts as a clinical intervention. For example, Sarkamo et al report that patients in the acute recovery phase of a stroke benefited significantly from listening to music while in hospital, with improved recovery in the domains of verbal memory, focused attention, depression and confused mood (Sarkamo et al., 2008). Loewy et al report significant benefits from the use of live music for children undergoing sedation when compared to the use of chloral hydrate, and report that at their hospital in New York music is now the sedation of choice over chloral hydrate as a result of this trial (Loewy et al., 2005). The dental literature has a few significant studies on the benefit of music, in particular, in terms of reducing anxiety in patients (dos Santos and de Aguiar, 2011, Kim et al., 2011, Mehr et al., 2012).

A review article published in the February 2010 issue of the American Journal of Public Health summarizes the results of several studies related to arts and health. This thorough paper reports on a significant randomized control trial of

patients with coronary artery disease, where those receiving music therapy and relaxation training showed improvements in atypical heart rates (Zablocki, 2010). However, the authors conclude that many of the studies were observational in nature and that the arts and health literature is made up of a wide range of studies of different intervention types, art forms used and disease states and thus comparisons and conclusions between small studies is hard to make. The authors conclude, however, that despite methodological and other limitations, the studies included in the review appeared to indicate that creative engagement can decrease anxiety, stress and mood disturbances (Zablocki, 2010).

The lack of definitive approach to using the arts in healthcare settings is a significant limitation and a lack of evidence for specific arts based interventions is evident in the literature. Art therapies are at present not currently governed by well tested assessment models or treatment approaches. Evaluation of benefit is also a complicated issue in arts and health work, for example providing evidence of the benefit of a film festival, a community arts festival or a hospital based arts intervention is difficult. The arts may, overall, be considered a resource for psychological intervention, to help explore the illness experience but the evidence to support this is at present limited.

Arts have many functions in healthcare and health promotion professionals use the arts to focus attention and create impact around an issue. The arts may have many functions but primary among these is to ask questions and to challenge the established orthodoxy. The arts might help us to express ourselves and to give meaning to a disordered experience (Murray and Gray, 2008).

A study of arts and health research from 1995 – 2007 (qualitative and quantitative) bear out the findings in this review. This study identified that music

therapy was the predominantly studied intervention and concluded that whilst there is evidence that art-based interventions appear to be effective in reducing adverse physiological and psychological outcomes, the extent to which these interventions enhance health status is largely unknown (Stuckey and Nobel, 2010). Four primary arts practices emerged from this review – music engagement, visual arts therapy, movement based creative expression (for example dancing) and expressive writing. This literature review indicated that there were clear indications that artistic engagement has significantly positive effects on health but there were limitations which prevented sweeping generalisations of positive benefit to be made. These included that many of the studies were observational in nature, had limited or no control groups, small sample sizes and were short term studies. Randomised control trials were recommended for the future, as well as longer term studies and mixed methods. The authors identified future research questions to include which arts therapies are more effective and whether health benefits are sustained over a short or longer time. However, they also concluded that the mass of anecdotal positive evidence of the impact of arts on reducing anxiety, stress and mood disturbance indicates that larger controlled studies might well demonstrate the ability of the arts to improve psychological and physical health and wellbeing as well as quality of life. The large amounts of smaller studies indicate a strong case for investment in larger scale trials. These findings mirror those in this review.

#### **2.4.2 Cultural participation and well-being**

A recent and significant study by Cuypers et al (2011) indicates that participation in receptive and creative cultural activities is significantly associated with good health, good satisfaction with life and low anxiety and depression scores in both genders. This population-based study, with 50,797 adults, is one of the most significant studies in the literature to indicate a direct link between engagement in cultural activities (both receptive, for example,

attending a concert or gallery, and participative, such as taking part in art classes) and health. Higher frequency of cultural participation and the number of different activities engaged in were positively associated with good health. The study found that men who engaged in receptive (rather than creative or participative) cultural activities reported the best health-related outcomes. A limitation of the study was only to engage with people in the community and not people who are in hospital or bed-bound. The study indicates a need to explore this area of work further (Cuypers et al., 2011b).

This study is supported by smaller studies which suggest that people who frequent cultural activities have better survival odds than those who rarely attend. In one study, higher mortality rates were reported for those rarely attending cinema, concerts, museum or art exhibitions (Konlaan et al., 2000, Bygren et al., 1996). In a study of 1,435 Americans a significant association was found between cultural activities and self-reported health, even after controlling for age, gender, marital status, race, social class and employment status. The more cultural activities people attended the higher their rating of self-reported health. Social life and reduction of stress were cited in this study as key components of engaging in cultural activities (Wilkinson et al., 2007).

Another study indicated a clear association between leisure participation and survival in Finnish men, although such an association was insignificant for women. The study examined 8000 people and controlled for other factors such as health status and demographic features (Hyypä et al., 2005). A smaller study indicates similar results regarding leisure participation and cancer survival rates (Bygren et al., 2009a). A study of Canadian young adults found indications that listening to music for self-determined reasons (for example, inherent pleasure and personal meaning) may promote global happiness (Morinville et al., 2013).

A challenge indicated in the Cuypers et al study was the inconsistent concept of culture. Culture can be understood as not only art or literature but also lifestyle, ethics, tradition, human rights and spiritual convictions (UNESCO, 1982). Cultural activities may include receptive activities (such as listening to a concert, visiting museums) as well as creative or participative activities (for example, singing, painting classes). Critics of these studies point out that social, educational and economic resources come first – if you are wealthy in these areas, then your cultural participation is likely to be higher and thus these may in fact be the main determinants of your health as opposed to your cultural participation (Cuypers et al., 2011a). Other authors point out that culture-based programmes with disadvantaged groups can help to empower people who otherwise experience marginalisation (Khawaji and Mowafi, 2006).

Matarasso (2006) identified fifty positive effects associated with participation in the arts, including increases in social activity, reduced isolation, encouraging self-reliance, facilitating health education and building social capital (Matarasso, 1997). A study by Greaves and Farbus found both qualitative and quantitative evidence that the health status of elderly socially isolated people improved over time whilst involved in creative and social activities. Greatest benefits were seen in psychological well-being and reduced depression but without a control group and rigorous study this result is another that indicates that reported benefits must be treated with caution (Greaves and Farbus, 2006).

### **2.4.3 Mental health and the arts**

A significant proportion of the literature on arts and health in clinical and therapeutic settings focuses on the role of arts in promoting mental health and enhancing mental health settings (Bradt et al., 2011b, Hacking et al., 2008, Meekums et al., 2012, Secker et al., 2009, Secker et al., 2007a, Stickley and Hui, 2012, Xia and Grant Tessa, 2009, Guerin et al., 2011, Johnson and Stanley,

2007, Leckey, 2011, Ruddy and Milnes, 2009, Twardzicki, 2008). There is growing evidence and conviction that participating in art projects can help people gain wider social networks, understand and deal with their mental health issues and gain confidence and self-esteem (Hacking et al., 2008). These benefits are regularly reported as common outcomes and aims of arts projects in mental health (Matarasso, 1997, White and Angus, 2003). There are, however, no larger-scale outcome studies to support the many smaller practice impressions, as is the case with most of the areas of arts practice in healthcare. There is also limited evidence that art or music therapy has been beneficial for people with depression or schizophrenia (Maratos et al., 2008, Ruddy and Milnes, 2009, Hacking et al., 2008). Nonetheless, many authors concur with Guerin et al who note the benefits of engaging in music and arts to include developing new skills, positive coping strategies, social opportunities, confidence and self-esteem, enhanced employment opportunities and expression of thoughts and feelings.

A two year study commissioned in 2005 by the UK Department for Culture, Media and Sport and the Department of Health aimed to develop the evidence base in relation to arts participation and mental health. One hundred and two arts projects in England were surveyed showing an impressive array of arts activity in the field but little organised assessment and few clinical trials. A small, uncontrolled outcome study of 62 participants in the UK concludes that arts and mental health projects were associated with improvement in participants' levels of empowerment. There was less secure evidence found of improvements in social inclusion and controlled studies with larger sample sizes were recommended alongside qualitative research to further understand the benefits. The study concludes that the evidence base for arts participation in mental health settings is currently weak (Hacking et al., 2008, Hacking et al., 2006).

A review of arts for health activity by the Health Development Agency, UK suggested that arts participation may have health-related benefits such as increased self-esteem and self-determination (Health Development Agency, 2000), with some studies suggesting benefits for mental health in particular, such as fewer hospital re-admissions (Colgan et al., 1991), lower levels of depression (Huxley, 1997) and reduced rates of GP consultation (Everitt and Hamilton, 2003). Despite the extensive literature on arts and mental health, much of it has been based on small-scale qualitative research studies and where larger studies have been attempted there are methodological weaknesses (Caddy et al., 2012). Whilst some research indicates improvements in mental health outcomes, it is rare for studies to address other issues such as relapse prevention or the longer term benefits of creative arts interventions on mental health (Clift, 2012).

Another section of the literature on arts and mental health focuses on the building design and environmental aesthetics of mental health facilities. Studies categorize the benefits of arts as providing meaningful, creative activity, creating a calm and therapeutic atmosphere and enjoyment and fun, as well as social benefits (Stickley and Hui, 2012).

Nanda et al report on the effect of visual art on patient anxiety and agitation in a mental health facility, indicating that medication dispensed by nurses for anxiety and agitation was significantly lower on days when a realistic nature image of a landscape was displayed as compared to days when abstract art or no art was displayed. The authors argue that this saved significant funds which would have been spent on medication (Nanda et al., 2011).

Further studies on arts and mental health include the effect of cultural arts programmes for youths in mental health services, the role of arts as a prescription in primary care and the benefit of film festivals on mental health

(Rapp-Paglicci et al., 2009, Quinn et al., 2011, Makin and Gask, 2012). Common themes across the literature are for larger sample sizes, clinical trials using validated scales and mixed method studies. Cost-benefit studies were also recommended. Common benefits included a positive approach to the possibility of recovery and the talents and achievement of people with mental health problems, as well as benefits in terms of enjoying life again, returning to previous activities and setting goals.

A systematic review of literature on creative activities and mental well-being in 2011 confirmed previous findings, once again finding the benefits of engaging in creative activities to include promoting relaxation, self-expression, reducing blood pressure and stress. None of the studies found included a randomised control trial and many of the studies have small samples and evaluate localised services. Research available was considered to be relatively weak in terms of methodology (Leckey, 2011). Choice of arts activity and the growth of creative activities as part of mental health services were found to raise many challenges, for example the contribution of different art forms has yet to be explored adequately. Despite this weakness of evidence, two UK Government documents have recommended that Arts and Health should be integrated into healthcare environments and mental health care, based on the wealth of qualitative data (The Arts Council England, 2007, The Department of Health, 2007).

#### **2.4.4 Quality of life, individuality and locus of control**

In reviewing the broad literature on aesthetics and healthcare, two key themes emerged. The overall aims of arts in health settings seem to be to improve quality of life for patients or to express the individuality of the patient. These two themes appear constant whether the arts intervention aims to address environmental, therapeutic or staff needs in healthcare settings.



Quality of life is difficult to define and is a concept which varies from individual to individual. Quality of life can be described as a multidimensional concept, encompassing social, psychological, and physical domains (Birren et al., 1991).

The term has also been used to refer to an overall evaluation of one's life, for example, how satisfied I am with my life overall, as well as to refer to various components of life such as social life, financial situation, work, or living situation (Brod et al., 1999). It is argued that the arts in all their forms may help to improve quality of life and to close the gap between the reality for patients in healthcare settings and how they would like their life to be. For example, arts programme and other social activities in nursing homes are seen to offer an improved quality of life for residents.

*Concerts (in hospital) enable situations in which patients can be stimulated both visually and generally, in which they can be expressive, take part and take notice of each other, and in which they are treated as whole beings (Trythall, 2006) p. 114.*

One's artistic preferences are unique. Being able to express one's personal preferences for art or music in hospital can greatly individualise a person's experience of hospital, for example decorating one's room with pictures or listening to music in the day room. A study of the benefit of live music for patients in acute hospital concluded that it was impossible to define 'relaxing music' as preferences were unique and every musical genre was listed as relaxing music by at least one patient in the study (Moss et al., 2007). Scher indicates 3 aspects to hospital experience – curing, caring and healing – and proposes that arts play a part in the latter two. The first, curing, is often the predominant concern for both staff and patients, whereby all focus is on treating the disease and curing it as much as possible. Less attention may be given to the psychological, social and spiritual fall out of such illnesses and experiences

(Scher, 1996) but it is argued that arts challenge the assumption that seriously ill people are capable of nothing (Kirlkin, 2003).

Locus of control is a psychological theory regarding a person's sense of control over their environment. The locus of control can be internal (for example, a person with a high internal locus of control will believe that events in their life derive primarily from their own actions, such as lack of preparedness if they fail an exam), or external (i.e. a person will feel that life is controlled by environmental factors that they cannot control). The arts, as seen in the literature above, may contribute to giving patients a sense of control over their own destiny in hospital.

*Patients often tell us that when they come to hospital they (and the medical team) become totally focussed on 'the bit of me that's ill' and they lose a sense of their own abilities, talents and interests. Hospital can be a frightening, intimidating place and a patient can become isolated from friends and family (Moss and Granier, 2006) p. vii.*

Stickley (2012) sums up some of the benefits of engaging in arts for patients as bringing a sense of purpose and meaning, hope and creativity, achievement, social belonging and individual personal experiences (Stickley, 2012). Langley Brown argues that there is a need for both individual personal experiences and empirical evidence in this research field, with both scientific cognition and artistic imagination playing a part in exploring the role of arts in healthcare (Brown, 2012).

The two themes (quality of life and individuality) identified here as linking much of the literature relate closely to Maslow's hierarchy of human needs (see Figure 1.4, Chapter 1.10). Aesthetic needs and self-actualisation needs are important

once the basic physiological needs are met. Patients in health settings arguably have a need to express themselves creatively and engaging in the arts may allow an individual in hospital an opportunity for self-expression and to take some control over their healthcare environment. This opportunity might be afforded through having a choice of music to listen to in hospital, to participate in choosing visual art for the healthcare building or by writing a journal while in hospital. Self-esteem, a sense of achievement and being capable are important needs for any human being and those in hospital need opportunities for these despite ill health and the restrictions of the hospital environment (Maslow, 1970, Maslow, 1969).

#### **2.4.5 Arts and older people**

Older people are proportionately the largest demographic group using health services and a better understanding of the interaction between aesthetics and health in this group can arguably inform investigative strategies for the whole population. A focus on older people is also of particular interest as there is mounting evidence of diminished cultural capital with advancing age (Goulding, 2012).

The literature on arts as a therapeutic and clinical intervention focuses heavily on the role of arts in the health and well-being of older people. An important study refers to the primary health benefits of arts interventions for older people, noting a heightened sense of control and social engagement following engagement in arts (Cohen, 2009). Another study examined the experience of thirty-six older people who attended art exhibitions and explored their understanding of successful aging and creativity. This was a qualitative study with content analysis used to determine six themes of successful aging: a sense of purpose, interactions with others, personal growth, self-acceptance, autonomy, and health. The findings also corresponded with Cohen's study, suggesting that creative activity helped successful ageing by fostering a sense of

competence, purpose, and growth. Artistic creativity is also suggested to facilitate successful ageing by encouraging the development of problem-solving skills, motivation, and perceptions (Fisher and Specht, 1999).

Cohen et al (2009) looked at which leisure activities most contributed to the delay in the onset of Alzheimer's disease for those at risk of the disorder: dance was at the top of the list and playing a musical instrument was third among the top five (Cohen, 2009). Other studies on arts and dementia include a Cochrane review of music and dementia, the effect of singing and music therapy for people with dementia (Brooker and Duce, 2000, Hammar et al., 2011, Vink Annemiek et al., 2003). There is some evidence that challenging behaviours associated with dementia reduce when people are engaged in music therapy and that music can be useful when used by staff and family to assist the person with dementia (Gerdner, 2005, Gerdner, 2000). A review of studies of music therapy and dementia showed evidence of music therapy improving mood and reducing behavioural disturbance on a short-term basis but finding no high-quality longitudinal studies that demonstrated long-term benefits of music therapy. The study recommended future studies to define a theoretical model, include better-focused outcome measures, and discuss how the findings may improve the well-being of people with dementia (McDermott et al., 2013).

The literature on the benefits of arts in stroke recovery is also growing, with a significant study indicating that listening to your five favourite CDs can assist in stroke recovery. This study demonstrated for the first time that music listening during the early post-stroke stage can enhance cognitive recovery and prevent negative mood (Sarkamo et al., 2008). Other small scale studies indicate some qualitative benefit from engaging in arts programmes post stroke. Again, the literature is small and varying in terms of art form studied and context. A qualitative review of sixteen participants in a community art group post stroke reported improved confidence, self-efficacy, quality of life and community

participation through involvement in an arts health programme (Beesley et al., 2011).

A study by Wikstrom (2004) is the closest study to the topic of this thesis, in terms of mapping the aesthetic interests of older people and exploring qualitatively what the arts mean to them (Wikstrom, 2004). Wikstrom identified two key themes regarding participation in aesthetic activities in older age: giving life a sense of meaning (participants describe becoming so absorbed and fulfilled in the artistic activities that they forget their worries) and arts as an initiator of activity (including increasing social interaction, physical mobility and intellectual stimulation). Wikstrom recommends that nurses should build programmes based on the aesthetic preferences of older people and that engagement in these preferred interests contribute to successful ageing and can be used as stimulation by nurses (Wikstrom, 2004). A more recent study verifies that aesthetic activities may enrich the lives of older people living in nursing homes and may improve their satisfaction with their living environment (Chang et al., 2013).

Ageing and the arts has become a significant area of study in recent years, with the establishment of the National Center for Creative Ageing in the USA, the Creative Ageing Centre in Australia and a festival of arts and older people *Bealtaine* hosted by Age and Opportunity in Ireland to name but a few arts initiatives specifically addressing the needs of older people. Many galleries and museums have specifically targeted programmes for older people and a recent interesting study focuses on how visiting art galleries affected the social and cultural capital of culturally inactive older people and may contribute to the well-being of older people (Goulding, 2012). This study highlights how linking social capital and cultural capital through engagement with the arts may have implications for health and may be relevant to policy makers when trying to engage less culturally engaged participants in the arts. The paper focuses on

Bourdieu's concept of three types of capital: economic capital, cultural capital and social capital. All three can be convertible into one another under certain circumstances (Bourdieu, 1986).

The National Center for Creative Ageing has collected together a huge resource of studies on ageing and arts, with one of their most significant recent reports being a US National Endowment for the Arts Report entitled *Art and Aging: Building the Science*. This report concludes that although arts interventions for older people show promise, most studies documenting these beneficial effects do not meet the rigorous standards of scientific research and few include a cost-benefit analysis. Studies on the benefit of music are most persuasive to date. Once again, the report recommends larger studies and more rigorous research (National Endowment for the Arts, 2013). Another important focus of the literature on arts and older age focuses on the artistic achievements of older people and the demographic dividend of older people. In this case, creativity in older age is viewed as a challenge to the negative perceptions of ageing and an area of success and achievement (Dormandy, 2001, O'Neill, 2011).

## **2.4.6 Community arts and health**

Community arts can be defined as

*An approach to creative activity that connects artists and local communities in using the arts as a means of expression and development (Johnson and Stanley, 2007) p. 28.*

In this context, arts can be seen as an important tool in the activation and reintegration of people who are disadvantaged or excluded from mainstream society. Arts can also play a role in regeneration of local communities and in the work of neighbourhood groups. The arts and community health movement was pioneered in the UK in the late 1980s, placing arts in health promotion and primary care contexts. Nowadays, arts in community health settings are a recognised component in the arts infrastructure of Ireland, UK and USA, although less documented in any other cultures (White, 2009). The key principle of arts in community health projects is that there is a relationship between creativity and health and that the arts can mediate or touch people, rather than indoctrinate with health promotion messages. Examples of community arts and health projects include art projects to promote healthy eating in schools, youth projects using arts to explore and reduce drug use and mother and infant music programmes for disadvantaged or at risk families in community health settings. White identifies four key dimensions of arts in community health contexts – using creativity to enhance social relationships, creativity as a route to wellness, engaging groups through arts and supporting the process of care. He also indicates that the arts and health field has, to date, not developed a unifying theory of arts in healthcare, which can be a disadvantage for furthering research and the search for evidence. White points to Dissanyake's term for art-making which is 'making special', identifying the key benefit of engaging in arts across contexts as the act of making something special, precious or unique (White, 2009).

A seminal study on the social impact of participation in the arts in the 1990s in the UK found that participation in arts is an effective route for personal growth, leading to enhanced confidence, skill building and educational developments, as well as contributing to social cohesion. The author recommends the arts as a flexible, responsive community development activity.

*The arts are a delight and enrichment to the lives of millions of people: that is why they participate, in countless ways, in countless places, on countless occasions (Matarasso, 1997) p. 72.*

Arts are a universally popular activity and can be used to engage people who do not normally access services. For example, in Matarasso's study, the two top adult education classes chosen in London were found to be music and dance. It is argued that engaging people in arts programmes which convey health messages can be more successful than some direct health promotion campaigns.



## 2.5 Medical Humanities

The literature on arts in healthcare contexts has porous borders with those of narrative medicine and the medical humanities. Each has aesthetics at its core, and each brings insights and articulacy to the other two. This section reports on the key findings of the literature review in this area.

The arts are reported to benefit staff working in healthcare environments, arguing firstly that the presence of the arts makes the workplace a more enjoyable, creative and relaxed environment. Engagement in the arts allows opportunities for understanding, sharing and role reversal (Davidson and Faulkner, 2010). Opportunities for aesthetic expression are also important for nursing students as they sensitize student nurses to the patients' situations (Wikstrom, 2000).

*... Rather than ... healing the physical body in a soulless, concrete box ... a very good thing that art does is to bring the community into the hospital. The barrier between illness and health is broken down. (Berhman, 1997) p. 584 - 585.*

It is proposed in some of the literature that modern society has, by and large, created an artificial separation between science and the humanities and that these disciplines need to be brought back together through the medical humanities (Wikstrom, 2002). Such education programmes may assist healthcare professionals to improve their reflection and understanding of the patient (Pardue, 2005, Wikstrom, 2000). Expressive art forms that result in empathic perception of an experience can result in improved nursing practice (Eggenberger et al., 2004).

The teaching of literature and narrative writing has become increasingly accepted in medical schools as an aid to strengthening reflection and self-awareness and the adoption of patients' perspective. It is proposed by Charon that through systemic and rigorous training in narrative skills (such as close reading, reflective writing and authentic listening to patients), doctors and students can improve their care of individual patients, commitment to their own health and fulfilment, care of their colleagues and continued fidelity to medicine's ideals (Charon, 2001). However, there is an absence of a widely agreed definition of medical humanities and the subject is often viewed as a marginalised, soft activity outside the core medical training of the university (Moss and O'Neill, 2012). Clear definition is seen as crucial to its progress within medical education programmes (Brody, 2011). Shapiro et al define medical humanities as:

*One or more of the humanities disciplines to investigate illness, pain ...to better understand and critically reflect on their (doctors') profession ... and nurture collaboration between scholars, healers and patients (Shapiro et al., 2009) p.192.*

Brody argues that university education was once a rounded activity, whereby the goal of a liberal arts education was to prepare for a full, active participation in society. Somewhere along the line, medicine has contracted its scope to become a narrow conversation intelligible only to specialists in certain disciplines (Brody, 2011). He argues for a need to prepare students for the wisdom, civic leadership and challenges of being a doctor, not just the technical cleverness that is tested so often.

Medicine practiced with narrative competence is proposed as a model for humane and effective medical practice. It is recommended that through reading literature and reflective writing one can examine the central narrative situations

found within medicine, that of the physician and patient, physician and self, physician and colleagues and physician and society. It is proposed that by bridging the divide that separates physicians from patients, colleagues and society, narrative medicine offers fresh opportunities for respectful, emphatic and nourishing medical care (Charon, 2001).

Narrative medicine is defined as

*...the ability to acknowledge, absorb, interpret and act on the stories and plights of others (Charon, 2001) p. 1897.*

Along with scientific ability, it is suggested that doctors need the ability to listen to the narratives of the patient.

*Patients need hospital environments beyond purely fixing medical problems ... they need to be accompanied through their illnesses in various ways. A scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering (Charon, 2001) p. 1897.*

A creative arts based bonding intervention between nursing students and patients to promote positive attitudes towards elders in Taiwanese nursing students found that after the intervention, the nursing group who engaged in creative activities with patients had significantly increased positive attitudes toward older patients than the 'friendly visit' group (Chen and Walsh, 2009). Medical humanities can help students to explore creatively complex issues such as death and dying and 'difficult' patients. It is believed that the active use of creative media can be a way of processing their own and patients' experiences.

*Although scientific skills are indispensable for physicians, narrative skills are equally important ....Creativity is often what*

*gives physicians the flexibility to discover novel solutions ... reason and imagination are the two vectors of profound awareness (Louis-Courvoisier, 2003) p. 1044.*

The arts can bring a creative, alternative view of the 'normal' activities of healthcare. An example is the work of the Finnish sculptor Hietanen who created sculptures of her hair when diagnosed with breast cancer and explored the significance of hair loss from a creative, original standpoint. Chambon and Irving argue that one of the best example of artists who shed new light on the predominance in our society of reason and knowing is Samuel Beckett (1906 – 1989), who explored silence, absence and unknowing relentlessly during his career.

*Beckett often spoke about throwing away all intellectual solutions and moving away from the destructive need to dominate life ... (perhaps humanities) shift the territory of bioethics from the certainty of the empirical and rational world to the uncertainty, ambiguity and indeterminacy of the artistic (Chambon and Irving, 2003) p.274 and 276.*

Aesthetics and arts can also play a part in training programmes for allied health professionals. An interesting study describes a nude drawing class as part of physiotherapy training (Fougner and Kordahl, 2012). The aim of the programme was to encourage students to reflect and interpret the experience and to view the human body in a different way. It was found that this artistic opportunity provided an opportunity for critical reflection and it is also noted in this paper that the experience of nude drawing was quite provocative for some students. Being exposed to nudity was an event that left few students indifferent. The assumptions, beliefs and cultural values of students were highlighted in their response to this challenging situation. Nude drawing also highlighted how

viewing the body is so different by artist and clinician, as an anatomical study or as an artistic study. This can raise awareness of different ways to observe the body, as well as the meaning and values students bring to an assessment of the physical body in a physiotherapy clinic.

Another study explored the role of a pilot arts and health programme in a graduate community nutrition programme. Involvement in an arts programme was seen by lecturers on the course as a way of fostering community participation, providing alternative ways of thinking about issue and exposing underlying assumptions in students.

*The arts help us make sense of the human condition through the exploration of emotion, ambiguity, complexity and uncertainty and through valuing the aesthetic as well as reason (Fox, 2009) p. 82.*

A significant study involved a randomised control trial of 998 health service workers, whereby workers were offered weekly participation in arts activities for eight weeks (choosing attending films, concerts, art exhibitions or singing in a choir). The health questionnaire short form (SF 36) was the main measure used. Fine arts stimulation was found to significantly improve physical health, social functioning and vitality and this contributes to findings that fine arts stimulation might be important for health (Bygren et al., 2009b). Downie points to the common goal of medicine and art, namely that of completing what nature cannot bring to a finish, to reach the ideal and to heal creation. The physician attends the patient, the artist attends nature. Art, like medicine, is not an arrival, but a search (Downie, 1994).

A fundamental issue in medical humanities work is that it remains unproven whether engagement in medical humanities programmes make more perceptive or ethically competent doctors or nurses (Gallagher, 2007). An interesting

example is Seamus Heaney's experience of teaching poetry to students in a troubled area of Belfast. A number of his students went on to join the provisional IRA, which left Heaney concluding that whatever effect poetry had on them it was not the one he had hoped for (Carey, 2005). It cannot be assumed that engagement in arts makes for morally better healthcare professionals. A number of authors argue that arts cannot be embraced uncritically in healthcare settings and that further research is required to guide arts interventions (Carey, 2005, Gallagher, 2007).

The arts might also play a role in other areas of healthcare development such as leadership development programmes (Romanowska et al., 2011). A study of an art-based leadership programme over eighteen months showed some advantages to using the arts, but again the authors recommend further larger scale studies to provide evaluation of the effectiveness of this alternative educational approach. The authors argue that arts based learning can give greater focus on

*... valuing than measuring, on surprise rather than control, on distinctions than on standard and on the imaginative or metaphorical than on the factual or literal (Romanowska et al., 2011) p. 79.*

In healthcare settings, creativity is proposed as the way to understand the world and to judge in the absence of rules.

*The duty of art is to handle human problems that are not possible to tackle with cognitive and rational methods (Romanowska et al., 2011) p. 79.*

A strategic paper on arts in nursing practice, education and research points to the benefits of engagement with arts in healthcare environment as including a

more holistic, collaborative and person-centred approach to healthcare practice; enhancing self-awareness and reflection on values and beliefs, supporting the learning of students and practitioners; and increasing understanding of the experience of service users and of what matters to them (The Nuffield Trust, 2005).

In summary, it can be seen that the arts appear to play a role in staff education as a channel through which to explore ethical issues, encourage reflection and emotional intelligence and to focus on the individual peculiarity of meaning. Scientific training may focus more on labelling and categorising and it can be argued that the arts play an important role in developing imagination and helping health professionals to deal creatively with the issues that arise every day in healthcare contexts. The medical humanities are perhaps, in summary, a portal to sensitise medical professionals to aesthetics as a human need. The most successful approach, then, may be to focus the medical humanities curriculum on students own aesthetic interests and needs and to develop this curriculum in collaboration with students (Moss and O'Neill, 2012).

## **2.6 Conclusion – The role of aesthetics in healthcare settings**

This chapter has reviewed the role of arts and aesthetics in healthcare settings. A large body of literature has been presented – from environmental aesthetics in healthcare to arts therapies to medical humanities – as well as specific attention to the effect of arts on the health of older people, quality of life and individuality.

From the literature review and current practice in the field of arts and healthcare, the research question and overall method for the research was developed (Section two).

The overall conclusions from this literature review are:

- There is relatively sparse empirical evidence of the benefit of arts on health and well-being, and a wealth of qualitative studies of arts benefitting users of health services. Methodological rigor and evidence of benefit is lacking in the current literature.
- A gap exists in terms of a baseline of knowledge regarding patients' aesthetic experiences and arts engagement. Many of the papers reviewed focus on participative arts for patients and it appeared that there was a lack of basic mapping of aesthetic interests prior to providing interventions
- There is very limited interest in the literature on receptive arts and this is a gap in the current literature
- There is qualitative evidence of the important role played by arts in healthcare settings, in terms of improving the environment, contributing to positive clinical outcomes and to training staff to reflect and be creative. Common benefits from participation in cultural activities emerged from the literature review, including improved social capacity, health-related outcomes, psychological health and mental health.



Rigorous research is required to provide information about the experiences and perceptions of stakeholders in order to underpin successful policy and practice

- Many studies recommend mixed methodology studies, larger sample groups and research with a variety of patient populations in healthcare contexts. The specific context of hospital aesthetics warrants further research as there is a gap in the literature in this regard.
- Whilst further work needs to be done to prove the benefit of arts in healthcare, it might also be important to explore whether hospitals are aesthetically deprived environments and to map and provide a baseline of the aesthetic interests of patients, prior to providing interventions that may or may not improve health.

Although there has been a burgeoning of interest in arts and healthcare in recent years, there are some basic issues of importance to advance the field. These include decisions regarding how the discipline of arts in healthcare will evolve and the need for evidence of the effectiveness of these practices. Dileo and Bradt recommend specific needs in relation to future research, which include clearly distinguishing the disciplines working in arts in healthcare, defining specific applications and types of approaches for designated settings and patient groups, identifying specific demographic and biographical variables that impact on the effectiveness of the arts practice, and identifying, with medical professionals, which are the most significant and meaningful outcomes to be studied for each arts practice (Dileo and Bradt, 2009). Cuypers et al (2011) note a lack of studies of the negative effects of arts in healthcare and conclude that credibility would increase if negative findings were reported more systematically. They also conclude that there is little information or research on dose-response or the longer term effects of attending cultural activities or how the benefits can be sustained. (Cuypers et al., 2011a).

It becomes apparent from the literature that there are very few, if any, scales of aesthetic deprivation and very little work done in terms of mapping patients aesthetic preferences and access (or not) to these while in hospital. There is also a need to further explore what the arts mean to patients while in hospital and what role they might play when one is recovering from a major health event. It is also apparent that arts in hospital are rarely an expected service and there is scepticism about the benefits. The notion of curatorship in a healthcare context is given hardly any attention in the literature and is an area worthy of further exploration.

Two routes were thus proposed for this particular research, which arose from this review - to conduct in depth interviews with hospital patients to find out more about their aesthetic interests and to design a survey to assess aesthetic deprivation amongst patients. Both methods attempt to map the aesthetic interests of patients and provide information relevant to arts programming in hospitals. It was decided, following this review, to focus on patients' experience of arts and aesthetics both in hospital and prior to hospital stay, provide baseline information on aesthetic interests and explore the possible deprivation experienced by patients through lack of arts. This was seen as an important gap in the research, which has tended to focus on trying to prove the benefit of arts in healthcare environments.

The literature indicated a need for further qualitative and quantitative research and the current tension between the two approaches led this researcher to select mixed methodology as the methodology of choice. The next chapter presents the formulation of the research question and choice of methodology in detail.

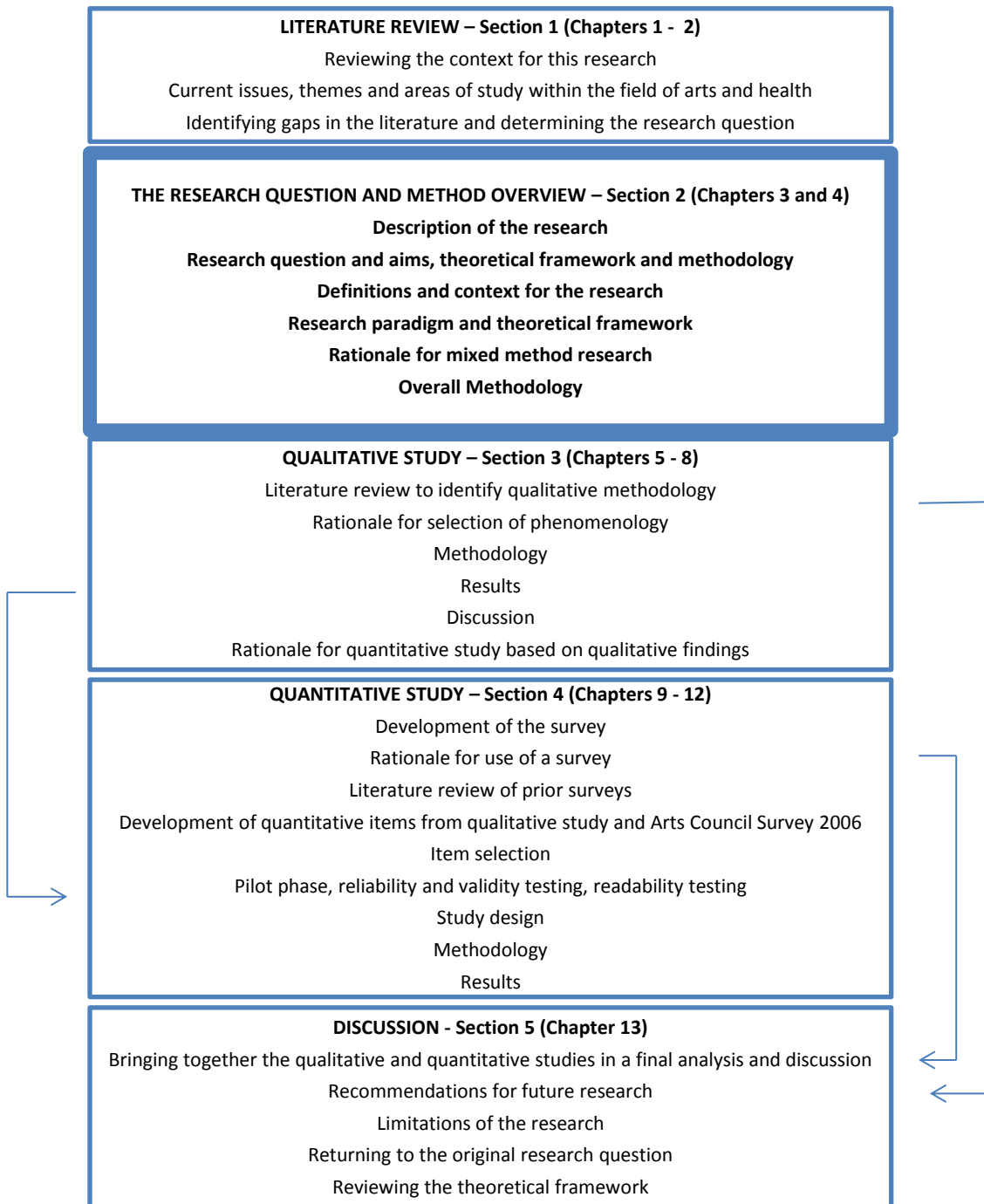
## ***Section One Conclusion***

This section presented the literature reviews undertaken to formulate the research question and set the context for this research. From the literature review and current practice in the field, the researcher developed the research question and overall methodology for the research. These are presented in Section Two.



## ***Section Two Research Question and Overall Methodology – Overview***

The purpose of this section is to present the research question, aims and theoretical framework (Chapter Three). Mixed methodology design (sequential-exploratory) was chosen for this research and the overall research methodology is explained in this section (Chapter Four). The research question arose from the literature reviews conducted in Section One. See Figure 3.1 for details of this section.



**Figure 3.1 Overall thesis design highlighting Research Question and Method Overview**

## **Chapter 3 Research Question**

### **3.1 Introduction**

This chapter presents the research question, aims and theoretical framework. This research was positioned within the field of aesthetics and older people in healthcare settings, following an examination of gaps and issues in the current literature (Section One). The context of the National Centre for Arts and Health at Tallaght Hospital, where the research was conducted, is presented briefly in this chapter.

### **3.2 Description of the research and research purpose**

This research centres on the concept that aesthetics, the arts, culture and leisure are important for well-being and that arts and culture is central to the public health agenda (Philipp et al., 1999, Royal Society for Public Health UK, 2013 , Rollins et al., 2009, The Arts Council, 2010, The Arts Council England, 2007). The research area of interest is the experience of patients in hospital of aesthetics. The primary purpose of the research is to provide a mapping of patient preferences, needs and perceived benefits regarding aesthetics and to explore the role of aesthetics in the everyday lives of older people attending hospital. The secondary purpose is to research how much access older patients currently have to aesthetic interests while in hospital and to develop a theoretical perspective in this area, in particular whether patients experience aesthetic deprivation while in hospital. This research will examine these questions through qualitative and quantitative approaches using a mixed method design.

### 3.3 Research Question and Aims

The overall research question is '*What is the role of aesthetics for patients in hospital?*'

Specific aims of the research are:

- To identify patient preferences and perceived benefits regarding aesthetics, before, during and after hospital stay
- To explore the role of aesthetics in older patients' lives, in the context of what changing health does to one's aesthetic infrastructure
- To explore the extent to which the hospital environment is aesthetically-deprived or enriched for each patient
- To develop a survey to begin to map older patients' engagement in aesthetics and to catalogue the possibility of aesthetic deprivation in hospital, with a view to developing a Measure of Aesthetic and Cultural Health

### 3.4 Definitions for purpose of this research

The term *aesthetics* is used for this research. Terms such as 'arts', 'aesthetics' and 'culture' are notoriously difficult to define (Davies, 2005). As stated in the literature review, the definition of aesthetics used for this research is:

*An attempt to theorize about art, to explain what it is and why it matters* (Graham, 1997) p. 2.

However, a further definition is useful to determine exactly what is meant by aesthetics in this context:



*As human beings we move along the aesthetic spectrum from our basic bio aesthetic condition of live creatures undergoing enjoyment or pain, to our prosaic everyday labour of dramaturgically presenting our identities to survive socially, on to the more refined artistic aesthetics in poetics creating literary, musical or visual artefacts and imaginary worlds (Mandoki, 2007) p. 51.*

Aesthetics for the purpose of this research, therefore, refers to the philosophy of arts and the role the arts play in society. It encompasses all art forms as well as broader issues such as the physical environment and everyday experiences related to beauty and art (Saito, 2007).

Arguments continue about what constitutes 'art', for example whether popular and mass art are 'art', and some definitions of art can seem somewhat narrow and elitist (Davies, 2005). The term 'arts', therefore, seems a somewhat narrow definition for this research, as the researcher wanted to remain open to the experiences and interpretations of patients, however they define their aesthetic or arts interests. For example, the interviews conducted in the qualitative study as part of this research allowed patients to express their interests in popular art, high art, everyday aesthetics (such as crockery or linen) or the aesthetic environment in hospital, without limiting this by the researcher's own definition of aesthetics. The scope of the interviews was deliberately broad, to allow an exploration of aesthetics or arts, however the individual defines, interprets or experiences these. Thus the term 'aesthetics' is used in this research, as per the definition above, as a broad reaching umbrella term to encompass all art forms and aesthetic experiences.

The definition of arts used for this research is the list of art forms included as 'arts' by The Arts Council of Ireland. These are architecture, circus, dance, film,

literature, music, opera, street arts and spectacle, theatre, traditional arts and visual arts (The Arts Council, 2006).

A final definition is important for this research. 'Arts and health' is a term with myriad definitions within the healthcare sector. For the purposes of this research, the definition used is from The Arts Council England, whereby 'Arts and Health' is defined as arts based activities that aim to improve individual and community health and healthcare delivery and which enhance the environment by providing artwork or performances (The Arts Council England, 2007). The field of arts in healthcare embraces a wide range of practices including medical humanities, design aspects of healthcare, arts in hospice/end of life care, arts therapies and arts and aging (Brener, 2003).

The subject of this research is more than purely about the arts; it is about how we find beauty and meaning in our environment and a desire to focus on the aesthetic interests of patients however they define them. Rather than focus on arts in healthcare (whether arts in mental health settings, the role of arts therapies or medical humanities) it was decided in this research to focus initially on the aesthetic preferences of patients, whatever form this takes.

### **3.5 The importance of this research, original thought and contribution**

The literature review undertaken by this researcher identifies a lack of rigour in much of the literature as well as specific gaps in terms of mapping aesthetic interests of patients (prior to implementing programmes), the possibility of identifying aesthetic deprivation (rather than trying to prove the benefit) and assessment of the aesthetic environment of acute hospitals (only a few studies, mainly in Nordic countries, have addressed this issue and these studies

recommended further studies with other populations). These were the primary areas of focus for this research.

This research seeks to make a contribution by furthering understanding of the aesthetic needs of older people in hospital, the importance of aesthetics for patients and the broader view of healthcare including patients' engagement with the arts. It aims to contribute knowledge by seeking patients' views prior to programming arts interventions and providing information from patients regarding the aesthetic environment of acute hospitals. Older people are proportionately the largest demographic group using health services and a better understanding of the interaction between aesthetics and health in this group can inform investigative strategies for the whole population. There is a relatively limited amount of evidence based research undertaken as to the nature of, and potential benefit from, aesthetics in health care and this programme of research hopes to contribute to knowledge in this field.

### **3.6 Context for this research**

This research takes place at Tallaght Hospital, Dublin, Ireland, a teaching hospital of Trinity College Dublin. The hospital arts programme was established in 2003 to improve patient care and to promote the benefits of the arts in health. In 2008 the National Centre for Arts and Health was established and the centre aims to improve the hospital experience for patients, to explore the therapeutic potential of the arts, to build positive links with the local community and to make the arts accessible to patients who cannot access traditional arts venues. The current arts programme includes exhibitions, live performances, creative writing classes, arts therapies, design projects and participatory art sessions on wards and in waiting rooms. The art programme is free for everyone attending the hospital and all art programmes are tailored to the needs of

individual patients and clinical departments (Moss, 2010). Patients attend both as in-patients (for example, bedside art sessions and live music performances) and out-patients (for example, community based arts and health groups for people referred from the Rheumatology and Age Related Health Care departments).

This research arose partly from feedback from patients engaged in the programme, as well as through evaluations and pilot studies. This feedback indicated that some programmes were implemented without in-depth consultation with patients. Awareness grew, from working within the arts and health field, that it was important to ask patients about their perceptions of arts in healthcare. Anecdotal conversations with patients indicated the importance of receptive arts in hospital, the wide range of aesthetic interests of patients, the importance of asking patients what they prefer, the role of arts as clinical intervention (for example, arts therapies), the importance of arts in the aesthetic environment and the possibility that aesthetic interests were neglected in hospitals. A number of smaller studies with stroke patients, medical students and artists training to work in healthcare were undertaken prior to commencing this research (Moss et al., 2007, Moss and O'Neill, 2009, O'Connell et al., 2013, Moss, 2003). These built a picture of the need for both a study on the aesthetic needs of patients in hospital and for consultation with patients.

### **3.7 Research paradigm and Theoretical Frameworks**

It is important in any research to set out the theoretical perspectives or paradigms that underpin the study. The section describes the framework, concepts and theories that support this research and demonstrates awareness of the theoretical perspectives that underpin this research topic (Bowling, 2009). This research starts from the perspective of a clinician and musician working in

the field of arts and health for nineteen years. The research began as a desire to interview patients in-depth to find out more about their experience of arts and its relationship to their health and well-being, in particular to identify and map patients' arts and aesthetic preferences. Thus, scientific objectivity was never the assumed stance of this study as it began with in-depth interviews with patients in a hospital context where the researcher had worked for eight years. Many scientific studies strive for freedom from values and assumptions; this was not possible in this research, due to prior knowledge, experience and a bias towards the benefit of arts for some patients in healthcare settings.

*It is naïve to assume that (value freedom) is actually achieved in any field of research (Bowling, 2009) p. 129.*

The method of investigation chosen depends on the researcher's assumptions about society. In this research, the aim was to make any prior assumptions explicit and to strive to conduct as rigorous and objective a research project as possible, given these constraints. This was particularly important given the many reports in the literature of studies with poor attention to methodological rigour and a lack of robust evidence of the benefit of the arts. This research is therefore *inductive* rather than *deductive*. With deductive reasoning, the researcher starts with general ideas and develops a theory and testable hypothesis from it. This research therefore leans to *inductive* reasoning, whereby the study begins with observations and builds up ideas and possibly testable hypotheses from these observations. Further testing follows on the basis of observations.

This research started with general ideas that the arts and aesthetics may play a role in patients' experiences of hospital, and that there may be a loss or deprivation of these interests in the hospital environment. Another premise was that arts managers in hospitals might be assuming incorrectly what arts programmes are preferable without a true understanding of patients' actual

aesthetic interests and it was believed that there was a lack of evidence in the existing literature as to patients' aesthetic interests prior to, during and after hospital stays. The interviews in the first part of the research were developed to test these ideas, based on literature review and formulation of a research question. In this research, the survey (quantitative arm of the research) was developed from the observations and ideas generated from the qualitative study.

*In contemporary social science the importance of inductive, or probabilistic, as well as hypothetico-deductive logic is emphasised: one does not necessarily begin with a theory and set out to test it, but one can begin with a topic and allow what is relevant to that topic to emerge from analyses (Bowling, 2009) p. 136.*

### **3.7.1 Research Paradigm Framework**

Tashakkori and Teddlie (1998) refer to four major paradigms, or world views, that guide researchers – logical positivism, post positivism, pragmatism and constructivism (Tashakkori and Teddlie, 1998). This research does not fall within the empirical, positivism paradigm, which underlines purely quantitative methods. Post positivism moved away from this purity but still maintains quantitative methodology and experimentation as the most useful way of gaining knowledge. Constructivism (also known as naturalism, interpretivism) grew as a reaction to the dominance of positivism, believing that there are multiple, constructed realities and that the knower and the known are inseparable. Qualitative methodologies belong in this paradigm. Tashakkori and Teddlie, however, present a fourth way, the pragmatist paradigm, whereby qualitative and quantitative methods are compatible and both objective and subjective views are important (Tashakkori and Teddlie, 1998).

Pragmatism fits this researcher's world view and the situation of this research and in this research the quantitative and qualitative sections are equal in weight. It was important to this researcher to follow a well-tested methodology and to ensure a robust and valid study was achieved, be that qualitative or quantitative. The setting, however, was accepted as unmanipulated and 'natural', with interaction between participants and researcher, rather than scientific laboratory style experimentation. See Table 3.1 for details of the pragmatist approach.

**Table 3.1 Four paradigms used in the social and behavioural sciences (Tashakkori and Teddlie 1998)**

<b>Paradigm</b>	<b>Positivism</b>	<b>Post positivism</b>	<b>Pragmatism</b>	<b>Constructivism</b>
Methods	Quantitative	Primarily quantitative	Quantitative and qualitative	Qualitative
Logic	Deductive	Primarily deductive	Deductive and Inductive	Inductive
Epistemology	Objective point of view.	Findings are probably objectively true	Both objective and subjective points of view	Subjective point of view
Axiology	Inquiry is value-free	Inquiry involves values but they may be controlled	Values play a large role in interpreting results	Inquiry is value-bound
Ontology	Naïve realism	Critical or transcendental realism	Accept external reality. Choose outcomes that best produce desired outcomes	Relativism

Whilst the paradigm is the philosophical underpinning of the research, the ontological, epistemological and methodological positions adopted in this research are also important and are set out specifically in subsequent sections (Sections 3.7.2 – 4.6) (Densin and Lincoln, 2005, Pope and Mays, 2006).

### **3.7.2 Ontology**

The ontological perspective can be realist (reality is 'out there' and a law of nature), critical realist (our own presence as researchers influences what we know) or relativist (knowledge is a social reality, value-laden and only comes to light through individual interpretation). The perspective of this researcher, and this research project, is critical realist - our own presence influences what we know but generalisations and conclusions can be drawn from group experiences and study of a phenomenon (Bowling, 2009).

### **3.7.3 Epistemology**

This research is pragmatist in that knowledge is not value free and bias should be acknowledged. Each individual constructs his/her own reality and thus in research there are multiple interpretations. However, this researcher also recognises the importance of experimental testing and the need to conduct studies that reduce the influence of context and this influenced the choice of a quantitative study as part of this research.

### **3.7.4 Theoretical framework introduction**

In this type of research, it is more appropriate to focus on the theoretical framework rather than the hypothesis. A theory predicts events in a broad, general context whereas a hypothesis makes a specific prediction about a specified set of circumstances and is tested against empirical data in order to eliminate falsehood. In this research, a hypothesis was not tested in a controlled study. However, a theoretical framework was identified upon which to explore research question. A theoretical framework sets out the boundaries and parameters of the research and is important as a way of framing the research question and subject. It can help to determine key areas of the research and the methodology chosen. It is based on literature review and usually arises from identifying gaps in the current literature. The theoretical framework helps limit



the research, determine what sorts of methods the framework lends itself to and fits the world view of the researcher (McGriff, 2013).

### **3.7.5 Theoretical frameworks for arts in healthcare and aesthetics**

There are few clear theoretical frameworks or models for arts and health practice in the literature and the field is broad which creates difficulties in finding definite models or approaches to follow. The search for an appropriate framework for this research thus covered a number of fields, from aesthetics to arts therapies, psychology to humanities, from occupational therapy to quality of life theories to art theory. A variety of models were explored and five frameworks are presented here: Maslow's Hierarchy of Needs, White's four key dimensions of arts in community health contexts, Veenhoven's four kinds of being 'Well', Brod et al's conceptual framework and Carper's 'ways of knowing'. The criteria for choosing an appropriate framework was whether the framework had a specific mention of aesthetics or arts; whether the framework made reference to older people or hospital experience and whether the framework fitted the researcher's ontological and epistemological perspective. A rationale is given for the final choice of theoretical framework suitable to examine this research topic.

### **3.7.6 Maslow's Hierarchy of Needs**

The arts therapies and psychology fields offer a number of theoretical frameworks, most commonly psychoanalytic, humanistic and behavioural approaches to working with people and engaging in creative activity. In psychoanalytic theory the act of making art is seen as a process of spontaneous imagery, released from the unconscious. This grows from the Freudian view that creativity arises from personal conflict where man acts against symptoms through unconscious defence mechanisms. Other frameworks within arts

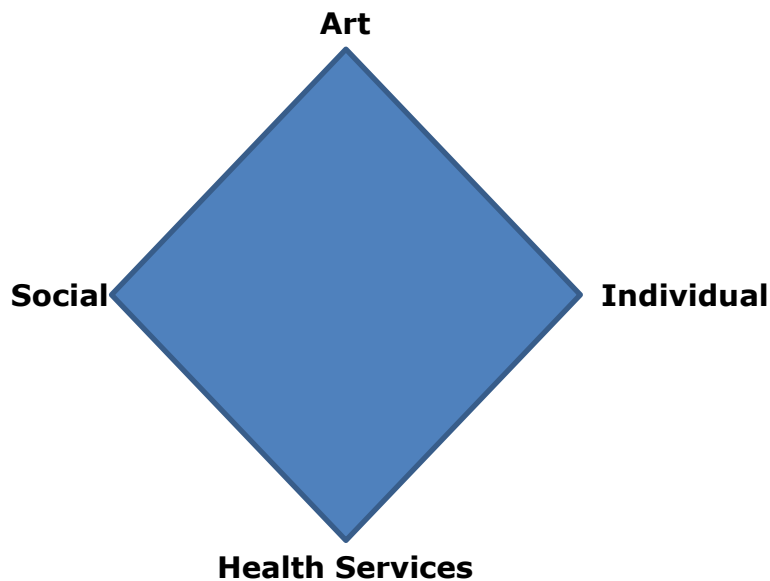
therapies and psychology include humanistic approaches, including Gestalt therapy, the Rogerian approach and Maslow's hierarchy of needs (Irving, 2013). The most relevant theory identified in an overview of arts therapies and psychology literature was Maslow's Hierarchy of Needs. This is one of few models that actually mentions aesthetic needs as one of five core needs we have as human beings (Maslow, 1970, Maslow, 1969). (See Section 1.10, Figure 1.4 for diagram of Maslow's Hierarchy of Needs).

### **3.7.7 White's four key dimensions of arts in community health contexts**

The fields of humanities and aesthetics offer another set of theoretical frameworks for the arts, but these tend to be discursive rather than clearly set out theoretical models (as found in health sciences). For example, a strong theory in aesthetics is that the arts act as a force to challenge norms and create social or political change. Alternatively, another aesthetic theory nominates the arts as a purely recreational activity or as an expression of perfection and beauty.

One of the few models emerging specifically from the arts and health field is that of community arts and health, by White (2009). White identifies four key dimensions of arts in community health contexts, named as 'art', 'social', 'individual' and 'health services' (see Figure 3.2). He argues that these four key dimensions of arts and health practice focus on six elements (White, 2009):

- The role of the arts in group engagement
- Building good social relationships that improve health
- Engaging groups to bring communities together
- Using creative methods to communicate health messages
- Providing creative groups for self-expression
- Arts projects that support the process of care



**Figure 3.2 Key dimensions of arts/health (White 2009)**

### **3.7.8 Veenhoven's four kinds of being 'Well'**

A Scottish report explored quality of life models in relation to cultural and leisure activities. It offers a series of indicators of quality of life and well-being rather than proposing one particular theory (Galloway, 2006). One of these, Veenhoven's theory of the four kinds of being 'well', appeared relevant as a theoretical framework for understanding the role of arts in health and well-being in this research (See Table 3.2). The arts can play a role in each of these items, although they are not mentioned specifically in this theory (Veenhoven, 1998).

**Table 3.2 Veenhoven's theory of the four kind of being 'well' (Veenhoven 1998)**

(i)	<i>Outer Qualities</i> Living in a good environment
(ii)	<i>Inner Qualities</i> Being able to cope with life
(iii)	<i>Life Chances</i> Enjoying life
(iv)	<i>Life Results</i> Being of worth for the world

### 3.7.9 Brod et al's conceptual framework

One of the few models discovered regarding aesthetics specifically in older age is Brod et al's conceptual framework. Here, focus groups were conducted with people with dementia, service providers and carers to develop a framework of quality of life domains for cognitively impaired older people (See Table 3.3).

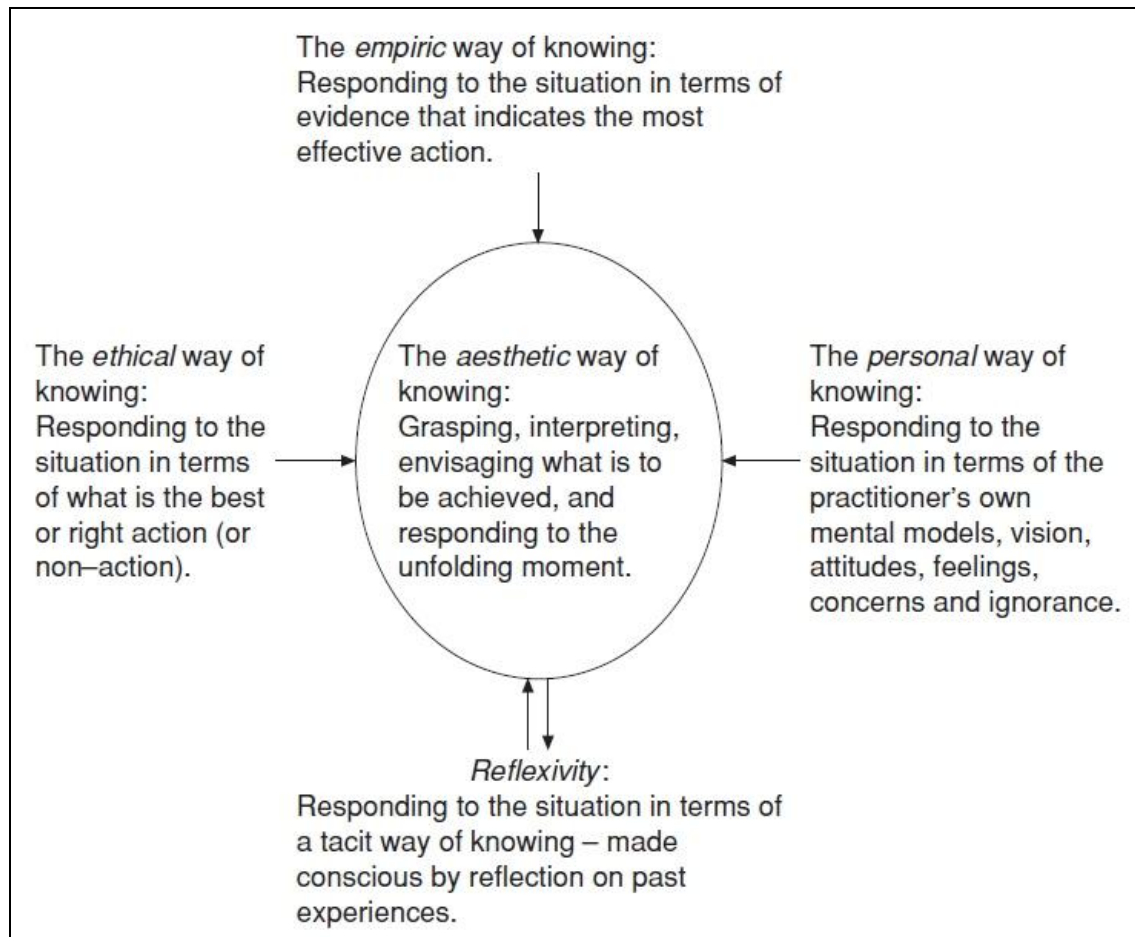
**Table 3.3 Key elements of the Dementia Quality of Life Instrument (Brod et al., 1999)**

<b><i>Area of functioning</i></b>	<b><i>Description</i></b>
Physical Function	Walking, reaching, bending
Daily Activities	Self-care, instrumental activities such as cooking
Discretionary Activities	Hobbies, work, productivity, exercise
Mobility	Ability to travel outside of the house
Social Interaction	Intimacy, happiness with family, social interactions
Interaction Capacity	Ability to interact with the environment
Bodily Well-Being	Symptoms and bodily states reflecting physical comfort, discomfort
Sense of Well-Being	Positive and negative emotional/affective states and perceptions of self
Sense of the Aesthetic	Sensory awareness
Overall Perceptions	Summary ratings and evaluations about one's health and overall life situation

Within the aesthetics category listed, aesthetics are further defined as enjoyment/appreciation of beauty and nature, creativity/artistic expression and appreciation and awareness and appreciation of surroundings (Brod et al., 1999).

### **3.7.10 Carper's 'ways of knowing'**

Finally, the field of medical humanities and nursing education were explored for appropriate theoretical frameworks. Carper's 'ways of knowing' is a theoretical concept derived from a study exploring reflective practice in nursing. This framework includes the empirical way of knowing (which accounts for evidence based knowledge), ethical knowing (which accounts for reflection and moral reasoning important for doctors) and personal knowing (Carper, 1978). The final way of knowing in this model, which brings together the other aspects mentioned, is the *aesthetic* way of knowing which is about grasping, interpreting, envisaging and responding to the unfolding moment (see Figure 3.3). This is one of few models or frameworks discovered that specifically mentioned aesthetics. In addition, Carroll adopts this model for medical humanities, in that the arts play a strong role in terms of developing a more empathetic and compassionate connection between doctor and patient as well as presenting personal narratives through the arts that aid understanding and compassion (O'Carroll, 2013).



**Figure 3.3 The four ways of knowing (Carper 1978)**

### **3.8 Rationale for choice of theoretical framework**

Maslow's Hierarchy of Needs was chosen as the most relevant framework for this research. It is one of few in the literature that actually mentions the importance of aesthetic needs as part of a person's core needs (Maslow, 1970, Maslow, 1969) and it also seemed directly relevant to the experience of engaging in arts and aesthetics within healthcare settings (See Section 1.10, Figure 1.4 for diagram of Maslow's Hierarchy of Needs).

In Maslow's theory, there are seven levels of needs, the most basic being physiological and biological needs (the need for food, shelter, to be free of pain). The second level is safety, with levels three and four focusing on belonging and self-esteem needs. Level five focuses on cognitive needs and it is in the sixth level of needs where Maslow actually mentions aesthetic needs, with the final level (seven) being the need for self-actualisation. Access to the arts and concern for the aesthetic in hospital can, in this model, contribute to the psychological health of patients.

In healthcare settings, the primary needs include pain control, physical health and safety as per Maslow's model. Aesthetic needs are less important and given less priority. We expect these to be less important when we are sick, and our pain and physical needs take precedence. However, Maslow points out that aesthetic need is a key need that must be met for full psychological health. This concurs with literature in the field which indicates the neglect of aesthetic needs in hospital and the possible benefit of engaging in cultural activities on survival rates and healthy older age. Maslow reminds us that aesthetic needs are still important needs in their own right, even if these appear of lesser importance in healthcare settings due to more pressing needs (Lawrence, 2001). Maslow also stresses that aesthetic needs and creative impulses are found in every culture in every age, back to cave dwellers, and that some research indicates that people can feel better in beautiful surroundings (Maslow, 1970). He also points out that some people never aspire to higher goals; these may be people who have experienced life at a low level and so might be satisfied by only basic physiological and safety needs. The higher needs tend to be given more prominence by those who have had all other needs gratified. The pursuit of higher aesthetic needs leads to greater, stronger and truer individualism (Maslow, 1970).

Maslow defines self-actualized creativity as a fusion of a primary creativity (spontaneous creativity, such as child-like art or jazz improvisations) with a secondary creativity (which includes hard work, peak experiences or inspirations and rigorous thought). Maslow points out here that creativity is for all, not just the great artists, which again concurs with the stance taken by this researcher and by arts and health programmes in hospitals. Maslow also points out that it is appropriate for higher needs to be postponed at times, without always causing ill effect.

Maslow's theory states that the 'higher' needs, such as self-actualisation and aesthetics, are as real and as integral a part of human nature as our need for food and our 'lower' needs in the hierarchy. The higher needs developed later in our evolution and can be delayed longer but satisfaction of these higher needs produces more happiness and leads to greater individual growth and flourishing. It is arguable that these higher needs are sometimes neglected in healthcare settings.

Maslow's definition of creativity sits well with the definition of aesthetics and approach of this research. Maslow defines the creative need as a widespread kind of creativeness which is the universal heritage of every human being that is born (Maslow, 1970).

Maslow further attempts to define the characteristics of self-actualizing creativeness, to include courage, freedom, spontaneity and integration.

This model was chosen as the framework and stance within which this research is situated. The assumption regarding this theory is that aesthetics are an important part of human life and possibly even a need that must be addressed when concerned with the health and well-being of patients in healthcare services. Another assumption of this theory is that basic needs are more



pressing than aesthetic needs and this is important for hospital arts programmes which must acknowledge basic physical needs and put the patient's clinical needs at the centre of any programme planning. Any arts programming must take into account the patient's needs and wishes and not impose an arts programme that is inappropriate at a time of vulnerability. In this research, a position is adopted whereby high and low art are equally valuable and patients' preferences are paramount, hence a desire to map which art forms are most popular with patients. This again links with Maslow's theory of creativity and aesthetic fulfilment. The arts can also be seen to play a role for patients at various stages of the hierarchy of needs, for example fulfilling the need for self-esteem and belonging and safety needs (Moss and Granier, 2006).

Situating this research within Maslow's theoretical framework allows us to ask questions about the aesthetic needs of patients, how these are affected by other more pressing needs (for example, physical changes that affect ability to travel to arts venues) and how patients rate the importance of their aesthetic needs when in hospital. Thus, questions around receptive vs. participative arts are involved, as are basic mapping of aesthetic activity before, during and after hospital, as well as discussion regarding access to aesthetics post hospital stay. Finally, it allows us to ask questions about whether and how aesthetic needs should be addressed in hospital, and to explore the possibility of aesthetic deprivation. This theory allows us also to limit the research to the role of aesthetic interests and needs in patients attending hospital, and not to address specific benefits of any particular interventions such as art therapy or curation.

### **3.9 Conclusion**

This chapter presented the research question, the aims and theoretical framework of the research, arising from literature review and practice in this field. The next chapter gives an overview of the methodology for this research.

## **Chapter 4 Methodology Overview**

### **4.1 Introduction**

The purpose of this chapter is to set out the overall methodology for the research. The research is mixed methodology, sequential-exploratory, starting with a qualitative study exploring broad themes followed by a quantitative study using survey method. The overall methodology is presented in this chapter.

### **4.2 Rationale for mixed methodology research**

A mixed method sequential exploratory (qualitative – quantitative) design was chosen for this research (Tashakkori and Teddlie, 2003, Teddlie and Tashakkori, 2009). In-depth qualitative interviews with twenty patients in hospital were chosen as the qualitative methodology, to provide a base line understanding of this area. A quantitative survey of aesthetic activity and hospital aesthetics developed directly from the results of the qualitative study. The aims of the quantitative study were to expand on themes raised in the interviews with a larger sample of patients in hospital, to continue to map aesthetic interests of patients with a larger cohort and to explore whether there is aesthetic deprivation in hospital.

The literature review indicated a need for both rigorous quantitative research and qualitative accounts by patients of the role of arts in their lives. The arts are currently viewed as not presenting definite benefits in terms of physical, psychological, emotional or mental health and a need for quantitative evidence of the benefit of arts is clearly indicated. However there is also a need, expressed clearly in the literature, to develop a narrative of why and how

cultural participation affects health and quality of life. The role of culture and arts in our lives may not be satisfactorily answered in purely quantitative terms. The literature advocates for further high quality qualitative studies.

The language of the arts is concerned with dreams, imagination and pushing boundaries in our society. In contrast, when a health problem arises, society looks at the evidence available to fix the problem and how we can address this effectively (Parkinson, 2013). These two discourses are highly contrasted. It is arguable, then, that mixed methodology is a perfect fit for this research and this field of work - the need for both a narrative account of the aesthetic and cultural interests of our patients as well as the need for quantitative evidence (or not) of aesthetic deprivation in our hospitals. There are few mixed methodology studies noted in the arts and health literature but a strong recommendation for these in the future (Daykin et al., 2008a, Paddona et al., 2004, Bradt et al., 2013).

### **4.3 Mixed Methodology Overview**

Mixed methodology research integrates quantitative and qualitative data collection and analysis in a single project or programme of inquiry (Teddlie and Tashakkori, 2009).

*The reason for mixing methods is to expand the scope of inquiry by accessing a wider range of data (Pope and Mays, 2006) p. 102.*

In mixed method studies, findings from different methods are checked against each other. The qualitative research can facilitate quantitative research by generating hypotheses for testing or generating items for a questionnaire, while qualitative and quantitative research together can provide a bigger or richer picture. In this research, qualitative research was used to explore a broad topic

and to generate items and language for a quantitative study, in this case a survey instrument, to map aesthetic and cultural interests and explore the presence of aesthetic deprivation in hospital. The aim of using mixed methods is to uncover different perspectives and hence more of the picture (Pope and Mays, 2006).

According to Tashakkori and Teddlie, data analysis procedures for the qualitative part of mixed methods studies need to take account of whether the purpose of the study is exploratory or confirmatory (Tashakkori and Teddlie, 2003). Exploratory research is used to generate or expand on theory and is descriptive in nature, whereas confirmatory research is primarily concerned with theory or hypothesis testing (McCabe, 2008). In this research, the approach was sequential-exploratory, that is one part leads to development of the next part (rather than running concurrently or having one method 'nested' in the other). The key benefit of mixed method studies is that one can flexibly combine methods to find the most appropriate methods to answer the question. This creates a freedom from being wedded to one approach.

*If resources are to be allocated to art-based initiatives within healthcare settings it is important that attempts should be made to evaluate their effectiveness. An exclusively quantitative approach to evaluation has severe limitations in this context. (Macduff and West, 2002) p. 340.*

Mixed methods approaches are widely used in health services research. A review of health service research methodologies in England in 2007 indicated that 18% of studies were mixed method. The main driver for using mixed methods was comprehensiveness and a desire to address wider questions than can be answered by purely quantitative methods. Qualitative research was also seen to

engage well with the complexities of health care. Surveys and interviews were the most popular methods used (O'Cathain et al., 2007a).

The challenge of mixed methods studies is to ensure validity, transferability and credibility, as well as to be clear about why these methods are used (Pope and Mays, 2006, Jick, 1979). Successful studies require researchers to be explicit about the rationale for using mixed methods and to take seriously both the individual components of the research and the process of integration between methods (Pope and Mays, 2006). Triangulation is a method used to combine and compare multiple data sources, data collection and analysis procedures (Teddle and Tashakkori, 2009, Jick, 1979). Inference quality refers to the standard for evaluating the quality of conclusions from the mixed methods, and inference transferability refers to the degree to which conclusions from this study can be applied to other settings, time periods and contexts. Blending and integrating a variety of methods and data, as triangulation demands, can range from simple to complex designs.

The archetype of triangulation strategies, and the one used in this research, is the 'between methods' approach, whereby the use of complimentary methods is thought to lead to more valid results. However, triangulation in this research is also involved with validating results across various methods and giving an enriched understanding of the phenomenon through new or deeper dimensions that emerge (Jick, 1979). Mixed method studies are particularly appropriate for broad or complex topics. Mixed method approaches can aid comprehensiveness by addressing research questions more widely and more completely. Mixed methods can also increase validity, whereby findings from two different methods agree (O'Cathain et al., 2007b).

In summary, mixed method design was used for this study as it brings together rational quantitative research with qualitative accounts of users' experience and allows for a more comprehensive study of this topic.

*While it is recognised that offering evidence for the arts and efficacy of creative expression for wellbeing is essential, it may be better to adopt more sociocultural approaches that emphasise the user's voice, for this needs to become central to our research and evaluation (Stickley, 2012) p. 214.*

#### **4.3.1 How the research aims were met by mixed method design**

Table 4.1 sets out the aims of the research and maps how these aims were addressed.

**Table 4.1 Summary of how the research question was addressed**

<b><i>Aims</i></b>	<b><i>Objectives</i></b>	<b><i>Part of study that addressed aims and objectives</i></b>
To identify patient preferences and perceived benefits regarding aesthetics, before, during and after hospital stay	Conduct interviews with a sample of 20 older patients in hospital	Qualitative
	Obtain quantitative data regarding most popular arts interests in a group of older patients in hospital	Quantitative
To explore the role of aesthetics in older patients' lives, in the context of what changing health does to one's aesthetic infrastructure	Conduct interviews with 20 older patients in hospital	Qualitative
	Obtain quantitative data regarding barriers to continuing aesthetic activities post hospital stay	Quantitative
To explore the extent to which the hospital environment is aesthetically-deprived or enriched for each patient	Conduct interviews with sample of 20 patients	Qualitative
	Obtain quantitative data regarding experiences of hospital aesthetics	Quantitative
To develop a survey to begin to map patients engagement in aesthetics and to catalogue the possibility of aesthetic deprivation in hospital, with a view to developing a Measure of Aesthetic and Cultural Health	Identify themes and items for a survey instrument of aesthetic and cultural health	Qualitative
	Survey 150 older patients in hospital	Quantitative
	Analyse whether demographic or health status factors affect experiences of aesthetics before, during and after hospital	Quantitative

## **4.4 Ethical approval**

### **4.4.1 Informed consent**

Ethical approval was obtained from Tallaght Hospital/St James Ethics Committee. Informed written consent was obtained in all cases and written information was provided to prospective participants, with time given to consider this before agreeing to participate. Written consent forms were completed for both arms of the research. Relevant contact details were also supplied in case of need for follow up after the study. Patients were informed of their right to refuse to participate and their right to withdraw from the study. Patients were assured that this would in no way influence their medical care. Permission was also granted from The Arts Council of Ireland for use of part of the Arts Council Survey 2006 (The Arts Council, 2006). See Appendix 1 Ethical Approval Documentation; Appendix 2 Patient Information and Consent forms and Appendix 3 Approval from Arts Council for use of parts of survey.

### **4.4.2 Sponsorship**

The Meath Foundation provided funding for this research. No commercial entities were involved in sponsorship and neither the author, nor the other investigators involved in the research, had any conflicts of interest.

### **4.4.3 Follow up of patients post study**

Patients were provided with an information sheet that included a nominated person within the team to contact post study, should any issues arise.



## **4.5 Research design**

### **4.5.1 Recruitment**

Patients were recruited from the Age Related Day Hospital at Tallaght Hospital, Dublin and Royal Hospital Donnybrook, Dublin. Specific issues relating to recruitment are detailed in each arm of the research (Section Three and Four).

### **4.5.2 Incentivism**

Participation was voluntary and no payments (monetary or otherwise) were provided, nor were expenses reimbursed.

### **4.5.3 Inclusion Criteria**

Patients included were:

- Adult, aged 65 or over and
- A patient of the hospital and
- In-patient stay of >7 days in the hospital in the previous 5 years

### **4.5.4 Exclusion criteria**

- Cognitive or language difficulties sufficient to hinder engagement with the interview or
- Patients whose stay in the hospital was >7 days in the last 5 years

### **4.5.5 Measures**

Two baseline measures were taken as part of both studies within the overall research project: a cognitive function test 3DY (Molnar et al., 2008) and the Barthel Activity of Daily Living Scale (Wade and Collin, 1988, Collin et al., 1988). The patient's diagnosis, age, in-patient and out-patient history were recorded. In the quantitative study, the Geriatric Depression Scale was also used.

#### **4.5.6 Barthel Activities of Daily Living Index**

The Barthel measure is a widely used and accepted measure of physical disability for use either clinically or in research. The aim of the Barthel Index is to score a patient on the basis of ability to manage individual physical activities, with the aim of improving clinical management of disabled patients. The Barthel Activities of Daily Living Index is proposed as the standard index for clinical and research purposes. Its validity, reliability, sensitivity, and utility are accepted and it is believed to be as good as any other simple index (Collin et al., 1988, Wade and Collin, 1988). See Appendix 4 Barthel Measure of Physical Function

#### **4.5.7 3DY Cognitive Test**

The 3DY test was administered to measure cognitive function. This test consists of four questions derived from the commonly used Modified Mini-Mental State Examination. This validated test was designed to take only 30 seconds and to require no pen or paper or visual cues. The aim of this test is to improve assessment of cognitive function through a quick simple test (Molnar et al., 2008). It is important to note that the authors of this test do not specify what exact results constitute cognitive ability (for example, to participate in an interview). For this research, the team decided that 3 out of 4 correct answers constituted a cognitive ability to participate. See Appendix 5 3DY Test of Cognitive Function.

#### **4.5.8 Geriatric Depression Scale (GDS)**

The GDS represents a reliable and valid self-rating depression screening scale for older populations (Yesavage et al., 1982 - 1983). Data on 806 elderly institutional residents suggest that as a psychometric measure of depression, the GDS is appropriate for use with older long-term care patients. The GDS performs as well with patients with dementia and other cognitively impaired patients as with cognitively intact older institution residents (Parmelee and Katz, 1990). See Appendix 6 Geriatric Depression Scale.

#### **4.5.9 Data Management**

Data management is an important part of any research design. The data from both interviews and surveys were collected by hand and stored using SPSS and NVIVO software. To maintain levels of security of data, the original handwritten surveys were kept locked in a filing cabinet on the hospital premises. The SPSS and NVIVO versions were coded so that no personal details were recorded. The computer used to store data was also encrypted to ensure safety of any patient information. Specific details for data management of each part of the research are given in Sections 3 and 4.

#### **4.5.10 Data Analysis**

Statistical analysis was carried out using NVIVO (qualitative study) or SPSS software (quantitative study). Specific details of data analysis for each study are given in Sections 3 and 4. An overview of the mixed methodology analysis method is given here.

#### **4.5.11 Mixed Methodology Analysis**

Tashakkori and Teddlie suggest four types of mixed data analysis strategies. These are:

- Data transformation - the conversion of one data type into another so that both can be analyzed together
- Typology development - the analysis of one data type yields substantive categories that are used as a framework for research in the other data type
- Extreme-case analysis - 'extreme cases' identified from the analysis of one data type are pursued by another type of data collection, in order to refine the initial explanation

- Data consolidation/merging - the joint review of both data types creates new data sets, which can be expressed in qualitative or quantitative form (Tashakkori and Teddlie, 1998).

This research primarily follows the second type of analysis – typology development. In this research, exploratory qualitative data creates attributes or themes which are used directly to create categories for a survey, in order to further analyse the data and carry out confirmatory statistical analysis. The quantitative data is also used to determine the degree of validity of the initial qualitative categories (See Sections 3 and 4). The data from the qualitative study is also consolidated or merged in order to create information, expressed in this case in qualitative discursive form, with proposed areas for further analysis identified. Sections 3 and 4 outline in detail how the qualitative study informed the quantitative study. Further analysis and comparison of findings from each study is undertaken in the discussion section (Section 5).

In this research, groups of attributes or themes were created through qualitative data collection and analysis, followed by confirmatory quantitative analysis. It is recommended, in mixed method studies, to create a narrative profile following completion of the quantitative results, with recommendations and conclusions based on statistical data. These are further transformed into qualitative conclusions (Tashakkori and Teddlie, 2003, Tashakkori and Teddlie, 1998, Teddlie and Tashakkori, 2009). This is how the discussion section of the thesis is formatted (Section 5).

The mixed method approach was welcomed by this researcher as equal value is given to both qualitative and quantitative approaches and pre-eminence is given to the research question over considerations of method or paradigm (Teddlie and Tashakkori, 2009).

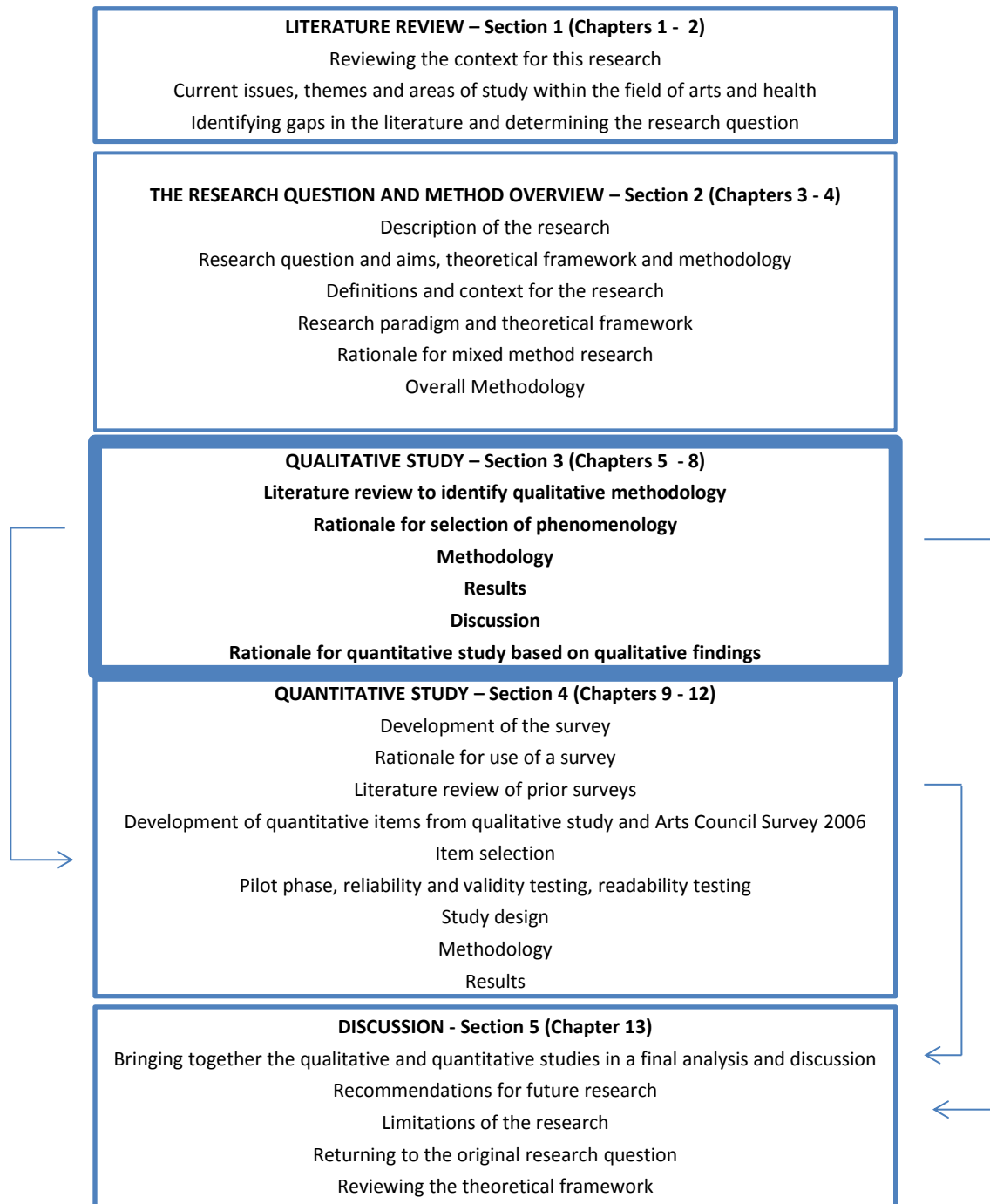
## **4.6 Conclusion**

This chapter set out the overall methodology for this research. Previous chapters presented the literature reviews and research question. This chapter concludes the overview of the research and the next section presents the qualitative study.

## ***Section Two Conclusion***

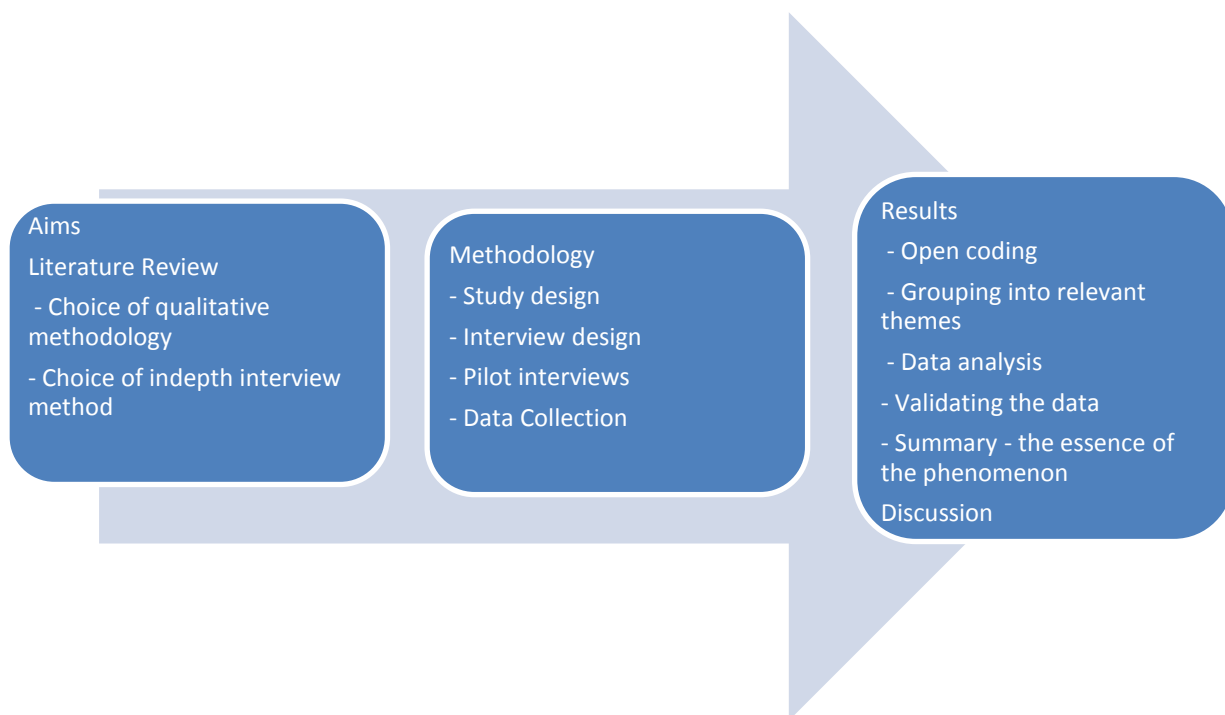
This purpose of this section was to describe the research question, aims, theoretical framework and overall methodology of the research. This research uses two interlinked studies to answer the research question. The first part of this two part sequential-exploratory research is presented next in Section Three (qualitative study) and the second part in Section Four (quantitative study). These are treated as two distinct study arms of the overall research, requiring relevant literature reviews, aims and objectives and methodological considerations of their own. These are detailed in subsequent sections.

## ***Section Three Qualitative Study - Overview***



**Figure 5.1 Overall thesis design highlighting Qualitative Study**

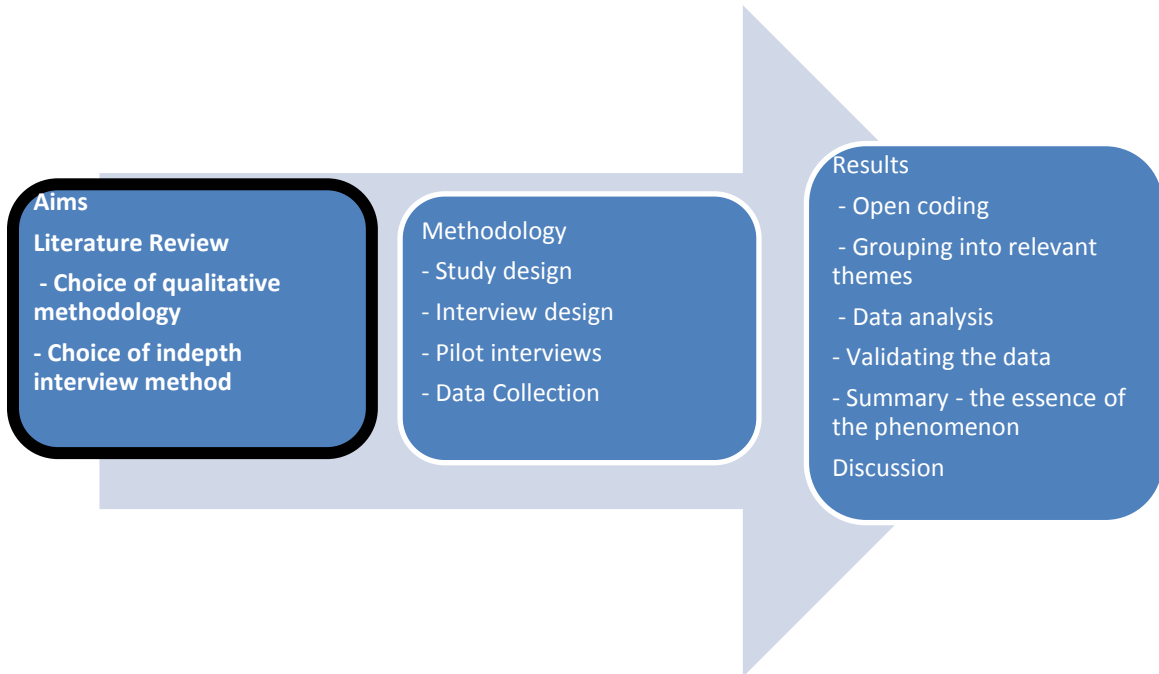
This section describes the qualitative study which forms the first part of this research (see Figure 5.1). In this section the methodology and results of the qualitative study are presented (see Figure 5.2). The section is divided into four chapters: Aims and Literature Review to choose qualitative methodology (chapter 5), Qualitative Methodology (chapter 6), Qualitative Study Results (chapter 7) and Discussion of Qualitative Results (chapter 8). This leads into Section Four, which will present the quantitative study. The quantitative study (a survey of 150 older patients in acute hospital) was created from the results of this qualitative study, hence the need to present the qualitative study first in its entirety. Figure 5.2 outlines the qualitative study in detail:



**Figure 5.2 Qualitative study**



## Chapter 5 Aims and Literature Review - Qualitative Study



**Figure 5.3 Qualitative study diagram highlighting Aims and Literature Review**

### 5.1 Aims

Aim:

The aim of the qualitative study was to explore the role of aesthetics for patients before, during and after hospital stay.

Objectives:

- To interview a sample of older patients in hospital to identify aesthetic preferences and perceived benefits regarding aesthetics, before, during and after hospital stay

- To explore the role of aesthetics in older patients' lives, in the context of what changing health does to one's aesthetic infrastructure
- To explore the extent to which the hospital environment is aesthetically-deprived or enriched for each patient
- To identify themes and items for a survey instrument of aesthetic and cultural health

The first step of this research was to establish a baseline of information and knowledge on aesthetics and healthcare through qualitative research with a sample of older hospital patients. It was important, first, to determine the most appropriate qualitative methodology for this part of the study. Literature reviews were conducted to address this issue (see Figure 5.3).

## **5.2 Literature reviews – qualitative study**

Three literature reviews were conducted to identify the most appropriate qualitative methodology for this part of the study. These were:

- A literature review to identify qualitative methodologies used in studies concerned with patients' perceptions of arts and health. Specifically, this review aimed to select the optimum methodology for the first part of this study.
- A brief review of qualitative methods that have been used for clinical tool development, as it was intended to move from qualitative investigation to development of a survey instrument
- A review of the various qualitative methodologies available, to determine their benefits and appropriateness to this study.

These reviews are presented in this chapter. The chapter concludes with a rationale for selecting the specific methodology used in this study, namely phenomenology (Van Manen, 1990).

## **5.3 Literature Review – Qualitative methodologies used in studies concerned with patients perceptions of arts and health**

The first literature review was conducted to gain insight into the qualitative methods used to explore patients' perceptions of the role of arts in healthcare to date, with a view to identifying the most common methodologies used (Moss et al., 2012). Details of this review follow.

### **5.3.1 Aims**

The aim of this review was to identify studies that used qualitative methodology in arts and healthcare or health-related studies and to explore which qualitative methodology was used. Specifically, this review aimed to identify research on patient perceptions of arts and health in order to inform selection of the optimum methodology for research this area.

### **5.3.2 Methodology**

A computer search was conducted using the following databases: PsycINFO (1872 – November 2011), PubMed (1940 – November 2011), CINAHL (1981 – November 2011), AMED (1995 – 2011) and Web of Science.

Searches were carried out using the following key search terms and key words: experiences OR perceptions OR views OR perspectives OR attitudes AND qualitative methodology OR research OR qualitative studies AND art OR arts and health OR Performing arts OR Music OR Art therapy OR Visual art AND patient(s) OR Hospital OR Inpatient OR Clinical setting OR Clinical environment.

Due to the scarcity of relevant papers recovered, a decision was made to consider arts therapies research as well as arts and health literature as there

appeared to be commonalities in terms of methodologies used to assess the role of arts in healthcare settings.

### **5.3.3 Inclusion/exclusion search criteria**

The aim of the search was to identify studies that used qualitative methodology in arts and health studies, and to explore which qualitative methodology was used. The only criterion used to select papers was that they explored qualitative methodology used in arts and health studies. Papers were excluded if they were not relevant to arts and healthcare, were not studies using qualitative methodology or were not in English. Papers relating to other arts based topics in healthcare were not included. In addition to these searches, papers were included that were discovered by other forms of search, specifically reference lists from the papers selected, recommendations from colleagues, previous literature reviews of government documents from UK and Ireland and references from the library of the Society for the Arts in Healthcare, (USA).

In order to extract relevant data from each of the selected articles the papers were analysed by extracting a database with the following key pieces of information from each paper: Qualitative methodology used; design of study (mixed methodology or single); brief description of study (clinical group, health setting, art form); sample size; data collection method and brief description of key findings. Each paper was then reviewed to determine whether adequate details of methodology were given. This was determined by whether the study gave enough information on methodology to be considered replicable and if the above list of information was available. If there was incomplete methodology or unclear definitions or descriptions of methodology then the paper was considered to lack rigour. For example, in some studies no recognised qualitative methodology was described, or inadequate details were given

regarding methods of analysis and processes to ensure authenticity and credibility.

The studies represented a wide variety of patient groups, clinical settings, diagnoses and art forms. This review did not aim to distinguish between any differences in age, gender, clinical issues or art forms but rather to study which qualitative methodologies were chosen for any study of any of the arts in any healthcare setting. The small number of studies found made limiting these criteria unnecessary.

#### **5.3.4 Results**

The search resulted in 680 citations included journal articles, government documents and published books. The number of citations for specific arts and health studies using qualitative methodology was modest (n=54). Thirty one of these citations were arts and health studies (n=31); thirteen were arts therapies research: music therapy (n=7), art therapy (n=5), combination of arts therapies (n=1); six were theatre or arts based projects (n=6) and three were concerned with patients' perception of the aesthetic environment (n=3). One combined music therapy and digital art. By art form, the most popular art form reported was visual art (including art classes and art therapy) (n=22), music (n=9), combination of art forms (n=11), drama (n=5) and environmental aesthetics (n=3). There was only one study found for creative writing (n=1) and sculpture (n=1) and two that used digital art (n=2). Most of the literature in this area was exploratory or descriptive of art therapies or arts in health work in various contexts (165 papers) or other arts related research, for example the role of medicine and rehabilitation for performing musicians (53 papers). The 54 papers selected were those that specifically explored patients' perceptions of arts in healthcare settings through qualitative research.

A variety of methodological approaches were used to shed light on the experiences of patients of the arts. The most common were phenomenology (n=9) and grounded theory (n=11). Twenty studies (n=21) described the qualitative methodology as 'thematic analysis' or 'content analysis' and four studies gave no details about the methodology (n=4). Five studies employed 'arts based action research methods' in their study, again there was less detail given here of replicable methodology (n=5). There were 3 ethnographic studies (n=3) and 1 narrative (n=1). Nine of the qualitative studies were part of larger mixed methods research projects (n=9).

The most common qualitative approach to collecting data was semi structured, in-depth interviews, with twenty nine using purely interviews as data collection method (n=29), and ten combining this with another qualitative data collection approach (n=10). These included focus groups, data from group therapy sessions, observations, questionnaires and data from art processes. Of the remaining 15 studies, data collection methods included observation techniques (n=5), theatre and other arts based research approaches (n=6), focus groups (n=1), written responses to open ended questions and qualitative questionnaires (n=4) and analysis of song lyrics (n=1).

Of note, the emphasis of all of the studies was on active or participative arts engagement (such as making art, writing poetry, creating drama productions or playing instruments) (n=54), with no focus on receptive engagement with the arts and aesthetics (such as reading or listening to music) (n=0).

The number of patients consulted for the studies ranged from 264 to 1 with a median of 18. Seven studies referred to children's arts and health services, the remaining 47 were adults in a range of health services, including cancer care, mental health, older age and physical disability. In total 2036 patient perspectives were recorded when all the studies were put together. See Table

5.1 for details of review and Appendix 7 for summary of findings from relevant studies of patients' perception of arts in healthcare, ordered by qualitative methodology.

**Table 5.1 Details of 54 arts and health studies using qualitative methodology**

<b>Art form</b>	<b>Number of studies</b>
Visual Art	22
Music	9
Combination of art forms	11
Drama	5
Environmental aesthetics	3
Creative writing	1
Sculpture	1
Digital art	2
<b>Total</b>	<b>54</b>
<b>Type of study</b>	<b>Number of studies</b>
Arts and health studies	31
Arts therapies	13
Theatre based	6
Environmental aesthetics	3
Combined arts and health and arts therapies	1
<b>Total</b>	<b>54</b>
<b>Methodology</b>	<b>Number of studies</b>
Grounded Theory	11
Phenomenology	9
Thematic analysis or content analysis (various approaches)	21
No details of methodology	4

Arts based action research	5
Ethnography	3
Narrative	1
<b>Total</b>	<b>54</b>

### 5.3.5 Discussion

Grounded theory and phenomenology were the most popular qualitative methods used in arts and health studies. Semi structured interviews were the most popular method of data collection.

Following the analysis of the studies presented here, three key points stand out regarding choice of qualitative methodology for arts and health research. Firstly, whilst the majority of the 54 papers chosen were rigorous and detailed studies, five papers in this sector appeared to lack detail about methodology, twenty alluded to 'content analysis' or 'thematic analysis' and most of the studies concluded that their sample provides only preliminary evidence and recommended further research in this area (Burton and Stevenson, 2010, Daykin et al., 2010, Daykin et al., 2008b, Gallagher, 2008, O'Callaghan, 2001, Odell-Miller et al., 2006). Whilst the smaller studies gave reliable evidence in themselves, there was a scarcity of larger sample groups in the arts and health research and much of the research tended to be qualitative. It was identified that it may be useful to carry out some larger studies, perhaps mixed methodology, to gather both intense individual accounts and research with a larger sample group.

Secondly, the most frequent approach to collecting data was the semi-structured interview. An individual approach (as opposed to focus groups or observation, for example) has been found by the majority of researchers in this study as appropriate in this context, perhaps because this allows the personal nature of hospital experience and creative activity to be explored in a confidential setting



and to explore in-depth an unfamiliar phenomenon. However, each context would need to be considered separately when conducting further qualitative studies.

Thirdly, arts and health research into patient perception is a broad topic and relatively unexplored. It is impossible to recommend one qualitative approach over another as context will determine choice but the need for rigour and attention to methodological detail is important. It is interesting to note, however, that a large number of the thematic analysis methods used gave a rigorous account of how they carried out the analysis and this raised the question as to the added benefit of following a method such as phenomenology or grounded theory which might be more cumbersome and time consuming.

A further interesting insight is the almost complete neglect of receptive engagement with the arts. This is puzzling given clear evidence of not only the universality of this aspect of the arts, but also its importance in terms of quantitative and qualitative measures such as government and consumer spending, as well as surveys of the general public (The Arts Council England, 2007, Hill, 2010, Lunn and Kelly, 2008, The Arts Council, 2006, Cuypers et al., 2011b).

There was a diversity of approach to methodology and client groups in the 54 studies found; hence it is difficult to draw strong findings from the data. The individual lived experience is at the heart of qualitative research and replicability of these studies is not of paramount concern. No single methodology was seen in these studies to offer adequate solutions to the question of providing evidence of benefit of arts in health settings (Gallagher, 2008, Gunnarsson et al., 2010, Odell-Miller et al., 2006, Robb and Ebberts, 2003, Secker et al., 2007b). It may be important for some studies to focus on larger sample sizes and to combine quantitative and qualitative methodologies.

It is interesting to note that while many of the studies were small, as a total all the studies together gave rich data from 2036 patients who gave their perspective on arts and health interventions. A common theme throughout all the studies was the perceived benefit for participants of arts and health, particularly in areas such as boosting self-esteem, self-confidence, sense of achievement, positivity at a difficult time of life and promoting a sense of hope (Lazzari et al., 2005, Lee and De Finney, 2008, Lind et al., 2010, Lloyd et al., 2007, O'Callaghan, 2001, Torkelson Lynch and Chosa, 1996, Van Lith et al., 2011).

A number of studies used arts based research to reflect the story and experience of participants in health and social services. For example, theatre and drawing were used as research tools. Lind et al report that arts-based research and participatory action research offer new ways of accessing marginalized populations' strengths and challenging harmful societal assumptions. Broadbent et al used visual art to assess how 65 students were affected by persistent headaches (Broadbent et al., 2009, Foster, 2007, Lee and De Finney, 2008, Lind et al., 2010, Mitchell et al., 2006). Rapport et al report on specific issues in qualitative methodology in health care research and argue for new methods (such as those described above) which might broaden out the scope of qualitative inquiry in health and social care. These arts based research methods are argued to address the crossing of boundaries from one discipline to another and to aid collaboration between distinct disciplines such as arts and medicine. 'Arts based methodologies' might offer a new way to research arts and health projects but to date the new methods are experimental and the studies using these methods do not offer detailed replicable methodology (Rapport et al., 2005)

This review concurs with Daykin that there is unlikely to be a single qualitative methodology that serves as the 'gold standard' in qualitative research (Daykin et al., 2008b). However, qualitative research needs to produce solid and rigorous evaluations and too many studies have either limited information or a lack of depth to the data analysis. There is a need identified in the current literature for larger samples, rigorous methodology and further research in this area and it is important that this is considered whichever methodology is chosen for an exploratory study of patients' perception of arts in healthcare settings. In addition, a focus on receptive engagement with the arts needs to be developed. This review also confirms previous findings that there is a need for more qualitative research in this field that pays attention to procedures and reporting of data collection and analysis, as well as studies that accurately focus the target for possible further experimental studies (Daykin et al., 2008a) (Ansdell and Meehan, 2010).

### **5.3.6 Conclusion**

Patients' participation in arts in healthcare settings is a relatively under-researched area, with much of the evidence available lacking rigour (Daykin et al., 2008a, Dileo and Bradt, 2009, Moss et al., 2012). The arts attract a significant portion of government spend in many societies and with this funding comes a responsibility to evaluate the appropriateness of arts programmes within healthcare contexts (Hill, 2010, Lunn and Kelly, 2008, The Arts Council, 2006). An important aspect of health service delivery is consumer satisfaction and thus arts programmes in healthcare need to be based on patients' preferences and their perception of arts programmes rather than curatorial notions of what is best for the patient (Caspari et al., 2007, McEvoy et al., 2008). This review confirms findings in earlier literature review chapters, indicating that while there are some measures of the temporal and financial engagement of the general population in arts and cultural activities, much

remains to be determined about the role of these activities in the lives of those who attend health services, the impact of illness on their access to, and participation in, arts and cultural activities, and on the possible impact of artistic and cultural enrichment of healthcare environments.

Following this review, it was confirmed that qualitative research represented the best initial approach to such a complex and under-documented aspect of health and well-being, through exploring the relative priorities, needs and wishes of those attending health services, and setting the parameters for future research, including quantitative research. There is a growing interest in describing the range of qualitative methodologies used in health care research in general (Shin et al., 2009) and such analyses can help to determine the strengths and weaknesses of current knowledge and approaches. Mixed method studies were also recommended and strengthened the researcher's own position that this methodology would be suitable for this particular research. From this review it was decided to carry out individual semi-structured interviews with approximately twenty patients, using phenomenological approach (Van Manen, 1990) as the first part of the sequential mixed methodology research. A published account of this literature review (qualitative methodologies used in arts and health studies) can be found in Appendix 8 (Moss et al., 2012).

## **5.4 Qualitative methods that have been used for clinical tool development**

A literature review was undertaken to explore which qualitative methods have been used for clinical tool development. As the aim of this study was to carry out exploratory qualitative research to identify key themes and then to develop a survey from these findings, it was important to review how qualitative research can contribute to the development of quantitative tools and whether

this needs to be considered when choosing methodology for this part of the research.

According to Gilgun there are two roles for qualitative methods in the development of Clinical Assessment Tools – firstly, to contribute to the development of concepts that compose the tools and generation of items and secondly, to evaluate the usefulness of the tool (Gilgun, 2004). In developing instruments there are several steps – identifying and defining the concepts to be measured, making decisions about the level of specificity of the items, generating an item pool, presenting the item pool to experts for critique, assembling the tool, piloting and field testing and finally testing for reliability and validity. Gilgun does not propose any particular qualitative methodology as more appropriate to these tasks. For example, in one tool, the Adolescent Menstrual Attitude Questionnaire, the items were based on qualitative data derived from open-ended interviews but in another, the Morse Fall Score, multiple sources were used including patient records, observation of the patients' environment and examination of patients to create the tool. It is proposed that the researcher's immersion in qualitative data can effectively facilitate the identification of items and concepts, along with literature review and consultation with practitioners. Interestingly, the role of qualitative research is also proposed to validate the pilot clinical tool, as any issues or problems experienced by those using the tool might be better identified through qualitative research methods (Gilgun, 2004).

A literature review was conducted to identify clinical tools that exist in terms of measuring arts or aesthetics in healthcare. Very few such tools exist and only two could readily be identified. The first was ASPECT: A Staff and Patient Environment Calibration Toolkit. This is based on a database of over 600 studies and is commonly used in the UK. It is a tool for evaluating the quality of design of staff and patient environments in healthcare buildings and identifies the

strengths and weaknesses of a design or an existing building. It aims to be useful for planning new buildings or to evaluate existing buildings. It is important to note that this approach, although widely used, does not seem to have been validated (Department of Health Estates and Facilities, 2008). Caspari also created a tool to measure aesthetic satisfaction in Norwegian hospitals (Caspari et al., 2007). This study focused on seven aspects of aesthetic environment.

Both of these tools were found to have a slightly different focus to this research. In the first tool (ASPECT) the focus was on design with items including privacy, company and dignity, views, nature and outdoors, comfort and control, legibility of place, interior appearance, facilities and staff (Department of Health Estates and Facilities, 2008). In Caspari's study the aesthetic focus included tidiness and cleanliness and other non-arts related items.

This review highlighted a need to clearly define aesthetics for the purpose of this research and to design a useful tool for this specific context and research question. It did not identify specific qualitative methods appropriate to tool development; hence semi-structured in-depth interviews were considered appropriate for this study.

## **5.5 A review of qualitative methodologies and appropriateness to this study**

A final step in determining the appropriate qualitative methodology for this study was a review of qualitative methodology used in health research. Given the lack of arts based studies, it was felt useful to explore health research in general and the use of qualitative methodology.

A study of 268 published qualitative studies in the Journal of Qualitative Health Research found that 106 studies used grounded theory and 67 used phenomenology. 95 of these studies did not name any particular methodology. Of the 67 phenomenological studies, 38% were identified as purely phenomenology, 31% interpretative phenomenology and 29% hermeneutic phenomenology. The approaches used included several scholars including Van Manen, Colaizzi, Smith, Giorgi, Moustakas and Ricoeur. It was found that within any one type of qualitative methodology, there can be a variety of data analysis processes. The authors identified three fundamental principles across studies which are critical to a good study: constant comparison of data, cyclical analysis (i.e. returning to data to check coding as the analysis proceeds) and emphasis on early analysis. It was found that a certain detachment from the 'rules' will help qualitative researchers to maintain reflective insight into data (Shin et al., 2009). Table 5.2 outlines types of qualitative analysis, a brief description of each and a rationale for whether this approach would be appropriate to this particular study.

**Table 5.2 Qualitative methodology and appropriateness to this study**

Method of qualitative analysis	Brief description	Appropriateness to this study
Grounded theory (GT)	Grounded theory has the goal of developing a theory which explains and provides insights into the phenomenon and the study. Interviews change and develop as the research progresses so that themes will emerge. As the study progresses the structure of the interview will change and become more focused so that specific aspects of the theory can be explored in more depth or detail. Grounded theory means progressive focusing on particular concepts and ideas important for the emerging theory. Initially the focus is centred on the phenomenon and then the theoretical ideas are further developed so that the theory can emerge. <i>Grounded theory is therefore a creative process that is appropriate to use (where there is) a lack of knowledge of the theory of the topic (or) when the existing theory offers no solution to problems (or) when modifying existing theory</i> (Holloway, 2005).	As this specific study is broad and exploratory and there is little existing theory in the area, this might be an appropriate methodology. However, in a mixed method study GT may be a too complex and lengthy process of analysis and may not be suited to this study as the aim is for a broad overview of major themes in this that will inform the quantitative study, rather than developing a theory.
Phenomenology	Aims to describe interpret and understand the meanings of experiences at both a general and unique level. The research question centres on <i>What it is like to be in or experience a particular situation?</i> This approach focuses on the depth of a particular experience, to describe the qualities of experiences that were lived through. Thematic analysis is undertaken, moving back and forth between whole meanings and part meanings	Previous studies indicate suitability of this approach and have been tried in both arts and health studies and in relation to exploration of leisure pursuits in patients with stroke. (Lane, 2005, O'Sullivan and Chard, 2010). Phenomenology was seen as especially appropriate for the O'Sullivan study as it sought to describe, understand and gain insight into the rich meaning of personal experiences from the



	(Holloway, 2005)	point of view of the stroke survivor. This seems to mirror the aims of this study, to explore the experiences of patients regarding aesthetics in hospital.
Template analysis, thematic analysis, content analysis	These approaches include a number of techniques for organising and analysing textual data thematically. Template, thematic and content analysis are more general qualitative approaches to drawing out themes, as opposed to in-depth specific methodologies.	Template analysis was used by McCabe to analyse her mixed method arts and health research. A useful tool for large numbers, but McCabe indicates that phenomenological studies could be considered more appropriate where each interview is analysed to a greater depth than in template analysis. A more in-depth, established method was preferred to Thematic analysis or Content analysis.
Ethnography	To describe, interpret and understand the characteristics of a particular social setting with all its cultural diversity and multiplicity of voices (Holloway, 2005).	Very few arts and health studies used this approach to date. As this study is not specifically aiming to explore the cultural or social context of aesthetics in hospital (this aspect is only part of a broader study of the subject area) this approach was not seen to be most suitable.
Arts based methodology	Arts based methodology emphasising the visual rather than the verbal, (for example children may be able to paint to express their views more easily than using words) (Rapport et al., 2005)	Could be useful in terms of understanding the benefit of arts for patients, especially using visual artwork created in art sessions as a way of exploring benefits and experiences for patients. However, it was decided to carry out in-depth interviews as all patients were verbal and articulate, so the need for arts based methodology was felt less necessary in this case. Review of this approach led to researcher using some arts based methods in the analysis of data.
Focus group	An approach whereby a group of subjects discuss issues relevant to the research.	It was decided that individual interviews would elicit more detailed answers and more honest views on the usefulness of the arts while in hospital. Also individual interviews were more appropriate given the personal nature of the questions about patients' illness and the

		experience of hospital.
Narrative based methodology	Narrative based methodology (such as discourse analysis) is a relatively new qualitative methodology, which uses reflection and critical self-examining to think narratively about experience.	The focus of this research is on patients' experience (especially as some studies indicate that patients' view of aesthetics is given little attention) and thus it was important to focus on patient experience more than to analyse the researcher's role in the study. Whilst self-reflection and memos were important as part of the researcher's practice and analysis, it was felt that discourse analysis and narrative methods were not the most suitable for this study.
Documentary analysis	Using documents such as reports, publications, press releases to analyse the area to be studied	It would be possible to use reports and documents about the arts and health programme (for example, Government policies on arts and health) to further analyse and explore the experience of patients in hospital. However, the focus of this study is on asking patients about their experience, rather than looking at wider policy and strategy in this area. A review of reports and documents were undertaken as part of the literature review.

## **5.6 Rationale for selection of Qualitative Methodology**

Previous sections of the literature review indicated that most studies concerning patients' aesthetic preferences and perceptions of arts in hospital were exploratory or descriptive, with an art therapies or arts participation focus. Few papers explored the lived experience of patients and a variety of methodologies were used which shed some light on the experiences of patients of the arts.

This study uses phenomenology as methodology, using Van Manen's approach, to gain a broad overview of the subject area and to explore the experience of patients in hospital. Qualitative research is concerned with meanings people attach to their experiences in the social world and how they make sense of that world. It is therefore concerned with trying to interpret social phenomena, interactions and behaviours in terms of the meaning people bring to them. Qualitative research also studies people in their own natural settings rather than in artificial or experimental ones (Pope and Mays, 2006). It was intended that the insight provided by a phenomenological study would enable the researcher to both form the quantitative study more appropriately and to assist in interpreting and understanding the quantitative data more fully. In conjunction with the literature review, it was hoped, through this research, to gain a broad understanding of the role of aesthetics for patients in hospital.

### **5.6.1 In-depth Interviews Method**

A decision was made to carry out in-depth interviews as an exploratory exercise within a mixed methodology research, based on previous studies in this area. In-depth interviews were selected (as opposed to focus groups or other qualitative methods of data collection such as written accounts, close observation or journals) to allow an honesty and depth to the conversation, to hear patients' experiences in a detailed way, as a means to explore patients' own account of the experience, their beliefs and their attitudes and to explore how the hospital experience of arts differed from arts experiences

outside of hospital. It was important to gain insight, in patients' own words, about how they experience the arts and how they experience the contribution the arts make (or not) to their health as well as to explore their understanding of aesthetics.

*The aim of the interview, as with any qualitative research data collection tool, is to explore the insider perspective (Holloway, 2005) p. 40.*

The aim of the interview is to capture, in the participant's own words, their thoughts, perceptions, feelings and experiences. Each interview is unique and is a description of an informant's own words, their account of the experience, beliefs and their attitudes.

*This uniqueness is important to the researcher who acknowledges the individuality, humanity and uniqueness of each individual. The qualitative interviewer learns what is important in the mind of informants, their meanings, perspective and definitions, how they view, categorize and experience the world (Holloway, 2005) p. 40.*

Interviews in this kind of research are non-directive and open ended. One of the arguments against this approach is that you cannot look for order and experience amongst the multiple accounts of experience and that this research is arbitrary and subjective. The next section presents the rationale for choosing a phenomenological approach.

### **5.6.2 Phenomenology**

The philosophy of phenomenology is concerned with the study of human experience in everyday life and the premise that 'reality' is multiple and subjective. The research setting is natural and not manipulated, interactive and jointly participative by investigator and respondent. Open-ended, unstructured in-depth interviews or participant observation are the key tools for research and the data is regarded as valid when the researcher and respondent reach a mutual understanding (Bowling, 2009). Phenomenology

is a philosophical perspective as well as an approach to qualitative methodology. It has a long history in several social research disciplines including psychology, sociology and social work. Phenomenology is a school of thought that emphasizes a focus on people's subjective experiences and interpretations of the world (Trochim, 2006).

*From a phenomenological point of view, to do research is always to question the way we experience the world. (Van Manen, 1990) p. 10.*

Phenomenology is an umbrella term encompassing a philosophical movement and a range of research approaches. Husserl (1936 – 70) was the father of phenomenology; he developed this radical new philosophy. Heidegger (1927 – 60) developed the interpretive dimensions known as hermeneutic phenomenology. The overall aim of phenomenological research is to describe and elucidate the lived experience of the world in a way which expands our understanding of human beings and human experiences (Finlay, 2009).

There are various approaches to phenomenology, including those of leading scholars Van Manen, Colaizzi, Giorgi, Ricoeur, Smith and Moustakas (Colaizzi, 1978, Giorgi, 1985, Moustakas, 1994, Ricoeur, 1976, Smith, 1996, Van Manen, 1990). Common to all is the search for meaning and essences, focusing on the wholeness of the experience, obtaining descriptions of experience from first-person accounts and viewing the data of experience as imperative in understanding human behaviour. A major difference appears between descriptive phenomenology and hermeneutic or interpretative phenomenology. Phenomenology is described as the pure description of lived experience, whilst hermeneutic phenomenology is interpretation of the experience via texts or other symbolic forms (Van Manen, 1990). This study takes a hermeneutic approach as the description of the experience of arts in hospital is mediated and interpreted by the researcher.

Hermeneutic research is always about studying people and always begins in the life world. It is fundamentally a writing activity and it attempts to gain insightful descriptions of the way we experience life rather than classify

behaviour, produce theory or aim to explicate meanings specific to particular cultures. It does not seek to classify experience according to certain social groups (sociology) or in other ways such as historical accounts, biographies or psychological explanations.

*Rather, phenomenology attempts to explicate the meanings as we live them in our everyday existence, our lifeworld (Van Manen, 1990) p. 11.*

The science of phenomenological research comes from the systematic practice of questioning and reflecting, being explicit in articulating experiences, self-critical in terms of continuous re-examination of the analysis of the experience and intersubjective in that the phenomenon is validated by the participants who are an integral part of the research process and analysis. The overall aim is to increase understanding of what it is like to live in the world as a human. Van Manen also argues that phenomenology is a *poetising activity* in that data is not reduced to common denominators but descriptions are written poetically to evoke the essence of the experience.

*To this purpose the human scientist likes to make use of the works of poets, authors, artists ... it is in this work that the variety and possibility of human experience may be found in condensed and transcended form (Van Manen, 1990) p. 19.*

A review of phenomenological methods was undertaken and Van Manen's approach was used for this study (Van Manen, 1990). The six steps of Van Manen's hermeneutic phenomenological study are (1) Turning to a phenomenon which seriously interests you and you want to study; (2) Investigating experience as it is lived rather than as it is conceptualized; (3) Reflecting on the essential themes which characterize the phenomenon (4) Describing the phenomenon through the art of writing and re-writing (5) Maintaining a strong orientation to the original question and (6) Balancing the research question by identifying parts and the whole.

Phenomenology is not an empirical analytic science, nor a mere speculative inquiry, nor does it set out to problem solve. It aims to be *presuppositionless*, without a pre-conceived fixed set of procedures. There are a guiding set of principles rather than a rigorous method to this approach. In this approach the original description is divided into units or initial themes, the units are transformed into meanings or groups and these transformations are combined to create a general description of the experience (Dowling, 2007). Moustakas defines the key techniques in carrying out effective phenomenological research as (Moustakas, 1994): (1) Identifying a phenomenon you want to study; (2) Identifying your biases as much as you can and put them to one side; (3) Collecting narratives about the phenomenon through open-ended questions to people who are experiencing it; (4) Using your intuition to identify the essentials of the phenomenon; (5) Laying out those essentials with exemplary quotes from the narratives and (6) Repeating steps 4 and 5 until you are sure there is no more to learn about the experience.

A key technique is to 'bracket' particular beliefs or one's own judgement in order to see the phenomena clearly. Hermeneutic phenomenology indicates that nothing can be encountered without reference to a person's background and understanding and the social and cultural context of the experience is indissolubly related to the experience itself, so personal experiences are used as part of the study rather than 'bracketed' and left to one side. The initial emphasis of phenomenology is description, not offering causal explanations or interpretive generalisations. However, where the experiences are also those of others, the phenomenological descriptions have a *universal (intersubjective) character* (Van Manen, 1990). The aim is to gather other people's experiences and reflections in order to better understand an aspect of human experience.

*We gather other people's experience because they allow us to become more experienced ourselves (Van Manen, 1990) p. 62.*

Whilst it is important to follow a method of phenomenological analysis, relying too heavily on techniques is cautioned. It is perhaps more useful to think in terms of the organizing principles surrounding the activities and topics in this kind of work, which Van Manen lists as (1) analytic induction (close up first-hand inspection of the work); (2) proximity (being close to the actual phenomenon in the field); (3) ordinary behaviour (research located in the natural, everyday world); (4) temporal sensitivity (any social action is unique and unlikely to be repeated); (5) descriptive emphasis (of what is happening in any one place or time) and (6) shrinking variance (i.e. discovering and explaining similarity and coherence). Several phenomenological studies were reviewed to learn about the style of writing a phenomenological analysis (Thomson et al., 2011, Madjar et al., 1999, Carroll, 2001). Writing is seen as a key aspect of phenomenological research. Van Manen believes that writing and rewriting is important as writing can orientate us from particulars to a more universal sphere and help to clarify thoughts.

*By writing and rewriting the essences and themes arising in the data... themes condense into a discursive whole which we may call 'theory'. Responsive-reflective writing is the very activity of doing phenomenology (Van Manen, 1990) p. 132.*

Phenomenological research is not external, top down research but involves a personal engagement in the experience. It seems this fits well in this context, as the researcher is also director of the hospital arts programme and works with patients programming arts on a weekly basis. This approach allows for this sort of personal involvement whilst having a rigorous and clear framework.

*Hermeneutic phenomenology is an original activity; there is no systematic sequence of events, no exact order we must follow to arrive at a conclusion. It must guard against purely describing or explaining but must reflect in some way the deeper sense of the experience... Its claim to validity as a method of demonstrating truth is having satisfied certain steps or stages. (Van Manen, 1990) p. 173.*



### **5.6.3 Summary of choice of Van Manen's phenomenology method**

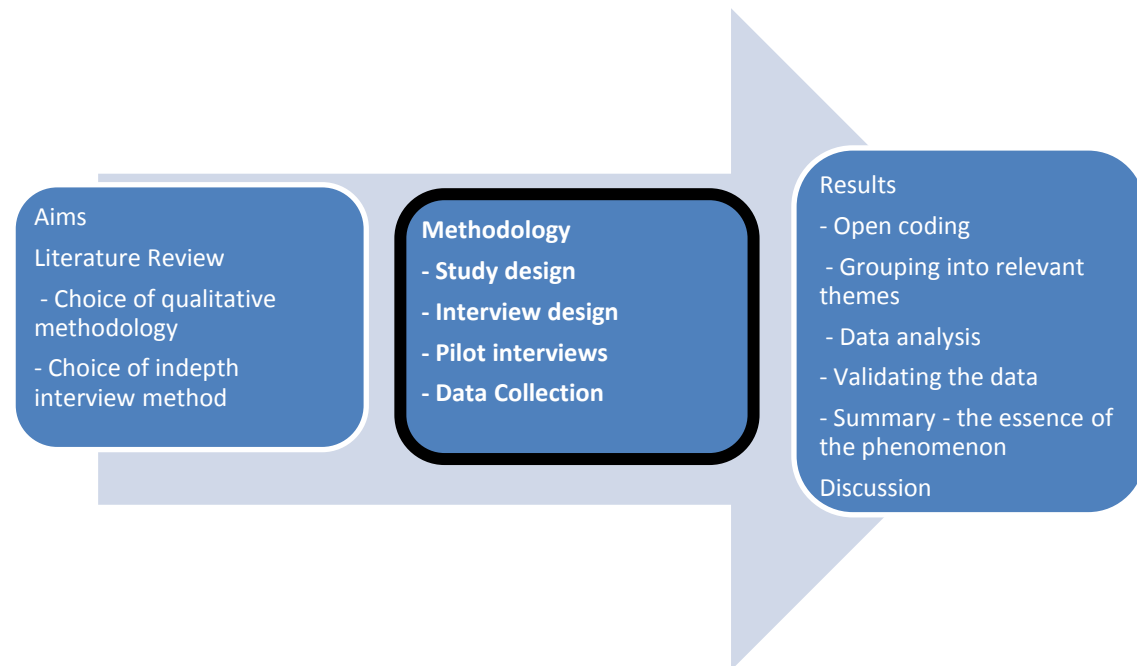
In summary, Van Manen's approach was chosen for this study for the following reasons:

- Van Manen cites that the method you choose ought to maintain a harmony with the deep interest you have, which in this case is a long career working in arts and health practice in hospitals. This researcher wanted an approach that would take this into account as an advantage rather than a disadvantage and would be clear as to how to use this knowledge and not let it hinder the research
- Hermeneutic phenomenology was chosen as it acknowledges that you always come with prior knowledge of a subject and proposes that there is no such thing as uninterrupted or uninterpreted data.
- Van Manen's approach was easy to read, follow and has been well used in nursing and other healthcare qualitative research
- Phenomenology is fundamentally a writing activity, which suits this researcher who enjoys this approach to research
- This method was most appropriate for the research aims. Specifically, this particular study leaned towards a broad exploration rather than aiming to make a theory, so grounded theory approach did not seem the most suitable and ethnography focuses too much on cultural issues for this study.
- A rigorous and critical analysis of the phenomenon was desired, and other methods such as content analysis or thematic analysis (a popular approach in the literature review) did not appear in depth or rigorous in approach.
- Phenomenology offers reflection as a core part of the study, which appealed to this researcher. One of the aims of doing this study was to take time to reflect on the practice of arts in healthcare. Creative reflection is encouraged by Van Manen and was used by the researcher during the course of the analysis.

## **5.9 Conclusion**

This chapter has given a thorough account of several literature reviews concerned with identifying suitable qualitative methodology for this study. It demonstrates a thoughtful approach to choice of methodology for this part of the research and a rationale for the methodology selected. The next chapter focuses on the methodology of the qualitative study.

## Chapter 6 Methodology – Qualitative Study



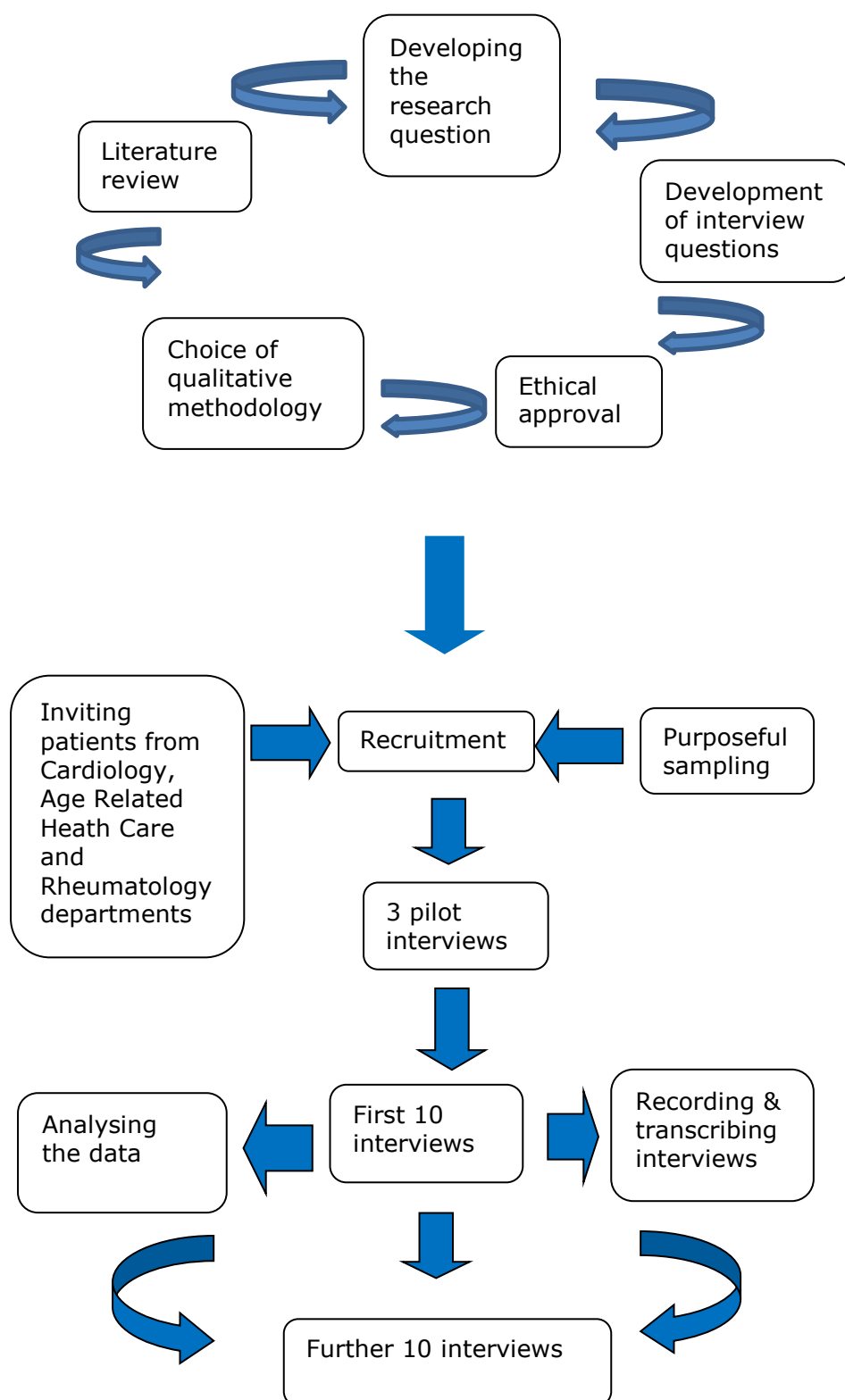
**Figure 6.1 Qualitative study diagram highlighting Methodology**

### 6.1 Introduction

This chapter describes the methodology of the qualitative study, including sample size, ethical issues and recruitment processes specific to this study (see Figure 6.1). See Section Two, Chapter Four for details of methodology for the overall research.

### 6.2 Overview of Van Manen's phenomenology method

Van Manen's six stages of hermeneutic phenomenological method were followed for this study (Van Manen, 1990) (see Section 5.6.2). The process for conducting this qualitative study is outlined in Figure 6.2.



**Figure 6.2 Qualitative study process**

## **6.3 Recruitment**

Twenty patients were selected to be interviewed, ten patients who had experienced the hospital art programme and ten who had no experience of arts in hospital. Both groups were asked the same questions and similar broad issues were explored in the interviews. It was believed that both groups would bring experiences important to developing an understanding the phenomenon and it was important to explore differences and similarities in the experiences of the two groups. The aim of each interview was to explore and gather experiential narrative material as a resource for developing a richer and deeper understanding of the human phenomenon (Van Manen, 1990).

### **6.3.1 Recruitment specific to qualitative study**

Participants were recruited by two methods. Patients who had participated in the hospital arts programme were sent a letter outlining the research and inviting them to participate. These patients were participants of visual art, music or creative writing programmes while in hospital or as part of their out-patient programmes but had ceased attending programmes in the last six months prior to the research. All art sessions attended were up to two hours long and participants attended a maximum of twelve weekly sessions. In order to attend an arts programme, patients from specific clinical departments were invited at random to attend. For example, in the Age Related Day Hospital, every patient attending on the day of the art group were invited to participate and given the option to not attend. Similarly, for the Cardiac Rehabilitation creative writing programme, all patients attending the clinic in the year prior to the study were sent a letter inviting them to participate in the writing group and those who responded were selected.

Those who had not engaged in the art programme were invited verbally after consultation with the Clinical Nurse Managers in the relevant areas. Written information was given to them and they were given time to decide if they would like to participate.

In both cases, patients were invited (either verbally or by letter) and were eligible if they had been in hospital for a minimum of seven days in the last five years. There were no other significant differences noted between patients in the arts and non-arts groups. In both cases, patients were invited to participate and the first ten to agree were included in the study.

### **6.3.2 Inclusion and Exclusion criteria**

Patients selected for inclusion in the study were all over 65 years of age and from the Age Related Health Care, Cardiology and Rheumatology departments. These three clinical teams had actively participated in developing arts programmes for their patients and had an interest in this research. Inclusion and exclusion criteria were as per general methodology (See Sections 4.5.3 and 4.5.4).

### **6.4 Sample size and theoretical saturation**

Purposeful sampling was used, in other words patients were selected from both groups who would be suitable to be interviewed. However, in both groups patients were invited to participate but self-selected as to whether to participate in the interviews.

There are several strategies for purposeful sampling cases. The methods most commonly used in qualitative studies are convenience sampling, maximum variation sampling, snowball sampling and sampling contrasting cases. In this qualitative study, *sampling contrasting cases* was the approach used. This was a comparative study with two population groups with distinct characteristics being interviewed – those who had engaged in the arts programme and those who had not. Comparison can help in analysing which factors contribute to a phenomenon as well as focussing on specific issues (Hardon et al., 2004).

Theoretical saturation occurs when there is no more relevant data emerging and when findings are well established and validated. Researchers cannot make a judgement about sample size until they are involved in the data

collection. Saturation normally occurs between 10 and 30 interviews (Thomson, 2004) and so in this study it was proposed to carry out twenty interviews, with additional interviews if saturation was not achieved at this point.

After carrying out ten interviews, an initial analysis was undertaken and then the following ten were completed. After twenty interviews it was considered that saturation had been achieved and relatively little new material was being recovered.

## **6.5 Interview process**

Interviews were recorded and transcribed verbatim. The researcher also recorded hand written notes in a journal throughout the process, reflecting on interview process, ideas and assumptions. Seven steps were followed in setting up the study to ensure this initial stage was true to phenomenological methodology (Moustakas, 1994):

- Literature review to review professional and research literature in the area
- Criteria set for identifying participants (or co-researchers)
- Providing co-researchers with instructions as to the nature and purpose of the study and ethical agreement/consent procedures
- Developing a set of questions or topics to guide the interview
- Conducting a lengthy one-to-one interview focusing on the questions and topic
- Organizing and analyzing the data
- Returning to the co-researchers to check validity of findings.

### **6.5.1 Interview questions**

Questions were based on qualitative methodology set out by Patton (Bowling, 2009) who describes six types of questions which build trust with the interviewee. Draft questions were created and these are presented in Table 6.1. The aim was to ask open-ended questions in the interview, as per phenomenological theory, to allow participants to describe the phenomenon

as freely as possible, without prompt, but to have some prompt questions ready should some participants need this. It was important to specify what was meant, in this study, by 'arts' and the list of arts used in a previous relevant survey was used (Drury, 2006, The Arts Council, 2006). This list of arts was shown to participants before commencing interview. See Appendix 9 for list of 'arts' for qualitative interviews.

**Table 6.1 Interview questions (Patton 1990)**

<b>Theme</b>	<b>Draft questions for this study</b>
Background questions that aim to understand the respondent's previous experience	<p>Tell me about your experience of hospital (when, how long, which ward, patient's story of their illness)</p> <p>Please tell me about your involvement in the arts* outside of hospital.</p> <p>*Explain that 'arts' refers to list of arts and show simple list as amalgamated from ESRI survey Card A, E, F, J (The Arts Council, 2006)</p>
Sensory – questions which determine respondents' sensitivity to sensory stimuli	What were the aesthetics of the hospital like? (How it looks, sounds, smells, arts, music, noise etc.)
Questions about knowledge and factual information	<p>What arts, leisure pursuits, interests, or hobbies do you enjoy and engage in normally at home or in your community?</p> <p>What arts, leisure pursuits, interests, or hobbies did you engage in while in hospital, if any? (how often, which art form, where it took place)</p> <p>Did this change post hospital?</p>
Questions to elicit descriptions of behaviour, experiences, actions and activities	<p>What was your experience of arts before you came into hospital?</p> <p>What was your experience of arts while in hospital?</p> <p>What were your expectations of arts while in hospital?</p> <p>Did your experiences change post hospital?</p>
Questions about feelings/emotions in order to obtain an understanding of emotional responses	<p>What was it like to engage in arts you enjoy before hospital?</p> <p>What was it like to be in hospital? (How did you feel? Did your feelings change? What made them change?)</p> <p>How did you feel when engaged in the arts while in hospital? Did your feelings change as a result of engaging in art sessions?</p> <p>Did you miss your access to the arts while in hospital?</p>



	What hopes did you have regarding arts while in hospital?
Opinions or value questions to inform about people's goals, intentions, desires and values	<p>What is your opinion of arts for patients in hospital?</p> <p>What are the most memorable experiences you have had of the arts in hospital?</p> <p>Has your engagement with the arts changed since you left hospital? If so, how and why?</p>

### 6.5.2 Pilot interviews

The draft questions for the interview were tested in two pilot interviews, which were conducted with patients who had attended arts programmes. The questions outlined above were used and the researcher learned that while broad open questions were needed, there was a need for supplementary prompt questions to help guide participants to discuss the issues relevant to the research. It was also discovered that it was important to help the participant relax before beginning the research and to 'warm up' before starting the formal interview. A further pilot interview was conducted with a participant who had not attended the art programme. Here it was discovered that some of the questions were less relevant and that it was important to allow the participant to discuss their leisure interests in more detail.

A list of art forms was found to be useful after the pilot interviews, to help participants to consider all the different sorts of art involved, as 'art' often is thought of as 'visual art' unless other art forms are identified. After these three pilot interviews, it was also decided to add one prompt question specifically about the aesthetic environment of the hospital (such as colour, visual art, food, noise) as the researcher was interested to explore this and this was not arising in the course of the interviews. It was found that some participants needed more prompting and support than expected in the interviews and a semi-structured interview seemed appropriate, given the very broad topic being explored.

## 6.6 Data collection

Interviews were recorded and transcribed verbatim into Nvivo software. Repeated readings of the data allowed allocation of text to groups and the creation of themes. Nvivo software was also used to assist analysis of the data.

## 6.7 Data analysis

The emphasis of Van Manen's method is to bring the essence of the phenomenon alive through written descriptions, with the aim being to describe and interpret the essences of the experience and what makes the experience unique (Van Manen, 1990). Van Manen's six stages are returned to again here, with specific details regarding data analysis:

- Turning to a phenomenon which seriously interests you and you want to study – *being grounded in the research question*.
- Investigating experience as it is lived rather than as it is conceptualized – *in-depth interviews, developing the questions (see above)*.
- Reflecting on the essential themes which characterize the phenomenon – conducting thematic analysis, allocating themes either by line by line coding, capturing fundamental themes from paragraphs and picking out essential phrases or statements. Also identifying themes through self-reflection, conversations with peers, artistic activities and collaborative analysis such as asking other researchers to code interviews and compare results.
- Describing the phenomenon through the art of writing and re-writing – using anecdotes, stories and quotes, writing and rewriting, to come to a draft description of the essence of the phenomenon.
- Maintaining a strong orientation to the original question – returning to the original question, testing the results, validation, including returning to 3 interviewees to validate preliminary results.

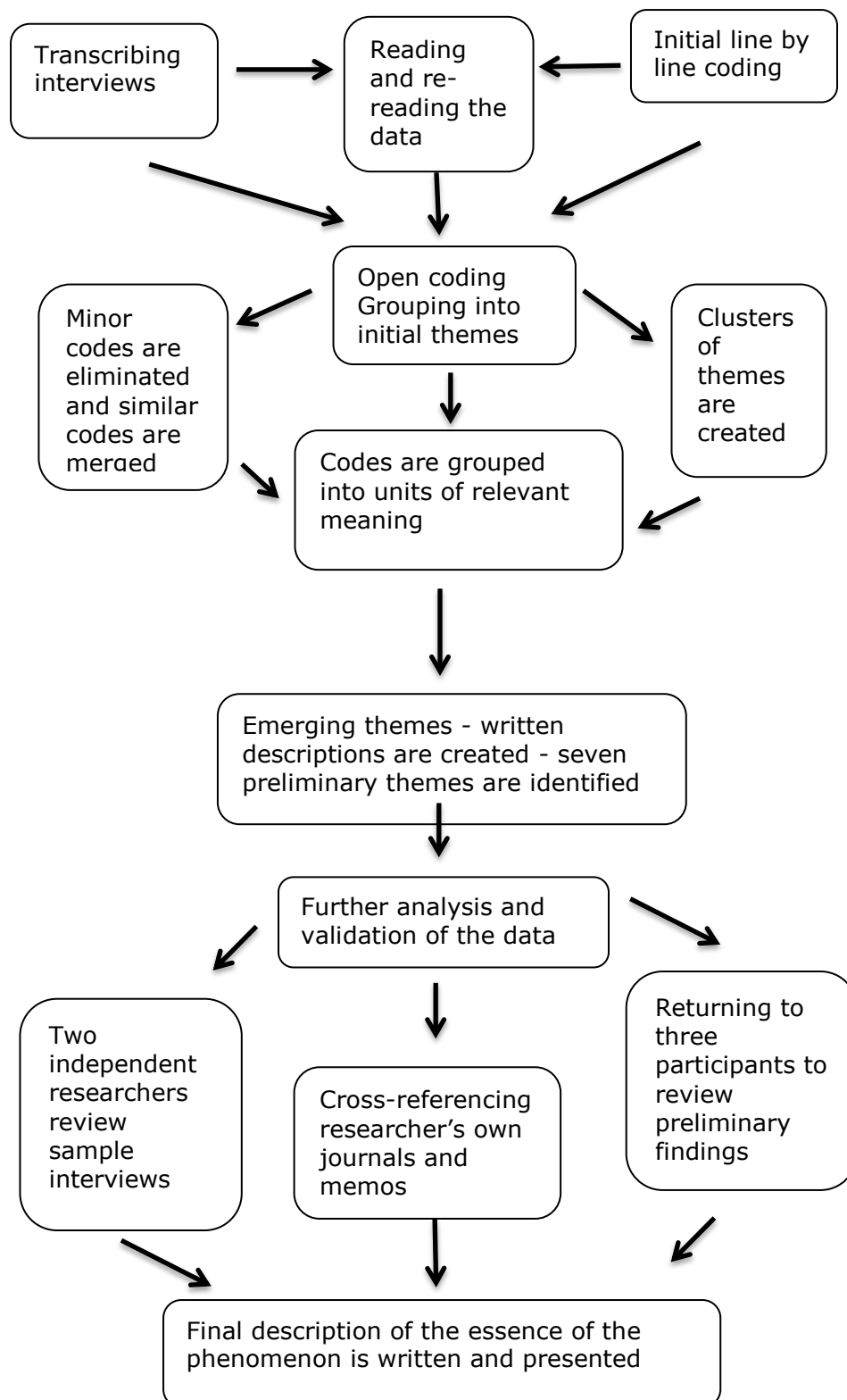
- Balancing the research question by identifying parts and the whole - reducing duplications and amalgamation of minor themes into larger groupings to give final essences of the phenomenon.

The method of analysis is presented in Table 6.2 (again, following Van Manen's approach).

**Table 6.2 Method of qualitative study data analysis**

<b>Step of Van Manen's approach</b>	<b>Activities in this study</b>
Open coding	Audio-taped interviews were transcribed verbatim by the author.
Open coding	Each written transcript was read and re-read numerous times. The text of each interview was coded, line by line, into initial codes. This created a large number of codes which were an initial, accurate portrayal of the material from the interviews. Nvivo software was used throughout this analysis to organize the codes.
Creating initial themes	Codes were clustered into initial themes. Every code and every quote attached to the code was reviewed twice, to check that they all fitted within the initial themes.
Grouping into units of relevant meaning	From these groupings, units of relevant meaning (i.e. words and phrases that illuminate the research question) were grouped together. Thus, statements related to the patients' experience of arts in hospital were highlighted. Minor codes were eliminated and similar codes merged.
Emerging themes	Finally, clusters were created around these groupings. Seven emerging themes across all transcripts were then created from the data. Themes were not predetermined, but arose from multiple analyses of the interview material as well as reflective journal entries. Smaller sub themes were here reconnected into these seven major themes. A key quotation was selected which seemed to best capture the theme. These emerging themes were presented as written descriptions, which were then tested and validated.

Figure 6.3 sets out the analysis process.



**Figure 6.3 Data analysis process**

### **6.7.1 Analysis of preliminary findings**

Once the initial coding was carried out, with initial themes identified, it was necessary to undertake further analysis, to validate the preliminary findings. To investigate the phenomenon further, an analysis of two groups was undertaken (the ten patients with experience of the arts programme and the ten without). A table was devised with patients' diagnosis, scores of cognitive and function tests, record of hospital history (in-patient and outpatient), diagnosis and age.

### **6.7.2 Validation and reliability**

Three activities were undertaken to increase reliability and validity of the findings.

1. Two independent researchers reviewed a sample of two interviews each. They coded and analyzed these interviews as well as reviewing the initial themes. Having multiple coders increases the likelihood of finding all the examples in the text that pertain to a particular theme and increases credibility (Bernard and Ryan, 2010).
2. The researcher returned to a sample of three patients who had been interviewed and asked them to examine the seven themes to further validate the study and to explore whether they agreed with the main findings of the analysis or had anything else to add. They were asked to read a summary of the seven findings and comment on (1) Did the themes described fit with your own experience of hospital and engaging with arts (2) Did any of the themes described seem wrong or not relevant to your experience and if so, which ones? (3) Did I miss out anything important from your experience of hospital and arts or from your interview? (4) Is there anything else you would like to add? This process aims to check whether the researcher has accurately represented the participants' descriptions and whether the researcher's own assumptions and biases are unduly influencing the researcher.

3. Both during and after each interview, the researcher recorded reflective field notes about the content and process of the interview, as well as any extra information or non-verbal observation that occurred (O'Sullivan and Chard, 2010). The reason for this reflection is to become aware of one's biases and assumptions in order to bracket them, or set them aside, in order to engage without preconceived notions about what will be found in the investigation (Laverty, 2003). To avoid bias the researcher took the following steps (1) Answered the research questions, to discover own assumptions and answers to the questions, to make these explicit and to be aware of them (2) Carried out three pilot interviews before beginning the process (3) Kept a journal of thoughts and opinions during the interview process (4) Ensured other independent researchers coded samples of interviews to check researcher's own findings (5) Returned to a sample of the participants to check findings against their own understanding of the phenomenon (6) Discussed the findings with research supervisors (Bernard and Ryan, 2010).

### **6.7.3 Establishing trustworthiness and credibility**

Coding consistency and validity are major issues of debate in qualitative research. Well documented weaknesses in some qualitative research include unclear methods of analysis, a lack of clear definition regarding the development of concepts and spending too much time on activities such as collecting large volumes of data and preparing interview questions rather than the intellectual work of analysis. Reliability is difficult to maintain as the interviewer might change questions from one participant to another. Compared to quantitative research, qualitative research is sometimes criticised as a mysterious and half formulated art (Miles, 1979, Van Manen, 1990). Eggenberger comments that establishing trustworthiness and credibility of theme identification is of paramount importance to ensure quality in qualitative investigations (Eggenberger et al., 2004). Trustworthiness is established by determining whether the description developed through inquiry in a particular setting 'rings true' for those persons who are members of the setting (Erlandson et al., 1993). In this study, three participants were asked to identify whether the findings 'rang true' for them.

### **6.7.5 Writing the themes**

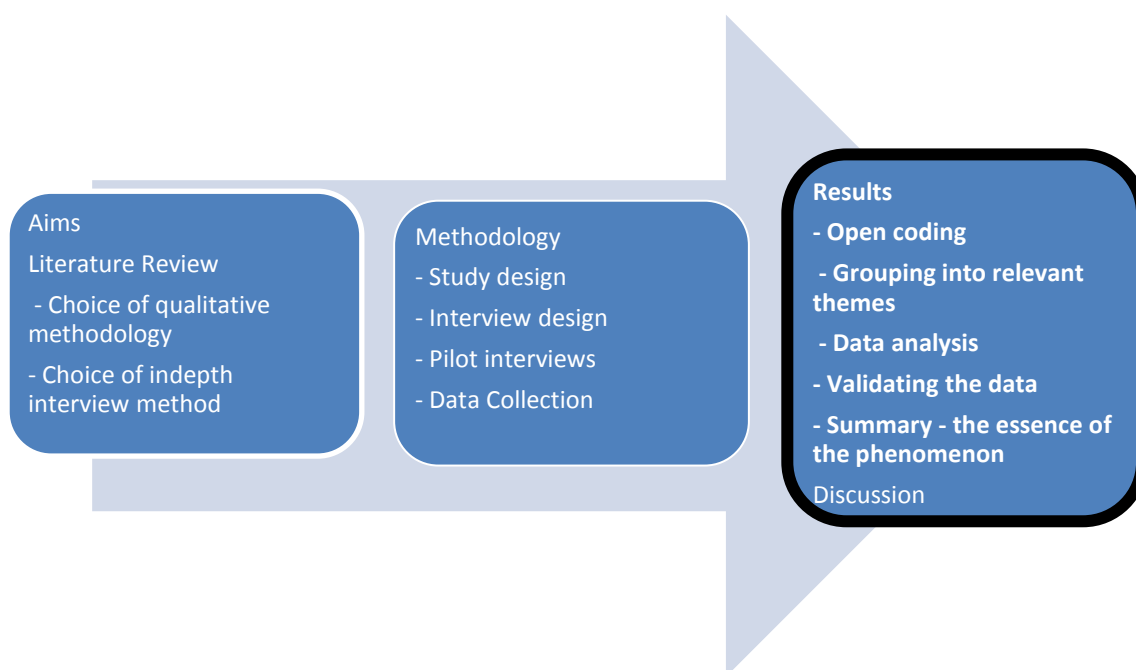
The final step in the analysis process was to write a description of the phenomenon, taking into account all that is known through the process described above. Nvivo software was used to query findings and find evidence in the data to support final themes chosen by the researcher. Rigour was established by methods of peer review, supervision and debriefing throughout the process with two co-researchers/supervisors. Both formal and informal approaches were used to seek collaborative assistance with theme identification, for example sharing the text with supervisors, advisers and colleagues and reviewing key findings with participants. The aim of these activities was to test the analysis to see if others perceived the essence of the phenomenon in the same way as the researcher (Van Manen, 1990).

As per Van Manen's approach the researcher identified key themes and then built a descriptive paragraph to describe each theme, with data used to illustrate the theme. The art of phenomenological research is, according to Van Manen, the art of writing and describing the phenomenon. Where appropriate, quotes and anecdotes were used to describe the experiences selected. The researcher also took time to reflect on the themes, write and rewrite and even improvising to creatively reflect on the themes. The researcher continued to go forwards and backwards through the research stages to reach final themes. The process of analysis was undertaken from March 2011 – Feb 2012.

## **6.8 Conclusion**

This chapter set out the methodology for the qualitative study, with details of recruitment, interview techniques, and plan for data analysis. The next chapter presents the results of this study.

## Chapter 7 Results - Qualitative study



**Figure 7.1 Qualitative study diagram highlighting Results**

### 7.1 Introduction

This chapter sets out the results of the qualitative study, beginning with a broad overview of themes arising from the qualitative data and then focusing on more specific and detailed results (see Figure 7.1). A final section gives a description of the phenomenon. These results form the basis of the development of the quantitative study (Section 4).

### 7.2 Data analysis

The plan for data analysis was described in detail in chapter 6. The results are presented as follows:

1. **Patient analysis** A table was devised with patients' diagnosis, scores of cognitive and function tests, record of hospital history (in-patient and outpatient), diagnosis and age (See Table 7.1).



2. **Open coding and initial themes** Line by line coding, major themes and sub themes.
3. **Grouping into units of relevant meaning and identifying emerging themes** Minor codes were eliminated and similar codes merged. Seven major themes were then created from the data. These are the final themes, with description and examples from the data. These were draft themes until the validation was completed (steps 5, 6 and 7 below).
4. **Arts vs. Non arts** Findings of comparisons between group who participated in arts and those who did not.
5. **Validating the findings** – coding review
6. **Validating the findings** - returning to the participants
7. **Validating the findings** – cross referencing my journal and memos
8. **Summary** The description and essence of the phenomenon

## 7.3 Patient Data

**Table 7.1 Patient Data**

<b>Subjects (initials and participant numbers)</b>	<b>Age</b>	<b>Arts in hospital</b>	<b>Barthel function score</b>	<b>Cognitive score</b>	<b>Gender</b>	<b>Number of in-patient visits of &lt;7 days in last 5 years</b>	<b>Number of in-patient visits of &gt;7 days in last 5 years</b>	<b>Number of out- patient visits in last 5 years</b>
AL – 001	70 – 75	Yes	17	3	Female	4	1	76
BB – 002	65 – 70	Yes	19	4	Male	1	1	21
CW – 003	80 – 85	No	16	1	Female	3	0	32
DG – 004	80 – 85	No	20	2	Male	1	9	74
DM – 005	80 – 85	No	16	2	Male	3	3	122
EM – 006	80 – 85	No	19	4	Female	3	3	62
HM – 007	80 – 85	No	13	3	Female	1	0	34
JW – 008	75 – 80	Yes	20	4	Male	2	4	25
JL – 009	75 – 80	No	20	4	Male	3	12	290
MB – 010	65 – 70	Yes	20	3	Female	1	4	93
MS – 011	85 – 90	No	18	2	Female	3	4	80
MO – 012	80 – 85	Yes	20	3	Female	1	0	122
NW – 013	90 – 95	No	20	3	Female	1	0	25
PO – 014	65 – 70	Yes	20	4	Male	1	2	24
PA – 015	75 – 80	Yes	20	3	Male	1	12	95
PF – 016	65 – 70	Yes	20	4	Male	1	7	80
RO – 017	70 – 75	Yes	19	4	Female	2	6	50
TM – 018	80 – 85	No	19	1	Male	1	1	20
TC – 019	85 – 90	No	17	3	Male	3	0	59

VC - 020	65 - 70	Yes	20	3	Female	3	3	28
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## 7.4 Open coding and creating 'trees'

Table 7.2 below shows the initial codes organized by the emerging themes (i.e. an overarching theme, with sub themes grouped together). The number of sources (i.e. how many participants were coded to this theme) and the references (i.e. how many individual references were coded to this theme) are shown after each code. These tables have been organized to be ranked from most coded themes to least.

**Table 7.2 Open coding and initial themes**

<i>Themes</i>	<i>Individual items</i>	<i>Number of interview sources</i>	<i>Number of individual comments</i>
Interests pre hospital	Music - listening, playing, concerts	11	12
	Dancing	9	10
	Theatre, acting	8	8
	Garden, outdoors	5	7
	Sport	6	7
	Crafts	3	7
	Walking, hill walking	5	6
	Reading	6	6
	Golf, pitch and putt	6	6
	Cinema	5	5
	Work	3	4
	Vintage cars	1	4
	Art	3	3
	Cycle	3	3
	Grandchildren	1	2
	Bridge, whist	2	2
	Yoga	1	1
	Personal development	1	1
	DIY	1	1
	TV	1	1
	Shopping	1	1

	Woodturning	1	1
	computers, photography	1	1
Experience of hospital	Positive experience	13	24
	Telling my story	13	17
	Negative experiences	10	16
	Social life in hospital	7	11
	Emotions of being in hospital	3	7
	Becoming institutionalized	3	6
	TV	3	4
	Visitors	3	3
Emotions and experiences of illness	Methods of coping	11	18
	Physical issues	9	16
	Loss	6	14
	Loss of confidence	7	14
	Isolation, loss of social life	6	10
	Being in hospital	5	6
	Positive approach to illness	4	6
	Frustration	3	4
	Diagnosis	2	4
Arts experience in hospital	Positive experiences	11	39
	Social life	8	20
	Stimulation, new skills	9	19
	Understanding illness	1	1
	Not interested in acute phase	10	13
	First time trying arts	8	12
	No expectation	10	12
	Art teacher in hospital	3	12
	Music in hospital	5	9
	Negative experiences	4	6
Aesthetics in hospital	Noise and sharing rooms	10	18
	Pleasant environment, treated well	15	17
	Music	7	13
	No reaction or interest	8	10
	Food	5	7
	Reading	6	7

	TV	5	6
	Hairdressing	1	2
	Aesthetics of art room	2	2
	Radio	1	1
Activities post hospital stay			
i) Effect of illness on activities post hospital	Effects of illness on ability to do activities	10	31
	Physical limitations	4	10
	Loss of confidence	4	4
	Frustration and irritability	1	3
ii) Art interests post hospital	Adapting activities	12	22
	Barriers to art	10	17
	Return to same activities	10	13
	Need for social life and meaningful activity	8	12
	New arts interests	5	10
	Sedentary activities and TV	5	5
Recommendations re arts in hospital	More art courses and longer	7	17
	Link arts to clinical support	4	12
	Enhance the environment	8	10
	A room for arts in the hospital	3	6
	Arts as entertainment and distraction	6	6
	No changes or improvements suggested	2	3

The initial analysis involved presenting each of the seven themes above with examples of relevant quotations from the interviews, to verify that these themes were relevant and emerging frequently. This analysis is presented in the next seven sections (7.4.1 – 7.4.7), before moving on to further analysis.

#### **7.4.1 Interests pre hospital**

The initial interview question was deliberately broad (*Tell me about your interests, hobbies, leisure pursuits before you came into hospital*) so that arts interests would emerge if relevant but would not be prompted if other

interests were more important. Every patient named their key interests pre-hospital easily and readily (see Table 7.3). Examples of interests are written below:

*I have an interest in Yoga. I like Yoga and I still do Yoga. Not the Yoga you would be able to do but we sit in chairs. AL*

*They went to work and I looked after the children, they kept coming and I looked after them, I was busy. AL*

*I like dancing alright... the dancing that you need men for! [Laughs]. AL*

*My main hobby was hill walking. I played bridge. DG*

*I have vintage cars. I have seven. That is what I do but I haven't been out there. ...Mainly the cars, going back to when I was fifteen or fourteen. PA*

*Always, always, we both found time for the garden EM*

Following this initial question, the interviewer showed a list of arts to see if any of these were of interest to the interviewee. The following examples indicate how arts were enjoyed by participants:

*I like music myself, certain types of music, I have a guitar. I am not a very good player but I have hopes maybe at some stage of being better. BB*

*I played in the show bands, in the good old days. PA*

*I did a lot of dancing as a younger person. I did, I used to really enjoy dancing. JW*

*I used to do ballroom dancing, cycling HM*

*I love the Tallaght theatre, the Civic, I think it's brilliant and whatever plays would interest me, I would go there. I wouldn't go to anything very challenging now. But something*

*light and you could have a good laugh at it and whatever else, yes. RO*

*I always liked, and went two or three times a year, to the National Gallery and other Galleries in Dublin and had a fairly good knowledge of what was there. DG*

*I would read anything I could lay my hands on. I love reading. And I was in a musical society. MO*

There was a wide variety of interests and passions noted and it was striking that all interviewees displayed passion about their key interests and hobbies. A common theme, despite the wide variety of interests, was that whatever one's favourite leisure activity or interest was, it was crucially important and a central part of their life. This interest had normally been put on hold while in hospital and/or lost by physical illness but was the one thing the participant would like to be able to engage in again. Examples follow, showing the diversity of interests reported by participants:

*I like doing practical things. I am very good at demolition, breaking things. I bought a cottage years ago to keep myself busy. BB*

*I was more of an outdoor person growing up. I would do my work and I would do my garden and then we were off to pitch and putt in the evening and then back home from work and the two boys, the four of us walking, we were always around; if it wasn't football it was something else. EM*

*Tennis when I was young. MO*

*I used to cycle a lot. I had a racing bike. PA*

Work and grandchildren also featured as important for some people pre hospital:

*My husband was a pharmacist and it was a full time job looking after the business. Somebody had to help with it. I*



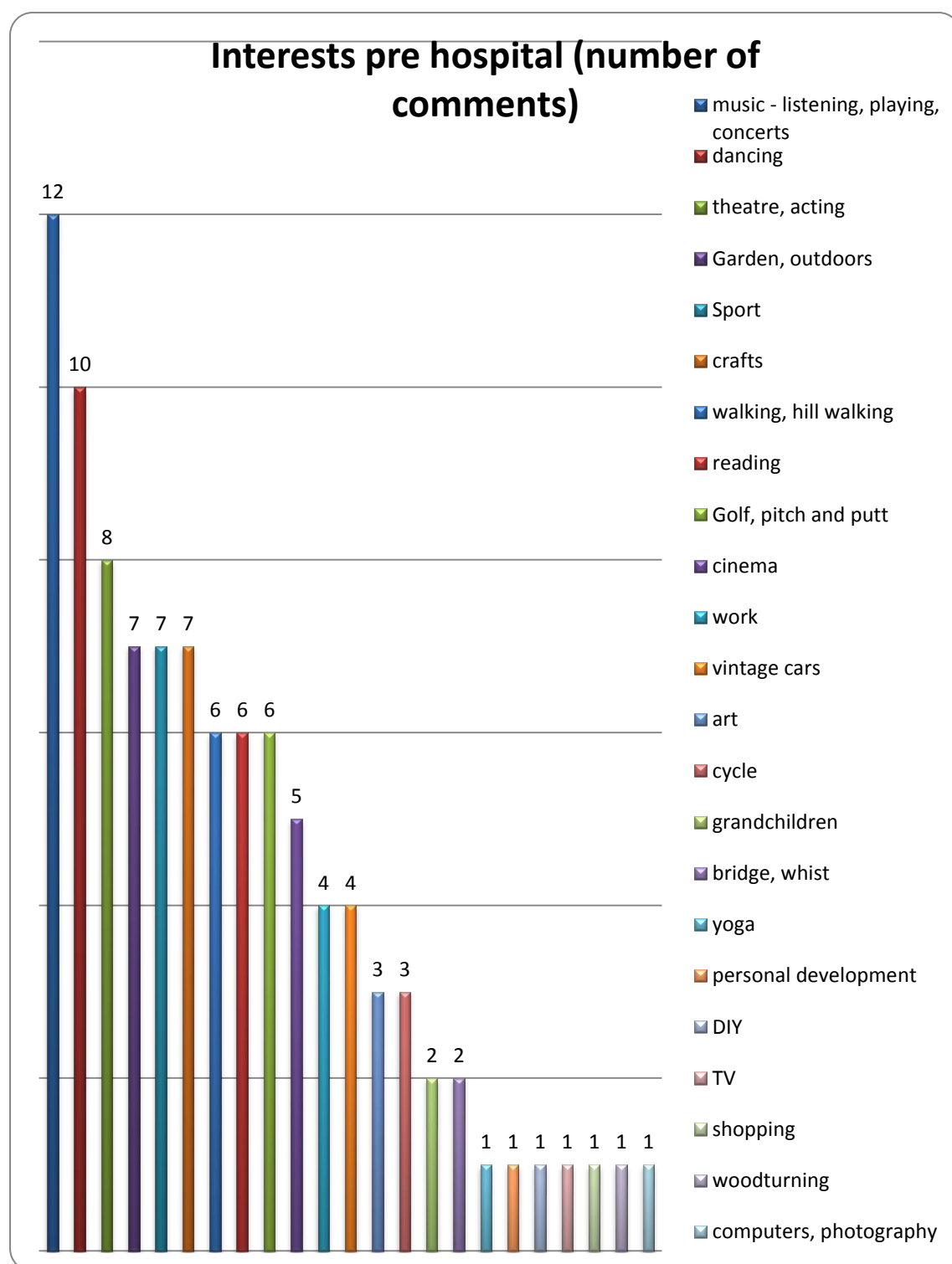
*did pharmacy as a mature student then. I qualified as an assistant. MO*

*Mainly it was art because I was involved in the lighting and I was a stage lighting designer as well. So, working on the movie industry and working sixteen or seventeen or eighteen hours a day so you have no time to do anything else. PF*

*I think I really got caught up with the children and the grandchildren AL*

Table 7.3 details most popular interests pre hospital.

**Table 7.3 Interests pre hospital**



### 7.4.2 Experience of hospital

Patients were asked a broad question regarding their experience of hospital. Telling their story was important, with most patients giving quite long descriptions of their illness and hospital visit. This was categorised as a theme because so many patients needed time to tell their individual story of their hospital experience, before they could move on to discuss arts or aesthetics. Stories were usually general, for example, about hospital care or being brought in an ambulance, rather than focusing specifically on arts or aesthetics. These can be broadly divided into positive and negative hospital experiences. Examples of positive hospital experiences:

*I found everyone very good; I certainly wouldn't have had any reason to complain. BB*

*I got extremely good treatment by terrifically expert people. Generally speaking the facilities, food and drink and accommodation were quite good. DG*

*The kindness. If I ever asked a nurse to do things for me - you wouldn't be putting on them because there was too many with strokes in my ward and you wouldn't put on them. You got up and did whatever little thing you could, but they were so kind and it wasn't just one. EM*

*You weren't able to shower for the first week or so and I was brought down and showered and they were really good. I could never say anything bad about them. EM*

*I found with the Tallaght Hospital that they were absolutely brilliant people, really, really nice and couldn't do enough for me. I was so impressed. I will always be so grateful because I feel they gave me back my life quite honestly. VC*

*I felt very cared for ...they couldn't have been nicer to be quite honest. The experience was very, very good and very positive. VC*

Examples of negative hospital experiences:

*I came in to A&E and I was in A&E for five nights on a trolley. It was horrible. I didn't like the A&E. I hope I never have to go back to it again. It was horrible. You were left on the corridor. The trolleys were really, really high and I couldn't even get up and down off the trolleys. I didn't like that about it. MB*

*When I was diagnosed with arthritis there was no counselling in the hospital which there should be ... I felt the physiotherapist was very abrupt with me. My attitude was that the people in physio should have had rheumatoid arthritis to know what the pain is like. They were too strict and I felt like they were picking on me. PF*

*I felt they have always been cooperative and – the only thing is – sometimes I feel that the long wait in the surgery – downstairs, you know for... your doctor, it is – one day I was here at 2 o'clock and I didn't get out of here until twenty to eight. That is ridiculous in anyone's books, do you know what I mean? RO*

*There was one fella alright there, a Priest; all he wanted to do was get out. God almighty he had us all plagued. The middle of the night he was like – I think I should go home now. Not that he was stupid or anything but he didn't like it until they told him he could go and we were all delighted at the end of it. TM*

*Just after my operation I was given a meal and there was 'nil by mouth' over my bed and as a result of that I had a significant stroke. Luckily enough a Doctor was passing by my bed and I feel that he saved my life. VC*

Other themes mentioned were the importance of social life, TV and visitors in hospital, the emotions of being in hospital and the institutionalization that comes with a long stay.

*When I went to the hospital first I thought it was just a normal check-up and he said – sorry, I have to operate on you and I was upset completely AL*

*I felt I was losing my independence. When I couldn't get out of the bed and I had the knee operation. I thought I could move towards the locker and then you feel you are losing your independence. It is an awful feeling. AL*

*(Being in hospital) can be worrying, you know, but I won't let it worry me, do you know what I mean. It is anxious. RO*

*I think I was angry and I wasn't in a fit state; with people I tended to feel angry. I had a short fuse. VC*

*I think I was angry. This is some sort of a dream and I am going to wake up, this is a nightmare. I hadn't expected it. It was a like a shock out of the blue. VC*

*Your concentration span is low and I think when you are in a hospital anyway, I think you have this institutionalised kind of thing, you know. RO*

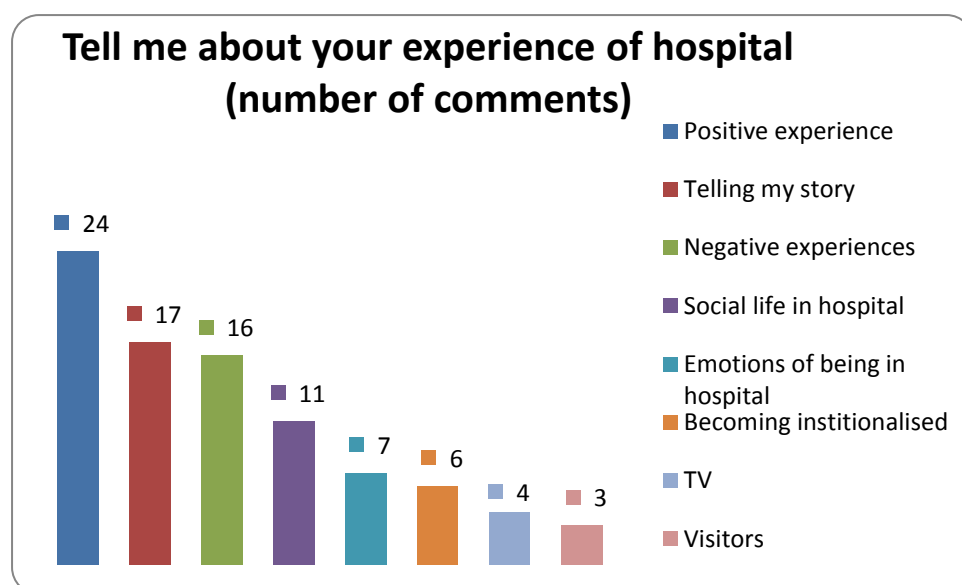
*I would hate to be institutionalised and I feel sometimes – even a week in the hospital can make you kind of feel that – especially the second week – when you are maybe feeling a little bit better, you have no structure – you are just there and you have nowhere to go... you have no choices RO*

*You usually get enough conversation in hospital from other patients and that will keep you going. TM*

*I made some friends – but you see the ward I was on, they were a very nice group of people. They were lovely. AL*

See Table 7.4 for frequency of comments arising under this theme.

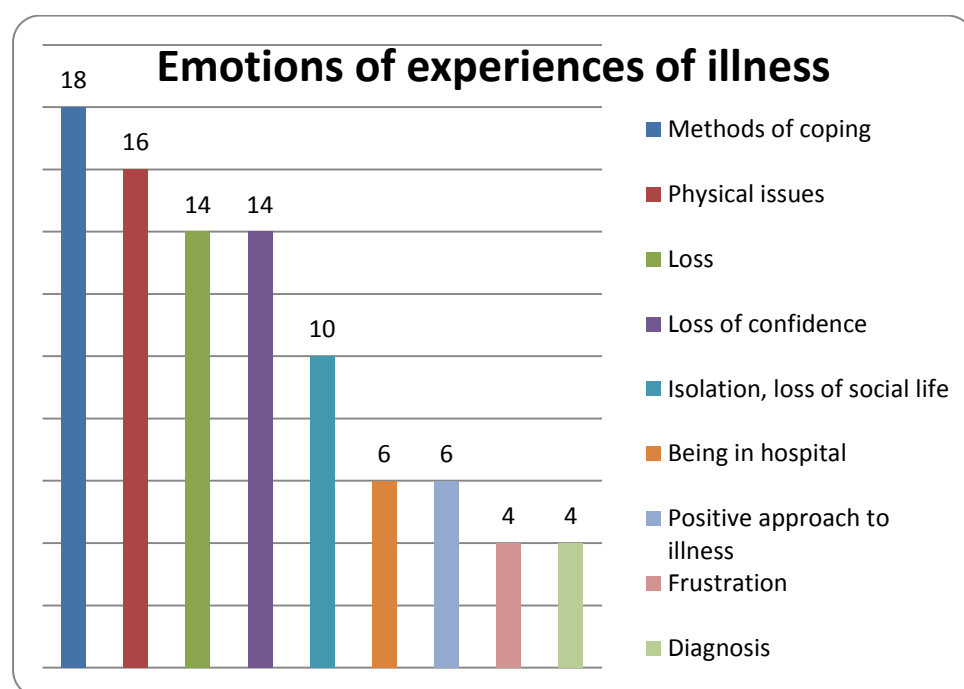
**Table 7.4 Experience of hospital**



### **7.4.3 Emotions and Experiences of Illness**

This theme arose due to the many comments about how people felt having an illness and the experience of being in hospital. The key themes arising from this section were loss (of confidence, motivation, social life, work and hobbies) and the impact of physical issues on their life and activities, including loss of arts and leisure pursuits. Methods of coping were discussed by patients. Table 7.5 sets out frequencies of comments under the theme of emotions and experiences of illness.

**Table 7.5 Emotions and Experiences of Illness**



Comments about this theme included:

*I think when you have a sickness or an illness.... I think you lose your confidence. The confidence isn't as good as I would like it to. RO*

*Did you stop doing golf after your stroke or did you carry on? I felt like I couldn't walk that much. That is the feeling I have, I have never tried it. TM*

*You can't socialise anymore. I miss - all my mates are gone, they don't know if I am alive some of them because you do have pub mates and you have real mates. ... I can't play with my grandchildren, I can't lift them up. They run at me and they hurt me but I can't tell them that. PF*

*It is harder to do everything when you have arthritis. It is harder to go up the stairs. AL*

*Do you miss the garden now? Yes, oh yes. Even running my fingers through the clay, but as I say I couldn't do it now. EM*

*I think I miss the golf badly. I can't hit a club anymore, or hit a ball, because the vibration of the club up through my wrists would be terrible. PF*

*Just about your stroke, do you feel it has changed your life at all? Yes it has of course. It has cut off my walking. It has cut off the freedom and the ease of which I went into town and did things, like meeting my friends and so on. DG*

*You see when you have arthritis you do suffer with pain and if you are going to a class and if you have pain before you go you are taking Panadol or something like that and the motivation wouldn't be the same as if you were well in yourself. AL*

*The motivation is not there because it is easier to mollycoddle yourself and say – 'that is a bit hard now I am not going to go.' I think if someone just knocked at the door and had a car and just drove me to the place I would be fine. AL*

*I am very curtailed in what I can do because I have Parkinson's disease and I can't move around as good as I used to. I used to love walking but I can't walk now. MO*

*Every day is a nightmare when I wake up because the first two or three hours are horrendous, the pain. The worst thing is trying to put on my shoes and my underpants which is a simple thing but it is not when you have got rheumatoid arthritis. PF*

Participants described their methods of coping and it was noticeable that a positive approach to coping with their illness or new limitations was taken by some:

*My husband is saying – let's live for today. Every day is very health conscious, go for a walk, it wouldn't be just time in the park it would be go for a nice picnic because my husband is retired as well. VC*



*Certainly my illness has changed me. I kind of implied that earlier on in terms of the exercise and the nutrition and so on and I mean I would be far more conscious now; I am energised in another way PO.*

*It was okay (hospital stay). I had no problem adjusting myself to what is happening. If there is a bad situation, I make the best of it. I don't let things worry me. There is always ways to solve it if you have the patience and the time. PA*

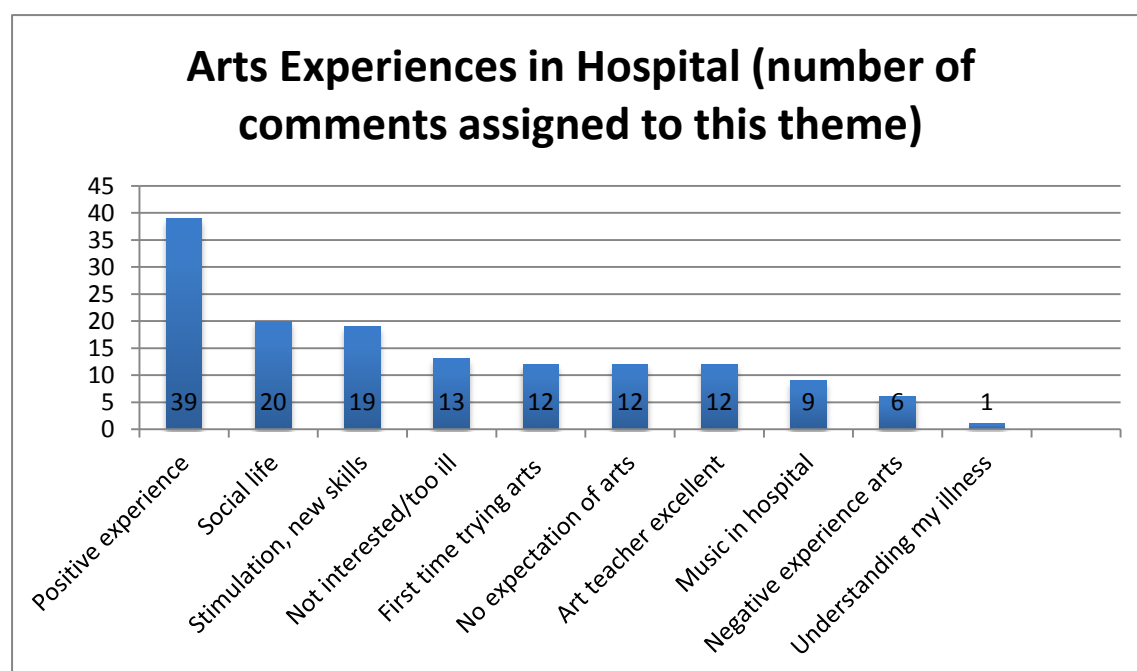
*You see, when you are in hospital like that you go into a different zone. There is no point in worrying about something that you want to do. You have to go to the zone that you are in the hospital, it is for a reason that you are in there. You have to do what you are told and if you don't you won't get better. So therefore, my aim is to get better and get out of the hospital. AL*

*I have to fight it and I have to live with it (arthritis) PF*

#### **7.4.4 Art experiences in hospital**

There were a very large number of positive comments regarding the arts in hospital. These included the social life of participating in arts, stimulation, acquiring new skills and gaining greater understanding of illness through art. 79 of the total 143 comments on art experiences in hospital were these positive comments, which was a very high number. Table 7.6 sets out frequencies of comments under the theme of art experiences in hospital

**Table 7.6 Art experiences in hospital**



Comments about the positive experiences of arts in hospital included the following:

*When we did the art appreciation I thought that was very, very good. It was a real eye opener because I had always been interested in art. I thought it was a great, great course. All in all I was so impressed. I felt that Tallaght Hospital cared about the patients ... with courses like this it does make people feel that they are important. Their aftercare is so important as well. VC*

*I think people need those sorts of things. I saw people on the courses and they just seemed to bloom. They were closed and then they were like flowers and they were opening out and it was great. The quietest person, in the long run, was very open and sharing and nice. PO*

*We have a monthly (woodturning) meeting and even in the times when I wasn't at the lathe because I kind of felt, 'Maybe this is bad for me' or something like that, I would still go to*

*the meetings because of the social milieu, you are meeting lovely guys. PO*

*I hadn't anything else to do and I said that I will have to get off my ass and try and meet people. It was interesting...But rheumatoid arthritis – it takes a lot to be sociable because of the pain. Something really has to hold your interest and the watercolours and the creative writing coach held my interest and it helped me in a way because I forgot about my pain when I was doing that. And getting involved with the exhibition here with the model that I did - that was a bit of fun. PF*

Some patients in the acute phase of illness felt that arts were of less interest than when recovering. It was also noted that there was low expectation that arts would be offered in hospital. Experience of arts in hospitals is very low. For many patients this was the first time they tried art in hospital.

Did you expect to have music or art when you were in hospital? No HM.

*It was just that I wasn't in the mood for reading. Because I was up I walked around. Up and down the corridor and that. I didn't spend much time reading because we had television and you would watch television. NW*

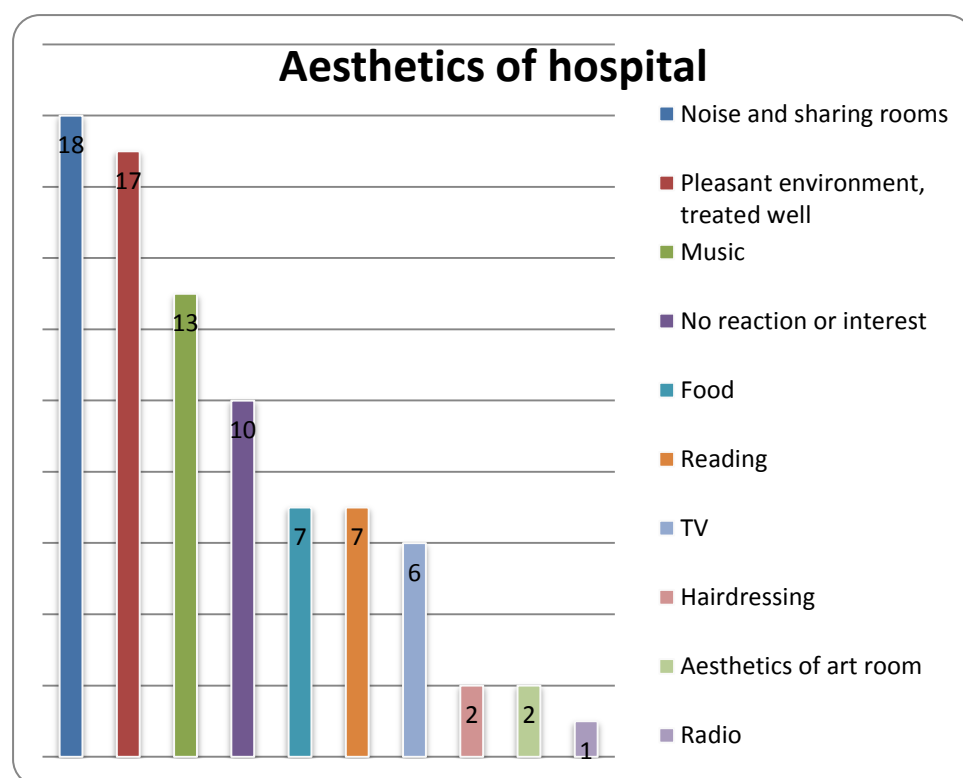
*I would bring my book but I couldn't concentrate on it. .... I couldn't concentrate on anything, no. MS*

Did you have any expectation that you would have any art or music while you were here? No. Generally speaking I find silence the most precious thing around. You never, ever get silence wherever you are. There is some tin can playing in every supermarket and every house and every bloody place you go and I hate it. DG

#### **7.4.5 Aesthetics of hospital**

Comments on the aesthetics of hospital were limited unless prompted. This section was the one which took most prompting by the researcher. It was perceived that without prompting there would have been few comments about the aesthetics of the hospital (e.g. design, artwork, fabrics, food, noise, access to reading, music). Patients were more interested in talking about life and their interests pre hospital, or telling their story of hospital in terms of the drama of illness, emergency transfer and treatment. This question was introduced following the pilot interviews to focus specifically on this question as it was not arising in response to other questions. General prompt questions were given where nothing was raised (for example, *What was your impression of the hospital? Did you notice artwork, music while in hospital?*). Participants were more likely to talk about their arts interests pre and post hospital stay than any in hospital. When prompted the themes that emerged included that the hospital was generally a pleasant environment and the food was commented on relatively frequently. Some noticed the art on the walls. Table 7.7 sets out frequency of comments regarding the theme of aesthetics in hospital.

**Table 7.7 Aesthetics of hospital**



Reading and listening to music were the key aesthetic experiences in hospital, and noise and sharing rooms featured most heavily as a problem. The noise of other patients in particular featured as an issue for some patients. Silence was also mentioned as important to one patient. Then again, one patient wanted to be in a room with others and became quite depressed on his own in a private room. The choice (or lack of it) of room or ward space arose as an issue, as well as the way people cope with the situation they find themselves in and whether they accept the situation or become annoyed by noise or other disturbances. Comments from participants included:

*There were no pictures of any kind in the ward. The corridors were well sorted out with pictures. They were all along and were quite interesting. So, you noticed the (art), you saw them? Yes, very much. I had a lot of time to walk around the corridors. DG*

Do you remember anything about the colours or the furniture or the decor? *No. They were all the same. TM*

Do you remember any artwork on the walls or would that be not relevant to you? *No. No. I don't remember that. MS*

*I suppose my privacy taken away would have been one of the biggest bug bears I must say. There were people who were complaining about the window being opened and my bed happened to be at the window. I had about six blankets on. It is quite difficult in that situation to be very tolerant as well although I am a very tolerant sort of person. VC*

*I was sharing a room with a very bad patient. But I put that by, I thought I am in to get well and that was it. She had some kind of machine going all night and we only had a screen between us. I was lucky to get in there. I was there to get well so I ignored it. NW*

*If it was very noisy in the day you would not be reading much. NW*

*They used to have the telly on (in the ward) and you'd want to be interested in it, they'd have it on all day. Well (at home) I listen to music; I do put the radio on, but not TV. I listen to music all day in the house. HM*

*I felt good listening to music and had (my) own choice of music. JL*

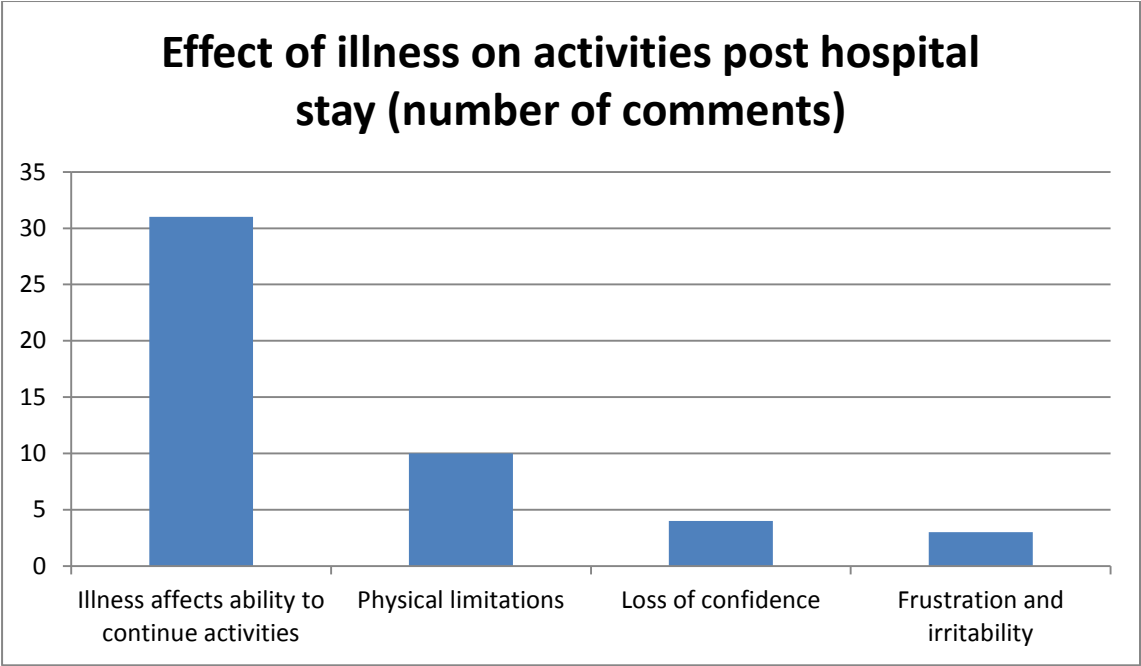
*I love listening to music. TC*

#### **7.4.6 Activities post hospital stay**

This theme can be split into two sections, the effect of illness on activities post hospital stay, and the change of arts activities post hospital stay. A large number of comments were coded as 'the effect of illness on activities post hospital stay'. The two major issues for patients were physical limitations and loss of confidence. These affected their ability to continue their leisure

activities and the arts interests they enjoyed. Over 50% of interviewees felt that physical barriers now existed so that they could not continue their activities as they used to and the majority cited physical issues and effects of illness on ability to continue activities (see Table 7.8).

**Table 7.8 Effect of illness on activities post hospital stay**

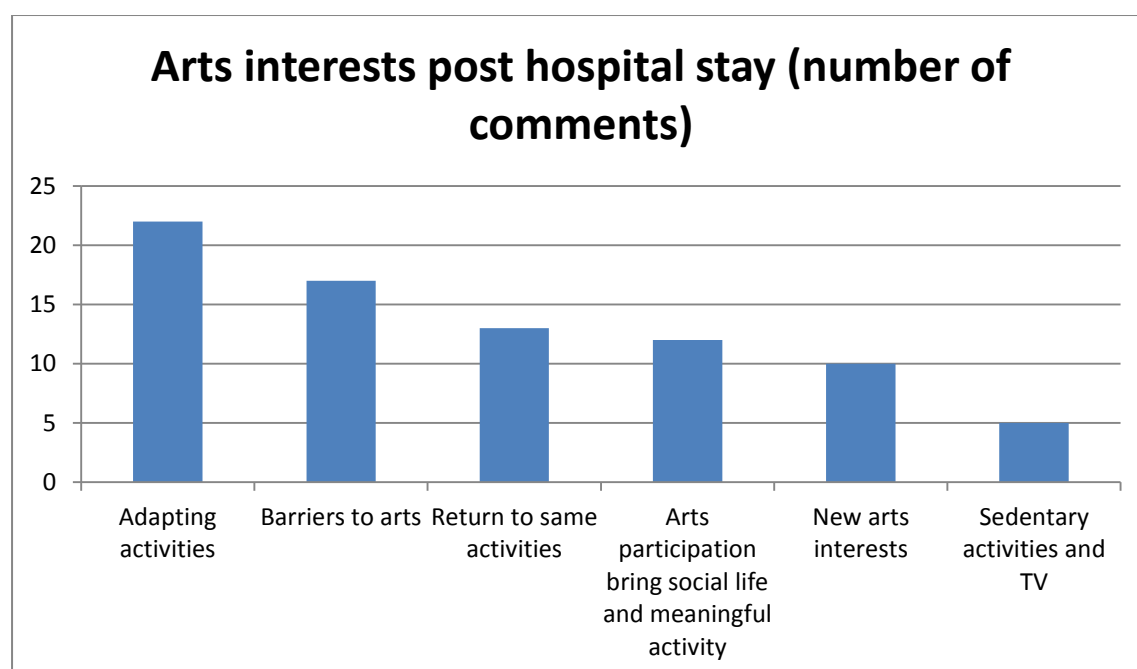


Some patients adapted their leisure interests to account for their new physical limitations, for example, taking up new arts activities that are sedentary (for example, taking up painting or attending a choir when giving up playing golf). Others were able to return to their activities and this depended primarily on the type of illness they had. Longer term chronic conditions (for example rheumatoid arthritis) affected patients’ abilities to continue activities, whereas acute conditions (such as heart attack) were followed by a return to normal activities. Loss of confidence in physical abilities affected many patients, whatever the illness.

Over 50% of patients said they had adapted their leisure and arts activities post hospital stay. 50% cited barriers to engaging in arts (for example not being able to access venues as easily). It is interesting to note that a large

number of comments were collected regarding the importance of a social life and meaningful activity post hospital stay. This was an important motivator for many of the interviewees and led some to participate in arts activities as a way to maintain or find new meaning when favourite activities became more difficult (See Table 7.9).

**Table 7.9 Arts interests post hospital stay**



Comments from participants included:

*I felt I couldn't remember and that was worrying now that was definitely worrying. I could not remember. And I took up bridge, so I play bridge now every – in the last year or so I am playing bridge every Tuesday night and I am back at swimming. RO*

*I wouldn't even go outside the door after hospital, I was just too nervous. MB*

*But you see I think when you have a sickness or an illness, especially with the problem here I have, I think you lose your confidence. The confidence wasn't as good as I would like it*



*to be. In the past when I did all those things I was as good as the best. AL*

*I get tired, it is a contradiction but rheumatoid arthritis, it really gets you fatigued out. I used to go to the pub of an evening and I would stay there till eleven or twelve and come home and have a bottle of wine or something. Now I can't stand being after nine or ten o'clock at night. PF*

*I don't have many hobbies now, I can't get out, I am housebound. My hobbies would be gardening, mostly gardening. When I was able I used to. I do nothing at the moment. NW*

*Even though I am only ten minutes from the LUAS, to walk to it is a nightmare because there's something wrong with my foot. PF*

*We had a trip planned to Scotland in June. I had to cancel it, I was afraid that I wouldn't be able for it. I thought I might be a nuisance to everybody. MO*

*My social life is very limited because I don't enjoy getting ready to go out because of the aches and the pains even though I am on medication. PF*

*I've nothing to do all day, only getting up, have my breakfast, have my next meal and then have dinner at night and go to bed and so on, it's a terribly boring situation. DG*

*The thoughts of going out put me off - I have to be delivered everywhere. PF*

*I think that really it took a while to return to normal. I am sort of back gardening and doing things. VC*

*You get very frustrated... I go out and walk up and down but you are tired. EM*

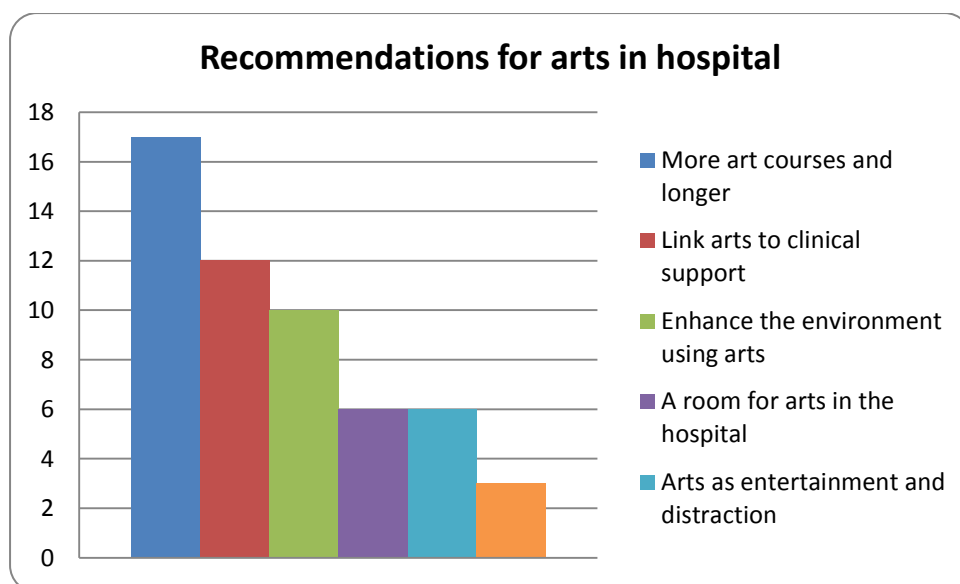
*Do you ever go to see a play? No, I couldn't sit that long. It is such a chore for me to get into the car or anything like that. It is such an effort. I would rather stay at home. NW*

*I don't do the things I used to, the gardening was what I could do and that was my passion. It's a big loss. It is too heavy and there's nothing I can do. You see I'm eighty plus now, I was eighty at the end of the year and there's not a lot I can do at my age now you know. And you listen to the radio? I love the radio, yes I love the radio, it's my life and I love that. CW*

#### 7.4.7 Recommendations regarding future arts in hospital

Participants had plenty of recommendations regarding future arts programmes and aesthetics in hospital, despite not having expectations or experience of arts while an in-patient (See Table 7.10).

**Table 7.10 Recommendations regarding future arts in hospital (number of comments)**



Comments included:

*I would have liked to have had the strings with me but the problem then of course is that you would need to be in a room where no one can hear you and fiddle around. You need privacy and well, okay, I was in a private room but I am not so sure that if you were in, let's say a semi-private or a public*

*room, that you could do play a fiddle or something like that.*

*BB*

*My sister came to visit me and we had a very good room that you could go and sit in and read. I used to bring my books up there and read. A quiet kind of room. Yes so you could get away from the bedroom. NW*

*I would have loved arts and music. The hospital wouldn't have time for that now. But I would, I definitely would now. A special room that we could go down to would be absolutely brilliant. AL*

*I must say when I was in hospital, when I was waiting, it was a pretty tense time...it was a waiting game and it would have been nice to have something like art or music, entertainment. VC*

*If people are going to get involved in the arts or whatever I think there should be counselling beforehand to say – what one do you want or how are you? What is life like and what are you doing? And then tailor it to fit. And then say – would you like to try one of these arts activities and give them a list or whatever. That is a really good idea. Because it is that suicidal effect which is horrible. I never want to go through that again. PF*

*The only thing I would say (about art for patients) is the more the merrier. Now, I have never been involved in pictorial art but I came that day to the hospital event, down in the room downstairs, where people's artwork was on display, and I just got the feeling of how health-promoting, how productive, how important this is for wellbeing, you know on a whole variety of levels. PO*

*Do you think there is anything you would have liked in hospital that you didn't have? Any changes that you would have liked? No, I didn't need anything now. We had plenty of books to read. There were loads of books. NW*

## **7.5 Grouping into units of relevant meaning and identifying emerging themes**

Following the initial coding and preliminary analysis (7.4 above), the next two steps in Van Manen's analysis are 'Grouping themes into units of relevant meaning' and creating 'Emerging themes'. The initial themes were thus grouped into units of relevant meaning (i.e. words and phrases that illuminate the research question and seemed most important). Various smaller codes were here grouped together and clusters created into seven major themes. These emerging themes were written as preliminary descriptions (the descriptive writing is an important element of Van Manen's method). One pertinent quote from the data was assigned to each of the seven emerging themes and these themes were then tested and validated in further sections (Van Manen, 1990). These two steps are described in detail here.

### **7.5.1 Grouping themes into units of relevant meaning**

Initial codes emerged easily from the open coding and preliminary analysis. Certain codes attracted more references and initial themes began to overlap and merging some was possible. In this stage of the analysis, it was possible to eliminate minor codes and merge some codes. For example references to *Music* under both the codes 'Aesthetics' and 'Arts experiences in hospital' were merged, as were *Loss of confidence* references under both 'Emotions and Experiences in Hospital' and 'Effect of illness on activities post hospital stay'. The summary of codes created in this section is presented in Table 7.11.

**Table 7.11 Grouping themes into units of relevant meaning**

<i><b>Theme</b></i>	<i><b>Number of patients</b></i>	<i><b>Number of comments</b></i>
Interests pre hospital	18	27
Loss	18	58
Recommendations re arts in hospital	15	49
Music	14	32
Positive experiences of arts in hospital	11	60
No interest in art in acute phase	10	13
No expectation of arts in hospital	10	12
<ul style="list-style-type: none"> <li>First time ever doing arts</li> </ul>	8	12
<ul style="list-style-type: none"> <li>No reaction or interest in aesthetics in hospital</li> </ul>	8	10
Reading	8	12
Aesthetics in hospital		
<ul style="list-style-type: none"> <li>Pleasant environment and treated well</li> </ul>	15	17
<ul style="list-style-type: none"> <li>Noise, sharing rooms</li> </ul>	10	18
Impact of my illness and hospital stay		
<ul style="list-style-type: none"> <li>Physical issues</li> </ul>	13	26
<ul style="list-style-type: none"> <li>Methods of coping</li> </ul>	12	24
<ul style="list-style-type: none"> <li>Effects of illness on ability to do activities</li> </ul>	10	31
<ul style="list-style-type: none"> <li>Social life in hospital important</li> </ul>	6	10
<ul style="list-style-type: none"> <li>Emotions of being in hospital</li> </ul>	4	10
<ul style="list-style-type: none"> <li>Becoming institutionalised</li> </ul>	3	6
<ul style="list-style-type: none"> <li>Arts interests</li> </ul>		
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>Adapting art activities</li> </ul> </li> </ul>	12	22
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>Return to same arts activities</li> </ul> </li> </ul>	9	12
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>Sedentary arts activity and TV</li> </ul> </li> </ul>	5	5
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>New arts interests</li> </ul> </li> </ul>	4	8

### 7.5.2 Emerging themes

Descriptive written paragraphs were created around the seven core themes. These themes are now presented; these are the themes that were believed to be the key to the essence of the phenomenon, given the analysis to date. These were then further validated and tested in further sections of the analysis.

### 7.5.3 Theme 1: Interests and passions

Everyone interviewed had a key interest or hobby and a major passion or interest. All interviewees cited an interest in at least one art form and all could name one or two key interests, whether arts or other leisure activities. The most popular interests were music, dancing and theatre. These art forms were rated as the most popular interests by participants, even more popular than other leisure activities such as golf and walking. No prompting was given regarding arts versus other leisure activities, yet these three art forms were named the most popular. Walking and gardening were the next most popular interests.

The most interesting aspect of this part of the interviews was the energy and passion with which the interviewees all described their favourite activities and leisure pursuits, whether arts or otherwise. It was noted that this passion or interest was experienced as an important part of the person's identity and individuality and these interests are what people want to be able to access in hospital. It is also of note that some art forms (i.e. music, dance, theatre) are a universal interest among participants.

*Oh I love music. I was into old time (dancing). I think I danced seven nights of the week. Oh I loved it. MS*

*I am a very creative person and I knit quite a bit ... I am always anxious to get back to my knitting... I would be interested in what new yarns are coming on the market. I can't wait to go and get my few balls of the latest. I have an accumulation of scarves and things and now I am thinking – should I get a market stall or how will I market my knitwear? ...I do find that it goes everywhere with me. It goes on the Luas. I always have knitting with me. I did before hand; I would be sitting beside a lady on the Luas and I would end up selling her a copy of the patterns and exchanging... VC*

#### **7.5.4 Theme 2: Loss and the impact of my illness on my leisure activities**

Many patients described losses associated with being ill and in hospital. Loss of confidence in their bodies, resulting from stroke or major cardiac event, loss of interests and hobbies, the loss of not being able to work, missing friends, loss of social life, activities and interests such as sports or gardening and not being able to be physically active with grandchildren were cited as key losses experienced by patients. Other losses include the physical limitations of ill health such as having poor memory, not being able to see very well, not being able to walk and get out to the theatre or films. Physical barriers to accessing places (such as poor mobility) impacted on social life, ability to work and to access arts venues.

Many patients described the emotional impact of their loss, experienced when in hospital or very ill at home, as well as the frustration, irritability, anger and/or anxiety associated with a loss of control over one's own life and abilities. This loss, and the associated emotions surrounding a stay in hospital and a major illness, affected engagement in arts. Participants put their arts interests on hold while in hospital, or lost the ability to pursue them, or took up new arts activities post hospital as their ability to engage with arts they enjoyed, such as dancing (which eight of the interviewees cited) was too physical and they needed a more sedentary activity or as a way to meet people.

Eighteen of the twenty participants made reference to loss and 58 references were coded to this over-arching theme. It appears that this theme centres around the social and emotional aspects of illness, which might be an area where arts interventions can have relevance.

*It was a horrible experience when I discovered that I had this. Before that I had been in hospital with other things but to be told that you have rheumatoid arthritis is like being told that you have cancer. I was always a jolly guy and I was going to the pub four and five times a week and meet me mates and go for golf, I can't do those now. My social life is very limited*

*because I don't enjoy getting ready to go out because of the aches and the pains even though I am on medication ... Every day is a nightmare when I wake up because the first two or three hours are horrendous, the pain. The worst thing is trying to put on my shoes and my underpants which is a simple thing but it is not when you have got rheumatoid arthritis. Against that I have to fight it and I have to live with it. Doing the courses, doing the watercolour courses and the painting and doing the writing helped. From the writing one I think I am going to get a little small book published. PF*

### **7.5.5 Theme 3: Low expectation of arts in hospital**

None of the patients expected to have access to arts of any kind in hospital. Many of the patients took part in new arts activities in hospital that they had never tried before. Engaging in arts in hospital was almost universally a surprise and unexpected. Participants did not articulate a deprivation regarding arts in hospital (although none of those interviewed had successfully continued arts interests in hospital other than reading or listening to music) but did comment about how beneficial arts were when they did access them.

*I didn't expect to have any art in hospital. No. I mean I had never heard of it until I got the letter to see would I come up here and do it. JW*

### **7.5.6 Theme 4: The positive impact of arts in healthcare – arts made a difference to my recovery**

Those who did experience arts as part of their in or out-patient experience had many positive experiences of arts, most particularly in feeling cared for, the increased socialization that came from this activity and the discovery of new interests and achievements at a time of great anxiety and loss. There were a wide range and large number of positive experiences associated with engagement in arts either in hospital or during recovery from a major



trauma. Eleven interviewees made positive comments regarding arts in hospital and there were sixty references overall recorded to this theme.

*I thought it was a fantastic thing for Tallaght Hospital to put on these courses for people. I had done creative writing in the past. At first I thought this was like homework but then I thought no, this is very, very good. You just become engrossed in it and sharing ideas I thought and meeting people which is really nice. VC*

#### **7.5.7 Theme 5: Arts activities varied according to phase of illness – less importance attached during acute phase of hospital stay, receptive arts activities more relevant at this stage.**

Eight of the ten patients who had participated in arts in hospital indicated that arts were not very important to them during the acute phase of hospital. Even though there was low expectation of engaging in arts in hospital, many who had experienced arts in hospital felt that they would not have wanted arts at the most acute phase of illness as they were too busy coping with tests and treatment. They expected to put aside 'normal life' while in hospital. Participants described the emotional support they experienced through engagement in arts and identified arts as more relevant during rehabilitation or recovery phases. The arts associated most with the acute phase were reading and listening to music. The relevance of arts activities varied according to length of stay and type of illness.

*In the hospital ... I'm not so sure you are able or interested in it (arts) because I was lying in the bed for a couple of days ... some bug developed down there. In the mornings, do you know, when you're in a bed you twist and you turn, you're making yourself comfortable and then after a while that comfortable position no longer is comfortable. ... So you don't think music or anything would be really very useful to you in that situation.... No, I think at that stage you're kind of feeling a bit sorry for yourself. BB*

### **7.5.8 Theme 6: The aesthetics of hospital - noise, sharing rooms, social life in hospital**

The aesthetic environment of hospital was not of major concern to most interviewees, but when prompted patients commented on this aspect. Food, noise, sharing rooms and crowding were the most common unprompted comments regarding aesthetics. Patients were more likely to comment on the nursing and medical care than the physical building, with a high number of positive comments about the care they received. Many did not remember the art or colour of the room they stayed in and were more focused on the social life of the ward and visitors.

The significance of music and reading was apparent. Noise and sharing rooms were the most significant issue of anti-aesthetics, with the predominance of television in the wards being both loved and loathed. Overall this was not an area that attracted many comments, patients were more engaged in talking about the arts that they loved and engaged in outside of hospital.

The most commonly cited activities while in hospital were watching television, listening to the radio, listening to music and reading. As patients recovered, or began the longer process of adapting to ill health, they were more likely to cite benefits from engaging in creative participative activities such as writing groups or art classes. It seems important to be attentive to the role of receptive arts (listening to music, reading) during acute phases and perhaps offer a more interactive arts programme during recovery or longer term illness.

*This is my third trip to this day hospital and on one of the other trips there was a lot of music and young harpists came in. They were greatly appreciated because it's a terribly boring place up there, it's very boring indeed because everybody has to be looked after and it takes a lot of time and they can't seem to mass produce the results they have to do it in great detail, which from their own point of view is the only way to*

*do it, but from a patient's point of view it's a disaster..... And you would have found the music enjoyable and beneficial?....Oh absolutely, absolutely....I mean that, one of the best memories I have is the day they put on some Bach music in their music group, the harps, I can't remember who they were. DM*

### **7.5.9 Theme 7: Some changes can be made to improve my experience of arts in hospital**

Patients who had experienced arts in hospital asked for more arts activities in hospital and felt they were important. Those who had not experienced arts had many ideas about improving the aesthetic environment. More live music, a quiet room to use for reading or meeting visitors and a relaxing space on the ward were cited as important improvements that many would have liked in hospital as well as less sharing with disturbing patients.

*When we did the art appreciation I thought that was very, very good .... It was a real eye opener because I had always been interested in art .... I thought it was a great, great course. All in all I was so impressed. I felt that Tallaght Hospital cared about the patients. It wasn't just a question of – oh yes, come up now for an appointment – every year I come to Tallaght Hospital – but with courses like this it does make people feel that they are important. Their aftercare is so important as well. VC*

## **7.6 Further analysis - Arts vs. Non arts**

Further analyses were undertaken to test the validity of these seven themes. Differences between the ten patients with experience of the arts programme, either as in or out-patients (arts) and the ten without any experience of the arts programme (non-arts) were explored in detail. This analysis explored whether engagement in the arts groups in hospital affected the findings or

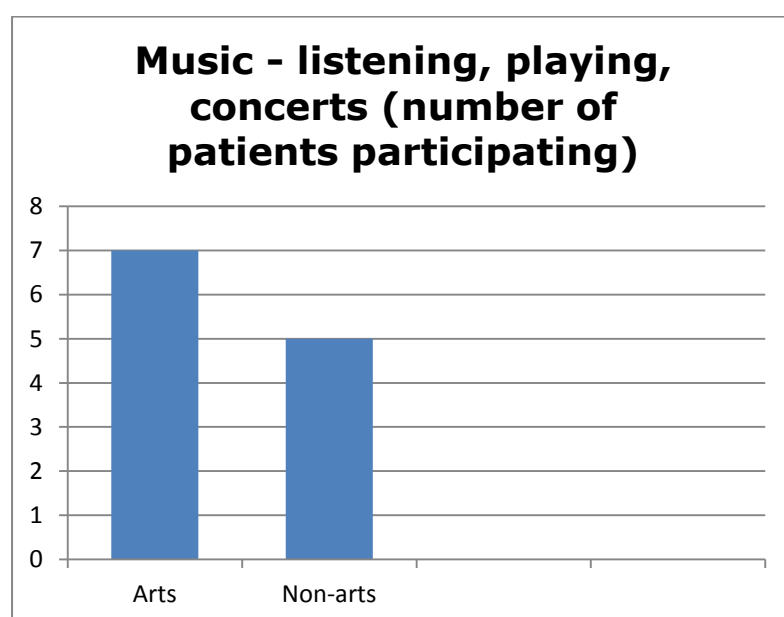
offered any further significant findings. Specifically, the data chosen to examine further was:

- The three most popular pre hospital interests – music, dancing and theatre
- Aesthetics of hospital – low expectation of arts in hospital, no reaction or interest in aesthetics, noise/sharing rooms, music, reading, not interested in arts in acute phase of illness
- Loss – Isolation/loss of social life, loss, loss of confidence
- Post hospital – Barriers to accessing art

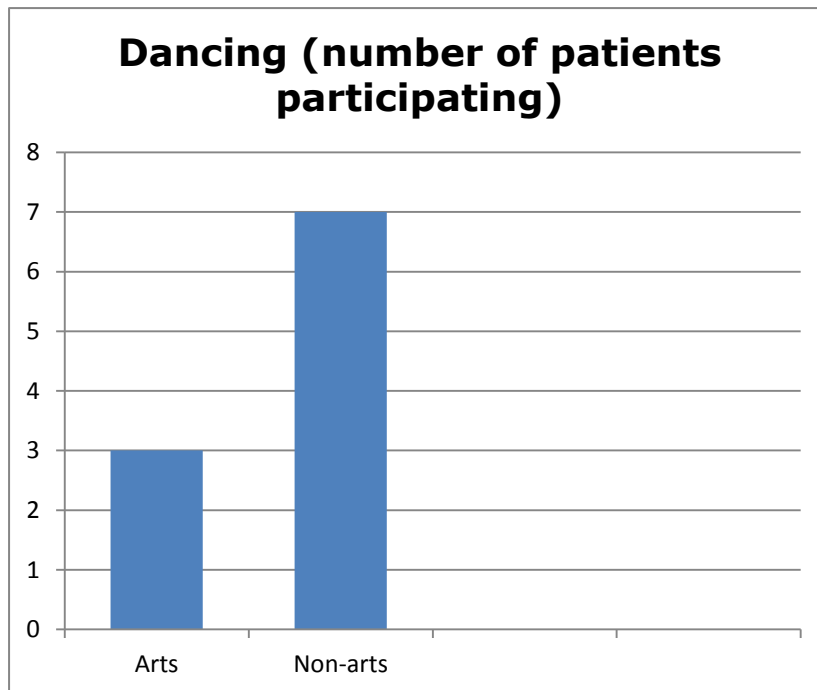
### 7.6.1 Pre hospital interests

The three most popular leisure interests (music, dancing and theatre) were analysed to see how comments were distributed between the groups who participated in arts and those who did not (See Tables 7.12, 7.13 and 7.14).

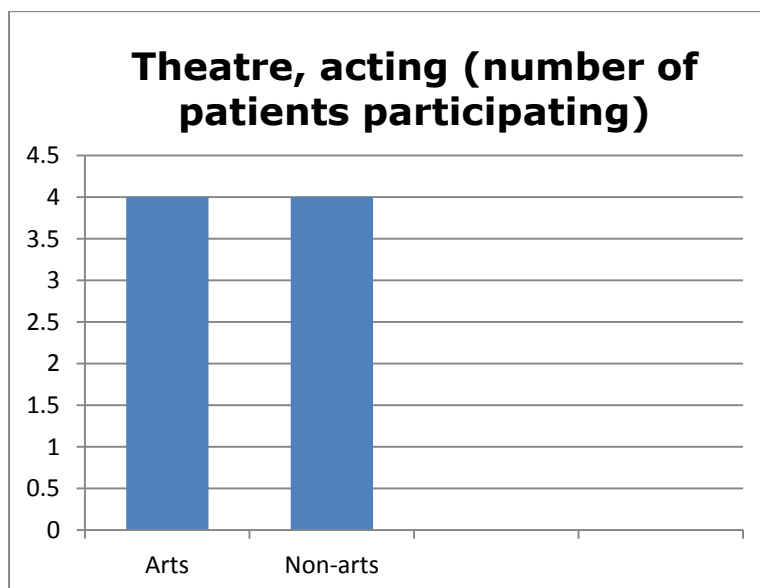
**Table 7.12 Music**



**Table 7.13 Dancing**



**Table 7.14 Theatre**

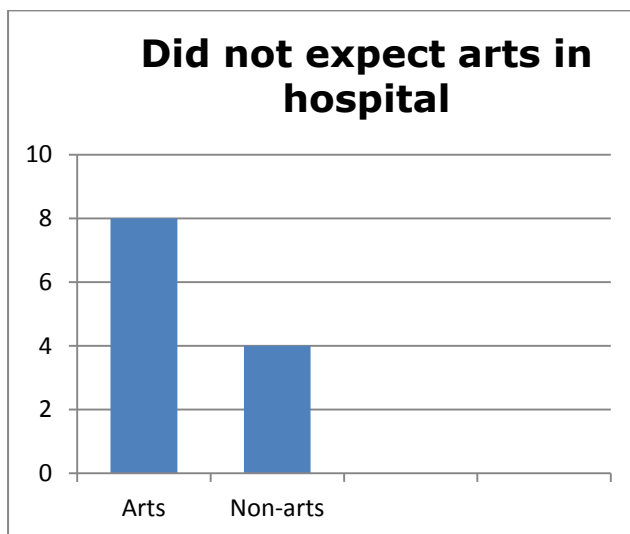


It can be seen that references to participation in these art forms are common to both the group who participated in arts and those who did not. Thus it can be seen from this small sample of patients that arts interests are common to all and rate as very popular in both groups. In fact, dance was a more popular interest in the group who did not participate in arts in hospital.

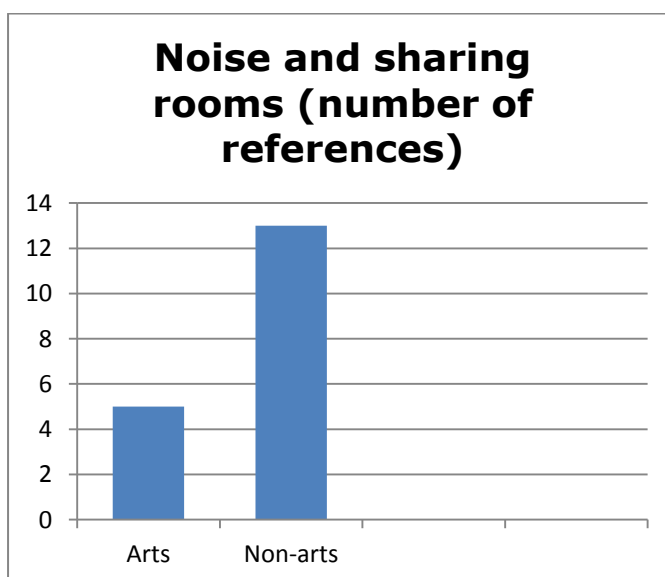
### 7.6.2 Aesthetics of hospital

There were twelve references coded as a lack of expectation of arts in hospital. The group who had not participated in arts in hospital were more likely to find noise and sharing rooms a problem, which was a highly referenced issue. However, they were also more likely to state that listening to music in hospital was important for them. Reading in hospital was also cited by both groups fairly equally (see Tables 7.15 - 7.18).

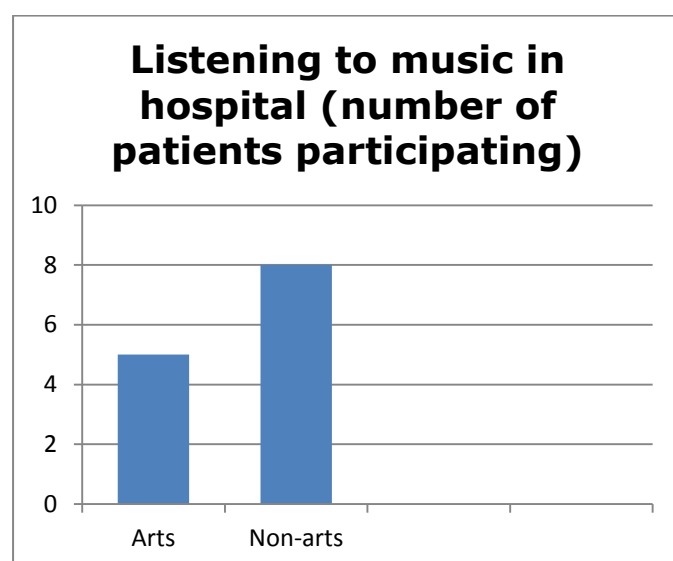
**Table 7.15 Expectation of arts in hospital**



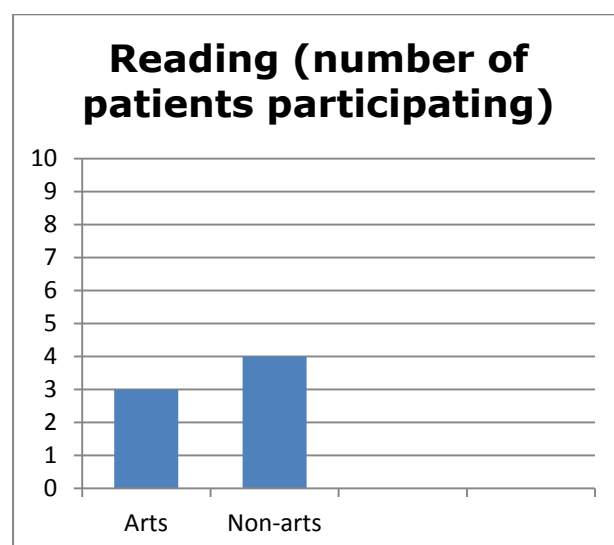
**Table 7.16 Noise and sharing rooms**



**Table 7.17 Music in hospital**

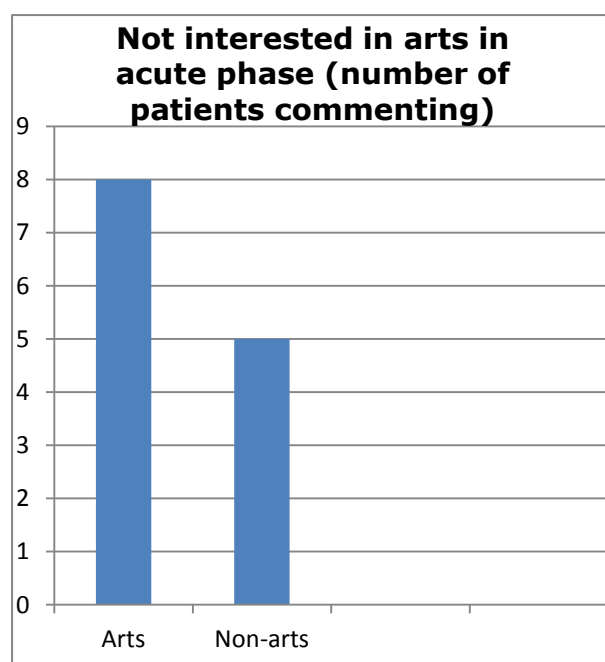


**Table 7.18 Reading in hospital**



Most of those who did benefit from arts in hospital stated that they would not have been interested in arts in their acute phase. They felt engaging in the arts was more relevant later on during the recovery phase of illness. This is relevant as it includes people who have an understanding and experience of arts as part of hospital life and recovery (see Table 7.19).

**Table 7.19 Not interested in arts in acute phase of hospital stay**

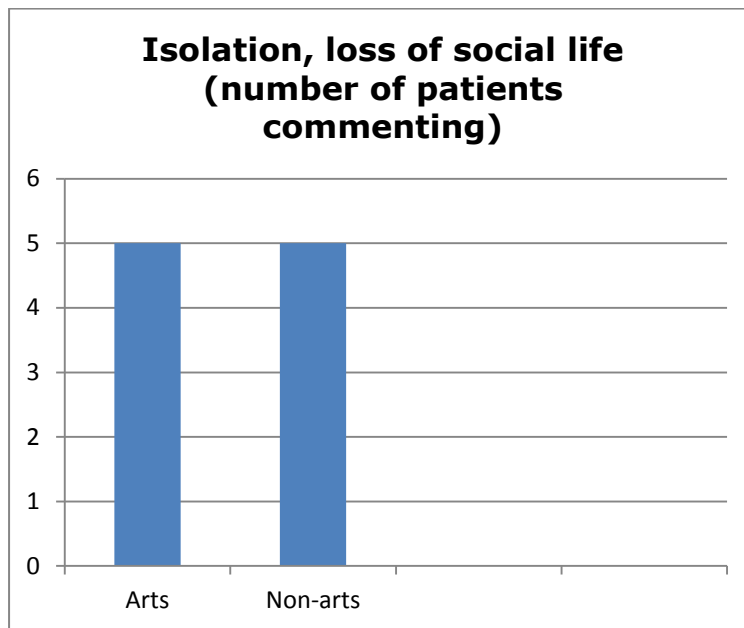


### **7.6.3 Loss**

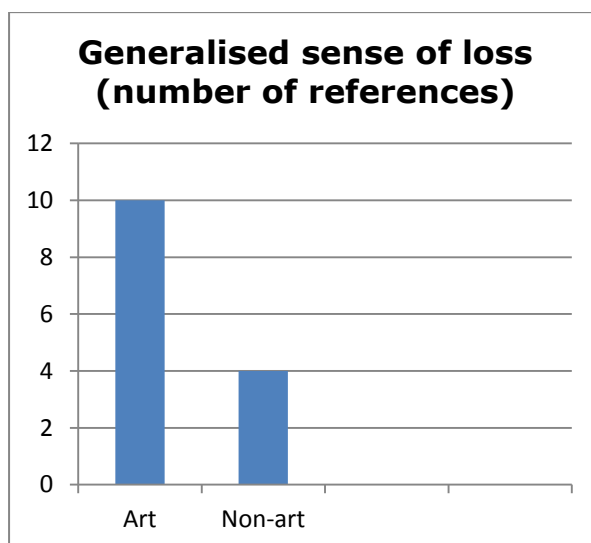
Loss was one of the key themes identified in the analysis. Three codes within this theme were analysed to see if there were differences in the two groups. Isolation and loss of social life was reported equally by participants from both groups, with half of all interviewees experiencing this loss. Loss of confidence and general sense of loss was reported more by those who participated in the hospital arts groups (see Tables 7.20 – 7.22).



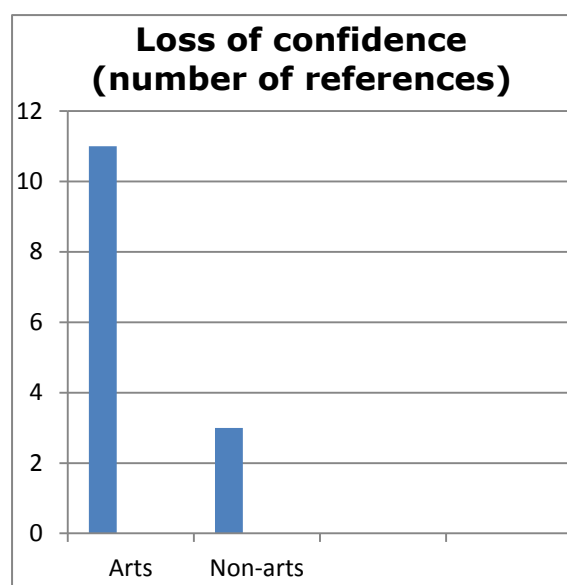
**Table 7.20 Isolation and loss of social life**



**Table 7.21 Generalised sense of loss**



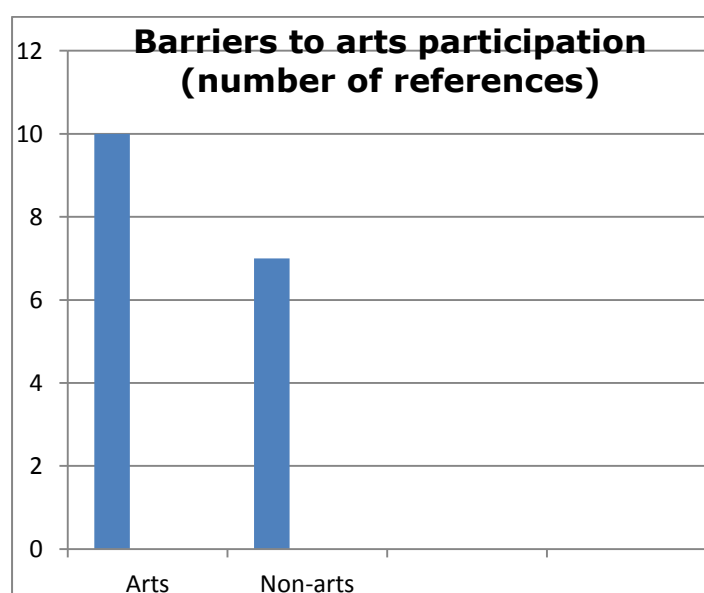
**Table 7.22 Loss of confidence**



#### **7.6.4 Post Hospital – barriers to accessing arts**

There were a large number of codes in both groups with regards to the barriers people experienced when attempting to access arts post hospital stay. Both groups stated that they felt there were barriers to their participation in their normal arts activities post hospital stay (see Table 7.23).

**Table 7.23 Barriers to arts participation in hospital**



It appears overall that the seven themes were well represented in both the group who participated in arts in hospital and those who did not. Significant differences were not found between the groups and the key themes were well represented in both groups.

## **7.7 Validating the findings – coding review**

Two researchers were asked to code two sample interviews, to check the validity of the researcher's coding. They were asked to go through two interviews and code them, highlighting any key themes or phrases and then to write a short summary of key themes and thoughts arising. These summaries are presented here in full, to show how they reiterate key themes identified by the primary researcher, as well as highlighting some further issues.

### **7.7.1 Researcher 1: Key themes identified**

Key themes of participation in arts programmes in hospital: (1) Belonging (2) Social life/social participation (3) Meeting people who have had similar experiences (4) Applying yourself (5) Discovering new talents (6) Benefit of arts programmes/courses and the disadvantage that they're too short (7) Getting involved (8) Positive distraction from pain of illness (9) Embarrassment that some people feel participating in activities/courses.

Key words/phrases re arts in hospital:

- Courses
- Pain/Suffering
- Disappointed
- Applying yourself
- Engrosses
- Painting/writing
- Therapeutic
- Relaxing
- Takes a lot to be sociable

- Passion
- Privacy
- Caring
- Positive
- Talent
- Counselling

Other comments:

*I loved VC's description of people 'blooming like flowers' through doing the workshops and courses. It's very clear that doing these arts courses had a huge positive impact on her. This is evident, simply in the number of times she mentions the word 'courses' in her responses. We can see a similar pattern in PF's responses. One thing they both had in common is the feeling that the courses they did weren't long enough, or that they'd like to do further courses. Maybe there would be room for an information booklet/programme about evening courses for adults in an OPD setting, to let people know there's ways to continue their education in these areas.*

*It's very poignant that PF said he 'forgot about his pain' while doing the watercolour painting. It really shows clearly the therapeutic value the arts can have, and the huge importance that patients place on such activities.*

*The other startling thing is the words and phrases used by both participants to describe the negative effects of their illnesses and being in hospital, such as 'agony', 'nightmare', 'tense', 'trying to keep up', and 'the people in physiotherapy should have had rheumatoid arthritis to know what the pain is like'. It is very clear that despite PF's painful condition, he doesn't want to be seen as 'having a disability'. He says he likes to keep busy, and doing the painting and reading provide a meaningful activity.*

*I had never really thought of painting-by-numbers as an activity for patients before. PF's thoughts on it were very interesting. It would certainly be easier than other forms of painting, especially for those who don't think they're very creative. PF constantly uses the words 'therapeutic' and 'relaxing' when*

*referring to this art activity. It clearly benefitted him greatly, and he thinks more people should do it.*

*It was also interesting to read PF's thoughts on the hospital building itself. His suggestions for the atrium were simply and effective. I especially enjoyed reading his insights towards the end, about photography for patients in the hospital, and that he'd even taken into consideration that patients might be in wheelchairs.*

*Overall, I think the clearest theme is that of the benefit of arts programmes and courses for patients. I found that in my own research also, that people said, almost always, that arts spending should be allocated to courses/classes for patients. It seems to have opened up more possibilities for VC, as she says she's thinking about doing other courses. Both participants placed huge value on these programmes, and on keeping busy with activities in general. I think the responses overall were very positive about the arts and their potential therapeutic value.*

### **7.7.2 Researcher 2: Key themes identified**

Key themes that really stood out were:

The arts programme allowed the patients to meet other people who were also in the hospital. This led to a feeling of belonging and sharing.

The arts programme provided a distraction to the patients from both their illness and filled time while waiting in the hospital. (It really struck me how PF spoke of how, while participating in the class, it held his interest to such a degree he forgot his pain!)

Participating in the programme made the patients feel cared for - that someone would go to that trouble to provide something like that for them, and that people cared about how they were in not just a medical sense.

Patients felt that their memory and concentration improved from getting involved in the art classes

The art sessions were found to be relaxing, and that the therapeutic or counselling side of them could be developed further.

It provided patients with new hobbies that could be continued on returning home, and nurtured talents patients had (and may not have known they had had previously). It struck me that the new or developed hobbies seemed to provide patients with a hope and focus for the future.

I also thought from reading the interviews:

1. There needs to be a greater frequency of classes, longer courses, and more choice for patients.
2. There needs to be more awareness of how to give patients that first "shove" to get involved.
3. Grandchildren - both patients talked about their hobbies in relation to their grandchildren. Could that be incorporated in a hospital arts programme?

### **7.7.3 Validating the findings - returning to the participants**

The seven themes were sent to three of the interviewees to validate the findings. A series of questions were given to the interviewees to explore how relevant the themes were to their experiences. Telephone or face-to-face interviews were conducted once they had completed a written response. This was experienced by the researcher as a key stage of the process – if the patients themselves did not recognise the themes then the researcher was surely on the wrong track! Results are presented here with initials to identify each respondent.

1. Did any of the themes described fit with your own experience of hospital and doing arts and if yes, which ones?

*BB: Agreed with all themes except one – 'Recommendations/changes can be made to improve my experience of arts in hospital' - I have no problem here.*

*RO: Yes, frustration, loss of control over my life. There is a lot you have to do for yourself. The supports are there and I would encourage patients to use the plan around them.*

*PR: The question of arts really only applies to me as an out-patient. I didn't think of arts when in hospital, though I was full of emotional unease. I think that, in hindsight, I would regard the cardiac rehabilitation programme as significantly 'aesthetic' (i.e. use of humour, vivid descriptiveness, anecdotes etc. by the staff and patients). I would identify strongly with the reference to the beneficial effects of out-patient arts group and activity, I would identify strongly with this.*

2. Did any of the themes described seem wrong or not relevant to your experience and if so, which ones?

*BB: Yes, no 5 (see above)*

*RO: All were relevant, peoples' interests vary.*

*PR: Generally speaking, no. Except perhaps the reference to patients being '... focused on the social life of the ward and visitors'. I felt I was too busy being sick to have any such focus. I do remember feeling very lonely when I was transferred from CCU to a private room.*

3. Did I miss out anything important from your experience of hospital and arts or from your interview?

*BB: No I don't think so as you appear to have covered everything.*

*RO: The wards need to be improved. This time (most recent stay) the curtains around the bed seemed to have been*

*cleaned and weren't falling down... made a very pleasant difference.*

*PR: I think not, it was a very full and substantial encounter, and I felt positively indulged by being listened to with such care and attention.*

4. Is there anything else you would like to add?

*BB: Only that I have a lasting impression of good people helping me over, and out of, a difficult stage of my life and for which I will be eternally grateful.*

*RO: Thank you for taking an interest in the patients' wellbeing.*

*PR: Just that I regard the presence of an Arts Office, complete with officer etc., as one of the jewels in the crown of Tallaght Hospital and its mission to assist and empower people with serious health issues to live and enjoy life to their fullest potential*

#### **7.7.4 Validating the findings – cross referencing my journal notes and memos**

This exercise aims to clarify the researcher's own biases and assumptions and to increase self-awareness when analysing the data. To increase self-awareness the researcher kept a memo, jotting down thoughts and ideas throughout the process. She also answered the interview questions herself, to understand what sort of answers she expected and her assumptions, as well to be more alert to different answers when they arose. A brief summary of the researcher's own issues throughout the process are given here:

*I am interested in this area of research due to a history of working in arts in healthcare, as a music therapist and then arts officer at a Dublin hospital. I bring to the research my years of experience, seeing the creativity and abilities of people often deemed to have little to offer, for example,*



*people with dementia who can sing songs or play the piano when they have lost the ability to continue a rational conversation. My first bias is thus that the arts are beneficial for people in hospital and make a huge difference to the environment and sense of well-being people experience. I had to suspend this belief to really listen to participants, some of whom did not think this was true at all!*

*My second bias is my love of music. I play music every day, I write songs, I perform on a regular basis. It is hard for me to imagine a life without live music. Again, I am aware that I might be overly attracted to this art form when listening to interviews. However, I believe that the process of data analysis shows dance and theatre to be important art forms as well as music and the Nvivo software helps to analyse and thus confirm or deny my own biases.*

*During the interviews I found my notes often centred on questioning the value of this research and this methodology. Did twenty interviews mean anything? Wasn't it too small a sample? Surely physical and clinical issues were more important to patients and arts less relevant to patients? I realized that I had a leaning towards quantitative research and that I struggled with the significance of this qualitative research, with such a small and subjective sample group. However, I had been sure when I started that I wanted to carry out research by interviewing people and hearing their stories and to understand the phenomenon of engaging in art when ill and in hospital. The broad scope of the interviews was a struggle and meant that I quickly tried to focus on key themes. The analysis of the data made me explore the findings widely and made me focus on what was in the data rather than trying to find definite answers quickly.*

*I was concerned at times, in my journaling, that I was leading the interviews with too many questions. The process of writing memos helped me to sharpen my interview skills by*

*reflecting on each interview afterwards. Every interview was entirely different and for some it seemed that arts might be an irrelevant area for them when their interests lay elsewhere.*

*I am aware that my own training and experience as a music therapist has been to focus on the emotional life of patients and to explore the emotional and social aspects of patients' health and well-being. It is important to 'bracket' these assumptions and experiences in order to analyse the data effectively and to be aware there might be a bias towards this aspect of the data. This was a concern on finding 'loss' as a key theme, as it arose also as a major part of my previous music therapy work when working with stroke patients. Again, the use of data analysis hopefully teased out the significance of this theme.*

*I am aware of a possible bias regarding the findings that art was not of interest to patients in the acute phase of their illness. My own brief experience of hospital stays would concur with this viewpoint and might cause bias; however other arts experts working in hospitals queried this result, stating that in their experience there was a definite, if specialized, role for arts interventions at acute stages (e.g. music therapy in ICU or at the end of life). It was important that I was able to discuss this issue in supervision and together with two experienced researchers was able to formulate a clearer view of this area of the research.*

In addition to these reflections, the validation also created some changes to the main themes. The independent researchers, who coded two sample transcripts, both commented on the positive aspects of engaging in arts programmes for patients and noticed recommendations coming through the data for future art programmes. As a result the researcher noticed and gave more weight to the positive aspects of art programmes for patients in hospital and recovering post hospital, as well as revisiting the theme of

recommendations for future programmes and realizing there was more data in that theme that needed to be considered.

## **7.8 Summary – the essence of the phenomenon**

In a phenomenological analysis it is important to search for the essence of the experience. To conclude this results chapter, the researcher wrote the essence of the phenomenon studied. The overall research question is *What is the role of aesthetics for patients in hospital?* For the qualitative, exploratory study undertaken here, the aim was to gain understanding and knowledge about what experience patients have of the arts before, during and after hospital stay as well as exploring their normal experience of the arts. The following description is a summary of the main findings of this research and follows Van Manen's direction to write a summary which sets out the essence of the phenomenon as clearly as possible, written from the perspective of the interviewees.

*The arts – notably in this study what music we listen to, what we read, dancing and theatre – are significant throughout our lives. They are integral to our leisure time, our enjoyment and are part of what makes us who we are. They are significant in terms of our social life, our sense of self and our recovery from ill health. In hospital, however, we suspend that interest in arts and other leisure pursuits.*

*We expect to have to put these parts of us on hold, or we are deprived of them, and we have low expectations that they will be possible or available in hospital. We are busy grappling with more urgent needs, such as pain, our physical being, even basic life or death survival. We are often not interested in arts when acutely ill. However, where arts have been offered as part of recovery or rehabilitation, or as diversion when in hospital, we found that they play a part in our sense*

*of health and well-being and there are many positive benefits associated with arts participation and reception. These include a sense of stimulation, enjoying a new activity, distraction from worries, providing a means for social connection and a sense of meaningful purpose in life.*

*The arts are with us throughout our lives but there are barriers to accessing our arts and leisure interests post hospital and sometimes adaption is needed to continue our arts interests and leisure pursuits. We are not sure, as yet, whether the aesthetics of hospital are important but we do know that noise and other disturbed or distressed patients are a problem to us. The access to arts programmes when recovering in hospital helped some of us feel more cared for and supported.*

*We have ideas about improving the hospital using arts, for example, linking arts programmes more closely with clinical treatment and enhancing the environment for patients and we are glad to have been consulted about this issue.*

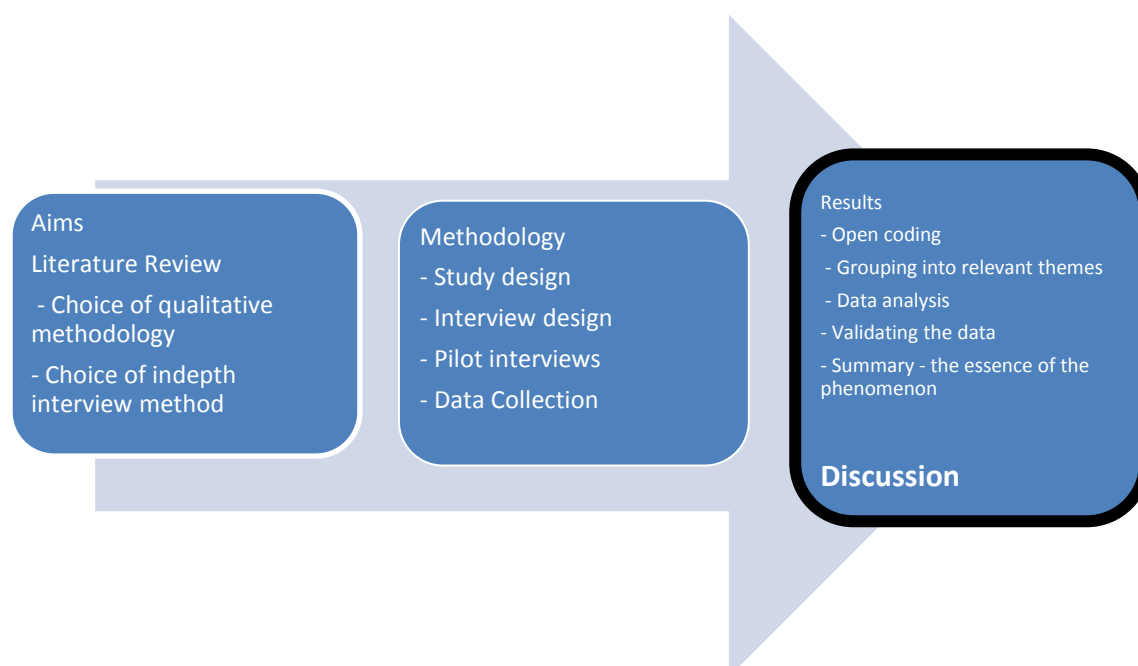
## **7.9 Conclusion**

This chapter presented the results of the qualitative study. The analysis began with broad open coding, moving through a distillation of broad themes into seven key themes, validation exercises and further analysis, resulting in a final summary of the essence of the phenomenon.

The next chapter provides a conclusion to this section, including a brief discussion of the findings and showing how these findings were used to contribute to and build the next stage of the research, the quantitative study (Section 4).

The method and results of this qualitative study were published, during this PhD study, in the Journal of Advanced Nursing see Appendix 10 (Moss and O'Neill, 2014).

## Chapter 8 Discussion – Qualitative Study



**Figure 8.1 Qualitative study diagram highlighting Discussion**

### 8.1 Introduction

This chapter draws together the findings from the qualitative study and discusses the implications of these findings. Specifically, it addresses the issues arising from this part of the research, key findings and limitations and how this exploratory study led to the development of the quantitative part of this study (see Figure 8.1).

### 8.2 Discussion of qualitative findings

Although there is much discussion in the literature of the importance of arts in health, little is known about the salience of aesthetic and cultural pursuits of hospital patients. This exploratory, qualitative, hermeneutic phenomenological study described the aesthetic and cultural pursuits of older patients in hospital. Specifically, it provided a mapping of patient preferences, needs and perceived benefits regarding the arts and explored

the role of the arts in their lives and through the journey of care in a general hospital. It also explored their perceptions of the aesthetic environment of the hospital, and captured the experience of those who had participated in an arts and health programme. The key conclusions of this study can be summarised as follows:

- Aesthetic and cultural interests are important in the lives of older patients admitted to hospital.
- Illness can create barriers to artistic engagement. Loss is a common feature of hospital stay and illness.
- Participation in arts activities may be more important during recovery and rehabilitation, with receptive arts being more popular during the acute phase of illness in hospital.
- Patients rarely expect their aesthetic and cultural interests to be available in hospital.
- Further research is recommended arising from this study, particularly to examine the role of the aesthetic environment for patients' health and well-being as well as receptive arts in hospital.

This study made a contribution by being one of few qualitative studies to explore the aesthetic and cultural preferences of patients in hospital and one of very few, if any, studies to compare the experiences of patients who have experienced hospital arts programmes and those who have not. This piece of research is situated within a new, emerging field with many previous studies in this field lacking methodological rigour. The findings from this study support findings in previous literature regarding the positive benefits of arts and aesthetic enrichment for hospital patients. However, following completion of this study, it was decided that further research was needed to examine the role of the aesthetic environment for patients' health and well-being and in particular the role of receptive artistic activities such as reading and music.

This study makes a contribution to healthcare services by highlighting the role of receptive arts (whereas most of the literature and practice focuses on participative arts for patients and staff). This research may also contribute to a more patient-centred approach to the development of arts and health

programmes in hospitals and indicates that arts and cultural interests are important to patients and should be given attention in hospital settings. The importance of aesthetic and cultural interests of patients is often ignored or even neglected and this study points to the potential role of arts for some patients and explores the needs and interests of patients regarding aesthetic, cultural and leisure interests. The result is a set of broad themes regarding the role of aesthetics in patients' lives before, during and after hospital stay and provides a basis for further study in this area. The findings of this arm of the overall research directly contribute to answering the research aims and objectives.

The findings suggest a need for carefully nuanced art programming in hospitals and consultation with patients regarding aesthetic and cultural interests. Arts programmes need to be carefully selected for different stages of illness and recovery: for example, specific therapeutic arts programmes were recommended by some patients at critical points in their care while for others arts were important as part of rebuilding social life and for intellectual stimulation post hospital stay. Future areas of study recommended include the aesthetic and cultural interests of nurses and awareness of the aesthetic needs of patients. The emotional needs of patients were a theme apparent in all the interviews and arts in health may be a means to a helpful expression of, and accommodation to, such losses (Moss, 1987). The lack of expectation of arts provision during the acute phases of the illness does not mean that aesthetics and the arts are unimportant. Rather, a sensitive curatorial role is needed for arts and health programmes at this stage of the illness, in conjunction with patients, nursing professionals and those who design and shape the healthcare environment (Kirklin and Richardson, 2003).



### **8.3 Rationale for quantitative study based on qualitative findings**

Although the qualitative study provided themes and areas of learning, it was hoped that developing a quantitative study would provide evidence to clarify and confirm or deny the themes arising in the qualitative study. The need for objective evidence in this field was important, thus, a mixed method design was adopted, with exploratory qualitative research followed sequentially with quantitative research to confirm or deny findings (Tashakkori and Teddlie, 2003, Teddlie and Tashakkori, 2009). Whilst there is little experimental research into arts in healthcare and few international studies, the impact of participation in cultural activities is increasingly recognised as relevant to a healthy older age and survival rates (Cohen, 2009, Cuypers et al., 2011a, Goulding, 2012, Hyyppa et al., 2005, Konlaan et al., 2000, Wikstrom, 2004, Daykin et al., 2006, Daykin et al., 2008a). This study adopted a mixed method approach to thoroughly examine the role of aesthetics in the lives of older people in hospital.

### **8.4 Limitations of the qualitative study**

This study produced qualitative findings from a sample of a specific group of patients in an Irish acute hospital and it may be difficult to generalise in other health systems and cultures from these findings. A limitation of this study is the small number of patients involved. It is difficult to generalise findings from these patients. As a result I decided to develop a survey instrument arising from these themes, to further explore this area. The population interviewed were all Irish and from one acute hospital. Further studies were thought to be important arising from this study, for example studies of the aesthetic interests of patients in a variety of health contexts (patients of mental health services, nursing home residents, international studies and so on). A further limitation is that patients were not categorised by type of illness or specific length of stay. The importance of aesthetic interests may be affected by type of illness and exact length of stay. For example, a short stay

of three days following a surgical procedure might be a very different aesthetic experience to a longer stay of a number of months. The experience in this study suggests that studies with longer term patients would be of interest as the aesthetics of hospital may be most relevant to these groups.

## **8.5 Reflections on the experience of conducting the qualitative study**

Conducting the qualitative study gave time for in-depth reflection, listening to patients and exploration of this new topic of research. The benefits of conducting a qualitative study included having time to listen to patients (recording the interviews was very effective in allowing time to concentrate on the interviewee). As the research proceeded, I realised how important it was to give undivided attention to the participants and to have the time to reflect and think about the role of the arts in hospital. This method of research seemed to me to be a very rich process of data collection and a chance to review the research question.

I found the validation process particularly beneficial in this study. Two independent researchers reviewed sample interviews and three participants reviewed my themes. This was the most important part, in my opinion, of the qualitative research process. Also, by answering the interview questions myself before beginning, I realised that I had no long term hospital experience and a heightened understanding of the benefits of music for myself. I was aware of my own limitations and biases in terms of understanding the phenomenon.

I was surprised by the results of the qualitative research. The frequency with which the emotional experiences of being in hospital were raised by participants surprised me, as well as the loss of confidence experienced by many interviewees post hospital stay. All the patients who participated in arts in hospital felt intimidated at the thought of engaging in arts. Most participants identified barriers to attending arts events in the community post

hospital and I had not realised how difficult it was for people to re-engage in the arts post hospital.

The qualitative research process also raised some issues worth noting. Despite many guides as to how to conduct interviews, I found the process an extremely subjective approach to gaining knowledge. I found this a frustration at times. The process led me to be keen to conduct quantitative research as the second part of the research and to provide more definite answers to my research questions. The qualitative process gave me a greater appreciation of the benefits of more objective research approaches. The issues that arose included:

- Leading questions: How to carefully prompt but not direct interviewees? How to balance the differences in disclosure between those who knew me (from previous contact with the arts programme) and those who had never met me?
- Support post-interview: Given the personal nature of the accounts of hospital, with traumatic events described in detail by some participants, was the support offered post interview adequate?
- The importance of pre-interview time: I found that offering interviewees a coffee and informal conversation before the interview seemed to ease the process and allow for more intimate disclosure than a more formal interview environment.
- Preparation for interviews: Should I have given the actual questions a week before the interview to allow people to prepare answers? Was the outline of the theme of the interview adequate?
- Diversity in the interview process: Each interview was unique – some participants needed to be steered towards topics of interest while others talked freely and focused on the research themes. Individual experiences were difficult to bring together into themes and at times I wondered if I would ever create themes from such diverse set of experiences!
- Analysis of data: I found the process of qualitative data analysis very useful (for example, moving forwards and backwards throughout the process, from interviews to themes, then returning to interviews and listening to recordings again).

In summary, my experience of conducting the qualitative research and then moving on to a quantitative study as the second part of this research, reflected current issues in the field of arts and health research. Throughout the course of this research I was engaged in discussions with arts and health and arts therapies researchers about the balance between qualitative and quantitative research and the increasing need for mixed methodology studies to meet the requirements for both in-depth experiences and empirical evidence. My personal experiences mirrored those of other arts and health researchers – a desire to be creative, listen and draw themes from rich qualitative data whilst also recognising the need to provide more robust empirical data to strengthen understanding of what role the arts play in hospitals.

## **8.6 Conclusion**

This study confirmed for this researcher that an in-depth consultation with patients is important as a starting point for more extensive research on how best to measure aesthetic deprivation and injury in healthcare settings, and how best to meet these deficits. This approach also identified clear themes and elements regarding aesthetics to be included in the quantitative study and contributed crucial insights which were used in devising a new survey in this field. Phenomenology was found to offer a useful method to describe the experience of patients and to develop an in-depth understanding about a new area of research. Further research is needed in this area, particularly on the role of receptive arts in hospital and how best to develop a more patient-centred model for arts and health programmes. The everyday aesthetics of healthcare continues to be a relatively neglected aspect of patient care and more attention could be given to the aesthetic environment for patients, in particular in our research the area of noise pollution. These findings support those of previous studies regarding the aesthetics of hospitals which indicate aesthetics to be a neglected field within healthcare. (Caspari et al., 2006, Caspari et al., 2007, Caspari et al., 2011) The cultural, aesthetic and leisure pursuits of patients were found to be important and warrant further attention.

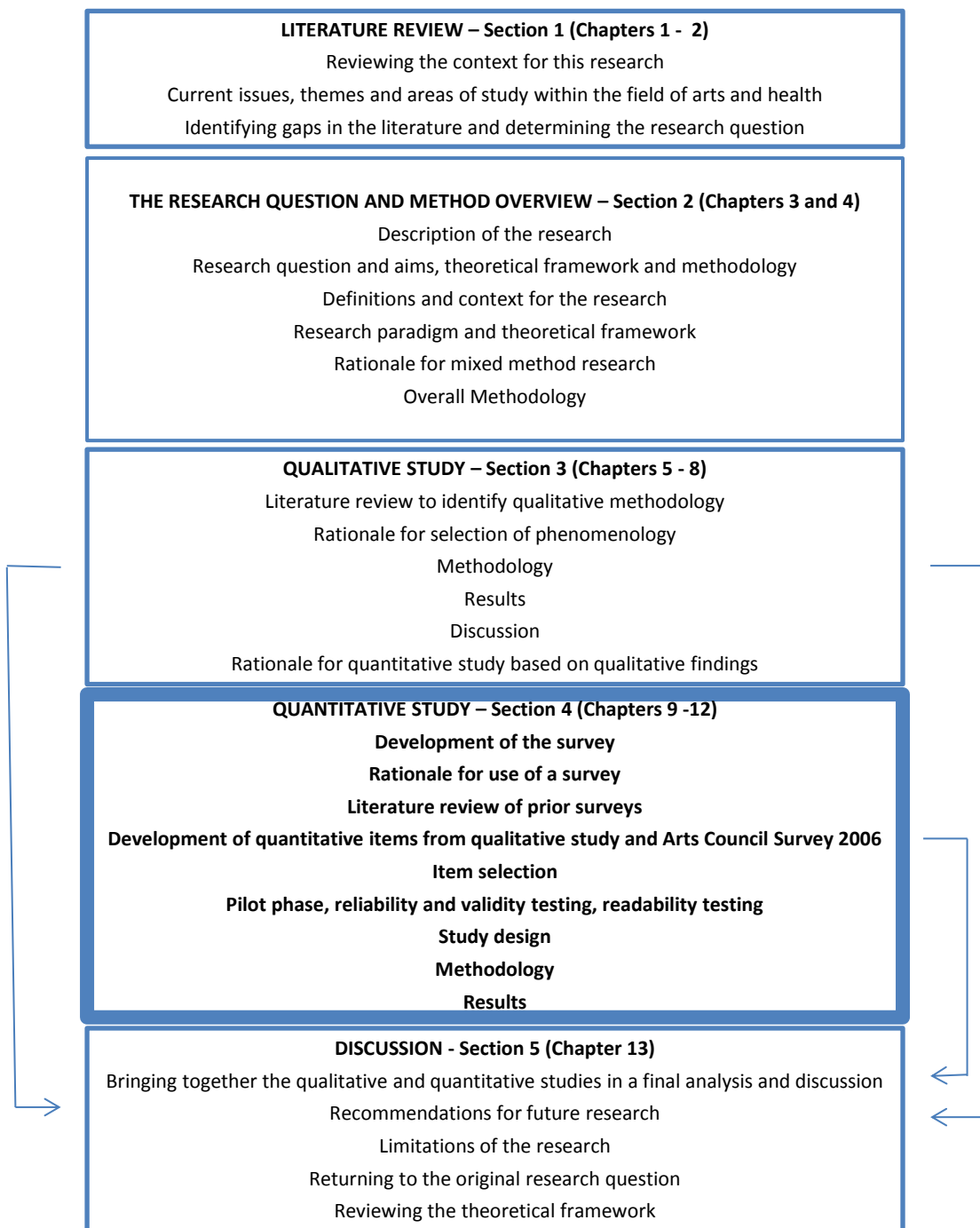
### ***Section Three Conclusion***

This section detailed the qualitative study which formed the first part of this two-part mixed method research. The methodology and results of the qualitative study were presented, as well as a literature review to choose qualitative methodology and a discussion of how these findings were used to form the next part of the research.

Following completion of this qualitative study, a decision was made to continue this research with a quantitative study, using the findings from the interviews to create a survey regarding aesthetic interests before, during and after hospital stay and the aesthetics of hospital.

Section Four presents the quantitative study and Section Five brings together the two studies with a discussion of the overall research findings.

## ***Section Four Quantitative Study - Overview***

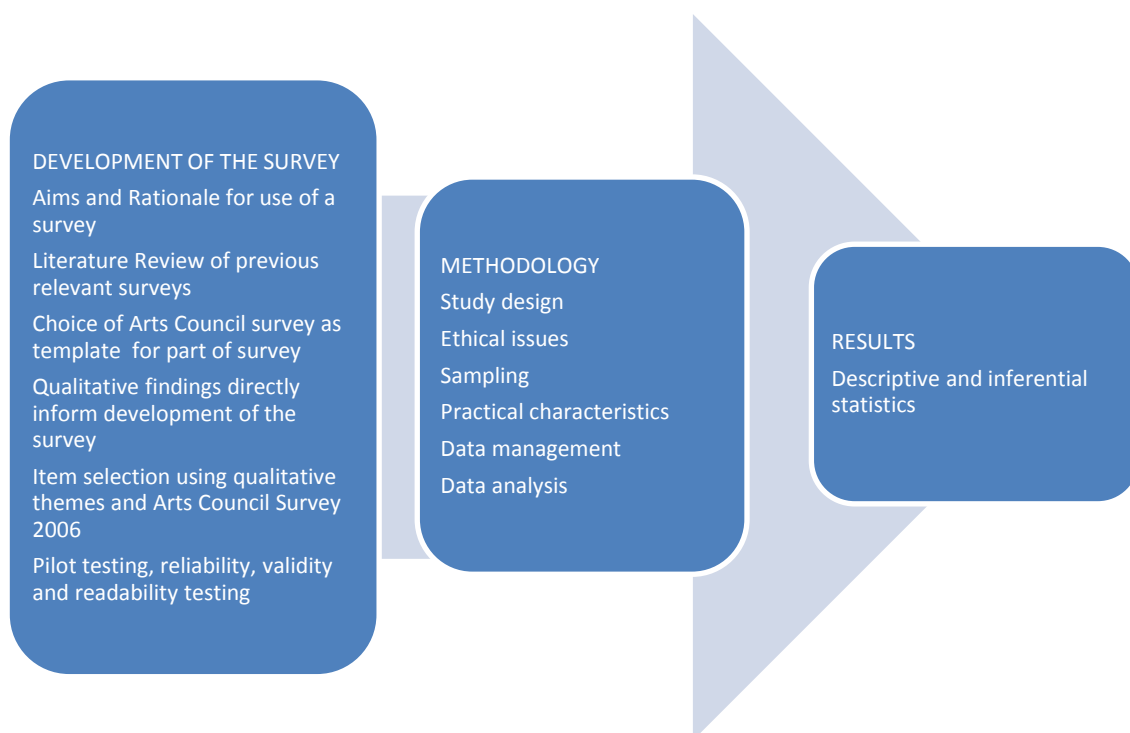


**Figure 9.1 Overall thesis design highlighting Quantitative Study**

The purpose of this section is to present the quantitative study (see Figure 9.1).

The aims and objectives are given, followed by a review of pre-existing surveys that might be useful for this study. As no appropriate survey was identified, a new survey was developed (Chapter 9). This section describes in detail how the new survey was created, how each item was selected and how the quantitative study grew directly from the results of the qualitative study. This section also includes details of the pilot phase, reliability and validity testing and presents the results in detail.

Figure 9.2 gives the structure of this section, the quantitative study:



**Figure 9.2 Diagram of the quantitative study**

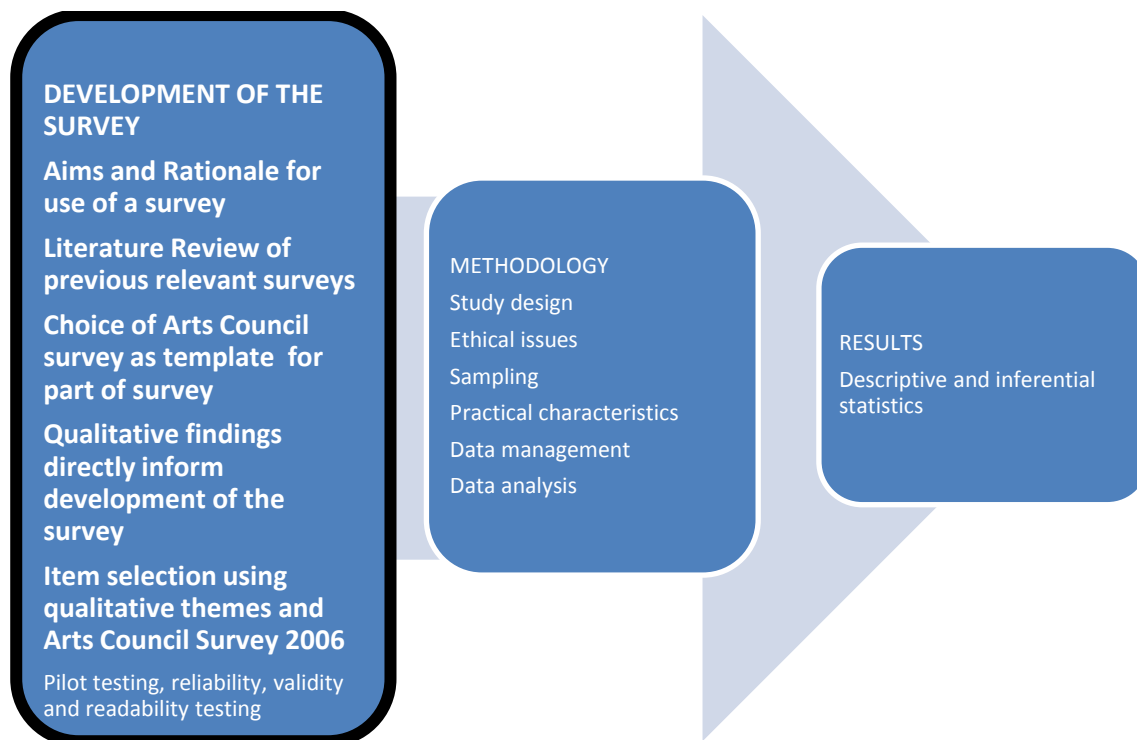


## **Chapter 9 Development of the Survey of Aesthetic and Cultural Health (SACH): Part I**

### **9.1 Introduction**

This chapter sets out the aims, objectives and rationale for the quantitative arm of the research, namely a survey of 150 older patients who had been in hospital and who were currently attending an ambulatory hospital service. It also details how the survey was developed. A literature review of previous relevant surveys is presented, followed by rationale for item selection from the Arts Council 2006 survey. A detailed account is given regarding how the qualitative findings informed the development of the survey, including specific details about how each item was selected for inclusion in the survey (see Figure 9.3). This is followed by reliability and validity testing and pilot testing (Chapter 10).

The survey was created in two sections. Section One used four questions from the Arts Council Survey (The Arts Council, 2006) to provide data regarding the arts events attended and arts activities patients participated in during both the last ten years and the last 12 months. It also asked patients if they currently had difficulty attending the arts events and activities they used to attend and the reasons for barriers to current participation in arts activities and events. Section Two was created directly from the qualitative themes. As no appropriate previously validated survey existed, the researcher created 32 items regarding the aesthetics of hospital stay. See Appendix 11 for the original draft survey and Appendix 12 for the final survey used post testing.



**Figure 9.3 Diagram of the quantitative study highlighting development of the survey**

## 9.2 Aims of the Quantitative Study

The aims of the quantitative study were:

- To develop and conduct an observational survey of patients before, during and after hospital stay
- To provide information about the aesthetic and cultural interests of patients
- To develop and explore further the themes presented in the qualitative study
- To identify patient preferences and perceived benefits regarding aesthetics, before, during and after hospital stay
- To explore the role of aesthetics in older patients' lives, in the context of what changing health does to one's aesthetic infrastructure
- To explore the extent to which the hospital environment is aesthetically-deprived or enriched for each patient

- To develop a survey (Survey of Aesthetic and Cultural Health) to begin to map patients engagement in aesthetics and to catalogue the possibility of aesthetic deprivation in hospital

The objectives of the quantitative study were:

- To survey 150 older patients who had been in hospital and who were currently attending an ambulatory hospital service to obtain quantitative data regarding (a) what the most popular arts interests are in a group of older patients in hospital (b) experiences of hospital aesthetics and (c) barriers to continuing aesthetic and cultural activities post hospital stay
- To examine whether demographic or health status factors (specifically age, gender, educational achievement, type of hospital accommodation, private or public patient status, physical functioning and depression levels) affected experiences of aesthetics before, during and after hospital

### **9.3 Rationale for choice of survey method**

A quantitative study was indicated to provide objective data to validate the findings of the qualitative study. The qualitative study was broad and exploratory and had only twenty participants. A survey was chosen to investigate the themes further and to collect data from a larger sample, given that it would be difficult to draw any strong conclusions from such a small qualitative study. Literature in this field also pointed strongly to the need for quantitative evidence from larger sample groups (Bradt and Dileo, 2009, Bradt et al., 2010b, Daykin et al., 2008a, Daykin et al., 2010).

Descriptive surveys are those which are designed to measure certain phenomena in the population of interest at one time. The information collected comes from a defined, random cross-section of the population at one point in time. This survey is a cross sectional survey; these are appropriate for producing descriptive data at one point in time, while

longitudinal surveys address analytic questions of cause and effect. Quantitative research is most appropriate in situations where there is pre-existing knowledge, which will permit the use of standardised data collection methods and/or to test hypotheses (Bowling, 2009, Fink, 2003b). The cross-sectional survey was chosen as method for this quantitative study as it allowed the researcher to collect data from a larger sample to explore further the themes that arose in the qualitative arm of the research and to provide data to further understanding the role of aesthetics for older patients in hospital. This method also took account of the lack of previous studies in this field. The aim of the research was to explore and contribute to understanding of the role of aesthetics in hospital rather than prove the benefit of the arts.

Several authors indicate that it is best to use a previously validated and published survey if available (Bowling, 2009, Boynton and Greenhalgh, 2004). If it is necessary to design your own survey, they recommend using one or more standard instruments alongside a short bespoke questionnaire (Whitfield et al., 2013). This was the approach taken in this study.

Given the qualities of the instruments reviewed (see next section), the Arts Council survey was chosen as the best fit as it had four relevant questions regarding aesthetic engagement. Section 1 of the survey aims to give a thorough account of the aesthetic interests of patients and only four questions from the Arts Council Survey 2006 address this exact question. The survey also aimed to explore the aesthetics of hospital and a new section was designed to address this aspect of the research aims. Items for this section were selected based on the findings from the qualitative study as no previously validated survey was found to address this area of research.

A wide variety of models exist regarding how to design a new survey, with many promoting consultation with local experts and iterative development of items (Flicker et al., 2010, Goodrich et al., 2013, Weatherburn et al., 2013). The literature points to widely varying degrees of testing required to validate a new survey (Baker et al., 2013, Boynton, 2004a, Boynton, 2004c, Salant and Dillman, 1994, Sapsford, 1999). Following review of these methods, the researcher decided to conduct validity and reliability testing.

The following sections outline exactly how the qualitative findings were used to develop these items for the survey.

## **9.4 Survey Design Method**

The following preparatory steps were taken to design the survey:

- Literature review of previous relevant surveys
- Review of qualitative findings and how these would inform item selection
- Item selection (Section 1 based on Arts Council Survey, Section 2 created from qualitative findings)
- Reliability and validity testing of new survey
- Readability testing
- Pilot of survey

The following sections detail each of these steps (Chapters 9 and 10).

## **9.5 Literature review of previous relevant surveys**

A review of pre-existing surveys was undertaken to see if an appropriate survey could be used for this study. In this case, an appropriate pre-existing survey was not found. The five surveys reviewed are presented here, namely The Arts Council Survey *The Public and the Arts* (The Arts Council, 2006) Caspari et al survey *Why not ask the patient?*, Short-form individual quality of life measure, Pleasant Events Schedule and The HUNT study, Norway (Cuyppers et al., 2011b)

### **9.5.1 The Arts Council Survey *The Public and the Arts***

A previously used survey was identified in The Public and the Arts 2006 report (The Arts Council, 2006). This was a survey of 2010 people in 2006 and was a representative sample of the Irish population. It was carried out by

the Economic and Social Research Institute. The survey and report was commissioned by the Arts Council to provide up-to-date information on the behaviour and attitudes of Irish people towards the arts. In particular it asked:

- What people think about the role of arts in society and arts funding.
- Attendance at arts events.
- Participation in the arts.
- The extent to which people purchase arts-related items.
- The extent to which people watch and listen and to the arts aside from live performance.
- The obstacles people have in interacting with the arts and with their sources of arts information.

This survey gave a broad overview of the Irish public perception of the arts and parts could be adapted and used for the hospital setting. It gave a good example of an extensive, validated arts-related survey which details people's opinions on the arts and it is believed that no such example exists in the health sector to date. This report is useful in terms of designing a research questionnaire for arts involvement in the hospital. We adapted and piloted this survey with forty patients with stroke in 2011 (Moss and O'Neill, 2014). Most of the questions were deemed unsuitable for this survey as they addressed issues irrelevant to this research such as public spending on arts and whether people attended rural or urban arts centres. Four questions were identified as relevant and a decision was made to incorporate these into the survey used for this study.

This survey also provided a list of recognised art forms to be used as a prompt for respondents and the list was adopted for use in this survey. In the qualitative part of this study, 11 of the 20 (5.5%) interviewees stated they had no arts interests, but when prompted listed a number of significant arts interests. Eight of the 20 people (4%) interviewed in the qualitative arm of this research stated arts interests without the need of prompts and 1 person (0.5%) reported no arts interests, even when prompted. Thus it was necessary, in this study, to use the prompt card listing art forms, given the varied interpretations of the word 'arts'.

### **9.5.2 Caspari's questionnaire *Why not ask the patient?* An evaluation of the aesthetic surroundings in hospital by patients**

Caspari has conducted a number of studies on aesthetics in healthcare (Caspari et al., 2006, Caspari et al., 2007, Caspari et al., 2011). In one study of Norwegian hospitals, 400 questionnaires were distributed with questions about the aesthetics of the hospital being rated from 1 – 6, where 1 was very bad and 6 very good. Caspari found no questionnaire or instrument registered as suitable for use, so in this study it was necessary to develop a questionnaire. Her findings propose that aesthetics might be more important for longer stay than short stay patients. She used 22 items in her questionnaire, including items such as tidiness, food and cleanliness. Those related specifically to arts concentrated on the aesthetic environment and patients were asked to evaluate items such as paintings, pictures, tapestries, sculptures, decorations, mosaic works and water decorations. This is the only survey found of aesthetics in hospital. However, there is no focus in this survey on the individual arts interests of patients prior to hospital. Caspari also proposes further studies on aesthetics with specific clinical groups and in different healthcare contexts.

Caspari's survey was too detailed regarding aesthetic items such as food, tidiness and cleanliness for the purposes of this study. It detailed items that did not arise in the qualitative part of this research, and focused more on the physical aesthetic environment of hospital and less on arts interests of patients and why they matter to people. Definitions of aesthetics vary and this survey did not fit with the definition of aesthetics for the purpose of this study.

### **9.5.3 Short-form individual quality of life measure (SEIQoL)**

The SEIQoL is an interview based questionnaire to determine quality of life (O'Boyle, 1994). Some aspects of this approach appealed to this researcher as they determine individual preferences regarding quality of life and allow

for participants to determine priorities themselves (Hickey et al., 1996). This would suit a new area such as aesthetics.

The most interesting questions for the purposes of this research were:

- What are the 5 most important aspects of your life at the moment?
- How would you rate yourself on each of these areas at the moment?  
(On a scale from worst possible to best possible)
- How do these 5 areas compare in importance to each other?

This survey gave useful ideas about how to design questions to find out the most important leisure interests of patients. However, this researcher decided to use simple yes/no answers to keep the survey consistent and simple to complete and analyse and to use specific art forms (as listed in the Arts Council survey) rather than open ended questions as used in this survey.

#### **9.5.4 Pleasant Events Schedule**

This survey was a self-reporting behavioural inventory of the subjective enjoyability of a number of commonly rewarding events (MacPhillamy and Lewinson, 1982). It is designed to find out about the things people have enjoyed during the past month and contains a list of events or activities which people sometimes enjoy. Participants are asked to go over the list twice, the first time rating each event on how many times it has happened in the past month and the second time rating each event on how pleasant it has been. The two key questions are:

*How often have these events happened in your life in the past month?*

*How pleasant, enjoyable, or rewarding was each event during the past month?*

0 = This has *not* happened in the past 30 days.

1 = This has happened *a few times* (1 to 6) in the past 30 days.

2 = This has happened *often* (7 or more) in the past 30 days.



- 0 = This was *not* pleasant
- 1 = This was *somewhat* pleasant
- 2 = This was *very* pleasant.

This questionnaire is useful in that it presents a very simple format with very quick answering. It is easy to use and we aimed to design a survey that was equally consistent and easy to complete.

### **9.5.5 Survey aspects of the HUNT study (Cuypers et al., 2011b)**

Cuypers et al carried out a study of patterns of receptive and creative cultural activities and their association with perceived health, anxiety, depression and satisfaction with life among adults in Norway (Cuypers et al., 2011b). Within this major study, receptive cultural participation was assessed in a survey format, asking the respondents:

*How often in the last 6 months have you been to a museum or art exhibition, a concert/theatre/film, a church/chapel, sport-events?*

Respondents could state: 'more than three times a month, 1-3 times a month, 1-6 times in the last 6 months, or never.'

Creative cultural activities were also assessed by asking:

*How many times in the last 6 months have you participated in the following: an association activity or club meeting, music/singing/theatre, parish work, outdoor activities, dance, worked out/sports?*

Similar scoring methods were used. For each cultural activity, the response alternative was quantified with 1 (never) to 4 (more than three times a month). Respondents were also asked to comment on their own perception of their health, for example being asked if they suffered from a chronic disease which reduced their daily functioning (yes/no) and whether they had any

physical or emotional problems which limited their social life. They also completed some measures such as the Hospital Anxiety and Depression Scale.

This survey covers many of the topics in a manner similar to the Arts Council survey and used a graded response from 1 – 4. However, the items were fewer and specific art forms or arts activities were not explored.

### **9.5.6 Choice of Arts Council questions**

Following review of these existing surveys, four questions were taken from the Arts Council Survey and used verbatim to form Section One of the survey. This was a previously tested questionnaire and the questions were used directly (Lunn and Kelly, 2008). Permission was granted to use these questions from the survey authors.

We tested this survey in a pilot study of the aesthetic interests of thirty eight stroke patients. This separate study showed that some of the questions were more relevant than others, and indicated the usefulness of some aspects of the survey. For example, the diversity of patients aesthetic interests were highlighted as well as the importance of individually preferred music being made available. This study indicated that patients were in hospital or recently discharged, thus questions about their normal levels of attendance at aesthetic and cultural events needed to be tailored to take into account the drop off in activity associated with hospital stay. Questions regarding purchasing art materials were deemed irrelevant, as were questions relating to urban and rural arts access, as this research takes place in a city hospital. This study was published and findings contributed to developing this survey. See Appendix 13 for published paper on the aesthetic interests of patients with stroke (O'Connell et al., 2013).

The next sections (9.6 – 9.7) detail how the qualitative findings informed the development of the overall survey.

## 9.6 Survey design – values

It is important to state the values that drove the selection of all questions. These arise from both literature review and review of the qualitative findings:

- Inclusivity – items were selected for the survey that drew opinion from all patients, not just those with some experience of arts in hospital
- Relevance – items were based on two specific questions which arose from the qualitative study, namely:

What are the aesthetic preferences of patients in hospital?

What is the current experience of hospital aesthetics and is there any aesthetic deprivation or injury in hospital?

- Simplicity – Patients are busy people, often dealing with complex health issues. The hospital sample group was comprised of older people from all educational backgrounds. For both these reasons, the survey aimed to be simple and relatively brief to complete.

## **9.7 Item selection for the survey**

The survey developed consists of 2 sections. Section 1 was based on the Arts Council Survey and Section 2 from the qualitative findings.

### **9.7.1 Section 1 of the survey – Aesthetic Interests**

Section 1 of the survey is formed from four The Arts Council Survey questions (The Arts Council, 2006). The questions used from the 2006 survey were as follows:

- Q1 of the Arts Council survey becomes Q1.1 of this new survey
- Q8 of the Arts Council survey forms question Q1.2 in this new survey
- Q 13a from the Arts Council Survey forms Q1.3 in this new survey
- Q14a and b are now Q1.4 and 1.5 in the new survey

Q14 a and b refer to barriers experienced by people accessing arts and this seemed particularly relevant to the hospital setting as the qualitative interviews had revealed that the majority of interviewees attended less arts activities post hospital stay and it was of interest to examine the reasons for this in more detail.

### **9.7.2 Section 2 of the survey – Aesthetics of hospital**

Section 2 of the survey was made up of 32 statements which respondents could answer *agree or disagree*. The statements came from the seven qualitative themes and were composed by the researcher. The qualitative findings directly informed the quantitative survey development.

See Table 9.1 for the seven themes from the qualitative study and details of how they were used to develop items in the survey.

**Table 9.1 Qualitative study themes informing items in survey**

<b><i>Theme from Qualitative Study</i></b>	<b><i>Rationale regarding use in the survey</i></b>	<b><i>Items in <u>final</u> survey relating directly to this theme(Appendix 12 for survey)</i></b>
Interests and passions	<p>All patients interviewed had a major passion or interest in their leisure activities</p> <p>Music and dance were listed most frequently by all interviewees. Patients identified key arts interests in their lives and expressed a loss of these due to ill health or hospital stay. Prior to hospital stay, these interests were crucial to a sense of individuality and enthusiasm for life. Patients expressed low expectation of arts being available in hospital and often put these interests 'on hold' while they were in hospital.</p> <p>As limited evidence exists in literature regarding patients' preferences towards aesthetic, cultural and leisure interests in hospital, it was decided to further examine this area in the quantitative study. Most studies have focused on participative arts in healthcare without attention given to the previous aesthetic interests of patients. Gaps in current literature point to a need for research in this area.</p> <p>A survey with a larger sample would bring useful information regarding the aesthetic interests of patients.</p>	<p>Q1.1 and 1.2</p> <p>A series of questions to create a baseline of previous aesthetic interests of patients in hospital. These questions are taken directly from the Arts Council survey.</p>
<p>Theme of Loss and the impact of illness on engagement in arts.</p> <p>And</p> <p>Appropriate aesthetic and cultural activities</p>	<p>Themes of loss and the impact of illness on pursuance of aesthetic interests were important issues for patients being interviewed. Loss of confidence, physical ability and motivation following hospital stay as well as loss of social life and ability to continue activities were cited by patients as barriers to accessing cultural venues.</p>	<p>Section 1.3 and 1.4</p> <p>A question to explore the experiences of patients post hospital, to see what effect hospital stay has on the ability of patients to access arts and cultural events and to further break down the reasons for lower attendance. This was an important part of</p>

according to phase of illness	<p>Arts possibly had more relevance when recovering from hospital stay and returning to life in the community than in the acute phase of hospital care. Interviewees suggested a possible drop in participation in arts activities post hospital.</p> <p>Many patients interviewed stated that they were not attending the arts and cultural activities they used to attend before hospital stay. Although current literature focuses on arts participation in healthcare, few studies explore the barriers that patients experience in continuing these activities post hospital stay.</p>	<p>documenting the current aesthetic and cultural interests of patients.</p> <p>Q14 (a&amp;b) from The Arts Council directly address this question so these were used.</p>
Aesthetics of hospital – in particular music and noise and the role of receptive arts	<p>Qualitative research indicated that patients were more concerned with their life pre and post hospital and less focused in interviews on the aesthetic experience of hospital.</p> <p>Issues noted in qualitative study were noise disturbances (patients, staff or sharing rooms), feeling institutionalized, lacking control over their environment, visual art on the walls, the role of receptive arts and music in hospital.</p> <p>Some interviewees could not remember or did not notice the aesthetic environment and this area of the qualitative study gave a mixture of views on whether this aspect of hospital experience was significant or not.</p> <p>It was decided to create a section of the survey dedicated to providing more information about these areas of the aesthetics of hospital, in particular the possibility of aesthetic deprivation or injury in hospital.</p> <p>Current literature on the aesthetic environment of healthcare rarely focuses on aesthetic deprivation</p>	<p>Section 2</p> <p>All questions in Section 2 focus on this theme. Specifically, these items are:</p> <ul style="list-style-type: none"> <li>• Control over the environment and choice of arts and leisure activities while in hospital</li> <li>• The most popular art forms - music, dance and reading and their availability in hospital</li> <li>• Noticing the visual art on the walls</li> <li>• Noise disturbance (sharing rooms, noise from staff, patients and machines)</li> <li>• Access to arts activities while in hospital</li> </ul>

	<p>and we wished to explore this concept further.</p> <p>The qualitative study revealed that receptive arts played an important part in patients' experiences of arts during hospital stay.</p> <p>Arts and health literature focuses primarily on participative arts and there is a dearth of work regarding receptive arts.</p>	
Recommendations to improve aesthetic environment of hospital	Recommendations in the qualitative study included quiet space to go to read, arts therapies as part of clinical programme and a wish to expand the arts service.	This theme was not included in this survey as it was felt that these themes were complex and each required further analysis as separate pieces of research. The survey, and the overall research design, had a specific purpose, to describe the aesthetic interests of patients and also to explore the possibility of aesthetic deprivation or injury in hospital. Complex recommendations such as developing arts therapies services could not be included within this specific focus.
Positive experiences of arts in hospital	This theme focused on the positive experiences of those who had attended the hospital arts programme.	The aim of the survey was to capture the views of the wide hospital population (not just the minority who attend hospital arts programmes). Decided to exclude this theme from the survey as it was only relevant to those who attended hospital arts programmes which were not the focus of the research and this major theme warranted further exploration in a separate study.
Low expectation of arts in hospital	None of the patients interviewed expected to be able to continue their arts interests in hospital. Although not of central concern to the research, this was an interesting finding from the qualitative research and warranted further investigation. It was decided to ask one question to provide more information on this aspect.	Q2.1.28

In terms of questions about hospital aesthetics, the key areas arising from the qualitative findings were identified and 32 items created to provide additional data about these areas, specifically:

- Access to arts activities while in hospital
- The most popular art forms - music, dance and reading and their availability in hospital
- Noise disturbance (sharing rooms, noise from staff, patients and machines)
- Control over the environment
- Choice of arts and leisure activities while in hospital
- Interest in receptive arts
- Noticing the visual art on the walls

These were the key issues that arose during the interviews under the theme of 'aesthetics of hospital' and they warranted further attention. Table 9.2 gives each specific item of the survey and an overview of how they are aligned to these key areas of hospital aesthetics, as well as to the overall qualitative themes and/or Arts Council questions.



**Table 9.2 Item Selection (1)**

<b>Survey Section</b>	<b>Item of <u>final</u> survey</b>	<b>How the item was sourced and selected (Qualitative theme or Arts Council survey)</b>
1	Q1.1 Please tick which of the following activities you have attended in the last 12 months/10 years	<i>Arts Council survey Q1 Qualitative theme 'Interests and passions'</i>
1	Q1.2 Have you taken part in any of the following arts activities in the last 12 months/10 years?	<i>Arts Council survey Q8 Qualitative theme 'Interests and passions'</i>
1	Q1.3 Do you currently have any difficulties in attending or taking part in those arts or leisure activities which interest you? Q1.4 If yes, please tick which difficulties you currently have:	<i>Arts Council survey Q14 a and b Qualitative theme 'loss and the effect of illness on attendance at aesthetic events and activities'</i>
2	Q 2 Aesthetics in Hospital - This section focuses on questions about your hospital stay.	<i>Themes from the qualitative findings are used to create individual statements (see below):</i> <ol style="list-style-type: none"> <li>1. Interest in receptive arts</li> <li>2. Noise disturbance (sharing rooms, noise from staff, patients and machines)</li> <li>3. The most popular art forms - music, dance and reading and their availability in hospital</li> <li>4. Noticing the visual art on the walls</li> <li>5. Access to arts activities while in hospital - expectations</li> </ol>
2	2.1.1 In hospital I was able to watch TV/DVD of my choice	<i>Themes: Receptive arts, choice, control over environment</i>
2	2.1.2 I was able to use a computer if I wanted to in hospital	<i>Theme: Receptive arts, control over environment</i>
2	2.1.3 In hospital I was able to listen to radio	<i>Themes: Receptive arts, choice, control over environment</i>

	programmes of my choice	
2	2.1.4 In hospital I had access to films of my choice	<i>Themes: Receptive arts, choice, control over environment</i>
2	2.1.5 In hospital I was able to listen to music of my own choice	<i>Themes: Receptive arts, choice, popular art form, control over environment</i>
2	2.1.6 In hospital I was able to read for pleasure	<i>Themes: Popular art forms, receptive arts, choice, control over environment</i>
2	2.1.7 In hospital I was able to use e-reading devices	<i>Themes: Receptive arts, choice, control over environment</i>
2	2.2.1 I had control over whether the TV was on or off while in hospital	<i>Themes: Noise, control, pollution, receptive arts, control over environment</i>
2	2.2.2 Sounds from TV or radio were disturbing to me when I was in hospital	<i>Theme: Noise pollution</i>
2	2.2.3 I had control over whether the radio was on or off while in hospital	<i>Themes: Noise, control, receptive arts, choice, control over environment</i>
2	2.2.4 Music being played on the ward was disturbing to me when I was in hospital	<i>Themes: Noise pollution, popular art form</i>
2	2.2.5 Sounds from other patients were disturbing to me when I was in hospital	<i>Theme: Noise pollution</i>
2	2.2.6 Sounds from machines or equipment were disturbing to me when I was in hospital	<i>Theme: Noise pollution</i>
2	2.2.7 Sounds from staff were disturbing to me when I was in hospital	<i>Themes: Noise pollution, control</i>
2	2.2.8 I was able to choose whether to share a room with other patients while in hospital	<i>Themes: Noise pollution, control, choice, control over environment</i>
2	2.2.9 I had access to a quiet place when I needed it in hospital	<i>Themes: Control, choice, control over environment, noise</i>
2	2.2.10 I had access to company and conversation when I needed it in hospital	<i>Themes: Control, choice, noise, control over environment</i>
2	2.3.1 In hospital I was able to listen to music of my own choice	<i>Themes: Receptive arts, choice, popular art form, control over environment</i>
2	2.3.2 I had control over the music I listened to while in hospital	<i>Themes: Receptive arts, choice, popular art form, control over environment</i>
2	2.3.3 I was able to listen to live music when I was in hospital	<i>Themes: Arts interest (most popular art form), control over environment</i>
2	2.3.4 I was able to play a musical instrument	<i>Themes: Choice, Arts interest (most popular art form), control over</i>

	if I wanted to in hospital	<i>environment</i>
2	2.3.5 In hospital I had access to films of my choice	Themes: <i>Popular art forms, receptive arts, choice, control over environment, control over environment</i>
2	2.3.6 I was able to dance while I was in hospital	Themes: <i>Arts interest (second most popular art form)</i>
2	2.3.7 I was able to write if I wanted to in hospital	Theme: <i>Arts interest, control over environment</i>
2	2.3.8 I was able to paint or draw in hospital	Themes: <i>Visual art, aesthetic environment, choice, arts interests, control over environment</i>
2	2.4.1 I noticed the visual art, pictures or photographs on the wall in my room or ward	Themes: <i>Visual art, aesthetic environment, choice</i>
2	2.4.2 I wanted to put art, pictures or photographs on the wall in my room or ward	Themes: <i>Visual art, aesthetic environment, choice</i>
2	2.4.3 I was satisfied with the visual art on display in the hospital	Themes: <i>Visual art, aesthetic environment, choice</i>
2	2.5.1 If I wanted to, I was able to continue the arts or leisure activities I enjoy while in hospital	<i>General question regarding whether arts were important for patient in hospital – qualitative findings indicated some patients did not expect or want arts while in hospital, control over environment</i>
2	2.5.2 My arts and leisure interests were not important to me when I was in hospital	<i>General question regarding whether arts were important in hospital – qualitative findings indicated some patients did not expect or want arts while in hospital</i>
2	2.5.3 I expected to have arts in hospital	<i>General question regarding whether arts were important in hospital – qualitative findings indicated some patients did not expect or want arts while in hospital</i>
2	2.5.4 Arts and cultural programmes are important in hospital	<i>General question regarding whether arts were important in hospital – qualitative findings indicated some patients did not expect or want arts while in hospital</i>

### 9.7.3 Further details of item selection

Table 9.3 sets out exactly which survey item corresponds to the themes from the qualitative study regarding aesthetics in hospital.

**Table 9.3 Item selection (2)**

<b>Theme</b>	<b>Specific items in final survey relevant to this theme and comments</b>
Interest in receptive arts	Questions 2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5, 2.1.6, 2.1.7
Noise disturbance (sharing rooms, noise from staff, patients and machines)	Questions 2.2.1, 2.2.3, 2.2.4, 2.2.5, 2.2.6, 2.2.7, 2.2.8, 2.2.9, 2.2.10
The most popular art forms - music, dance and reading and their availability in hospital	Music: Questions 2.3.1, 2.3.2, 2.3.3, 2.3.4, Film: Question 2.3.5 Dance: Question 2.3.6 Writing: Question 2.3.7 Painting/Drawing: Question 2.3.8
Noticing the visual art on the walls	Questions 2.4.1, 2.4.2, 2.4.3 Only 4 statements were allocated to this theme. More attention was given to music, noise and receptive arts, to reflect that this issue was given much less attention by interviewees in the qualitative study. For example, only 12 of the 20 interviewees noticed or remembered the visual art or colour of the hospital, whereas there were 18 comments about noise in the hospital.
Access to arts activities while in hospital - expectations and role of arts in general	Questions 2.5.1, 2.5.2, 2.5.3, 2.5.4. On the basis of the findings of the qualitative study, these four general overview statements were added by the researcher. These were to cover qualitative findings regarding patients' expectations of receiving arts in hospital, whether patients felt arts were appropriate to the acute phase of their illness and their view of accessing arts in hospital. These were key themes in the qualitative findings and it was decided to ask one question about this with the larger sample group, to gather some more information without focusing on this area in great depth.
Control over the environment and choice of arts and leisure activities while in hospital	The majority of the 32 statements listed had an element regarding choice or control over use of arts activities in hospital.  This theme is important both from the qualitative findings and also current literature that indicates the importance of choice of aesthetics and how this might make a difference to recovery and patient satisfaction in hospitals (Lawson, 2001, Lawson and Phiri, 2003, Ulrich, 1984, Ulrich, 1991, Ulrich et al., 1991, Caspari et al., 2006, Caspari et al., 2007, Caspari et al., 2011).

Additional information on item selection is given in Appendix 14, where the draft full survey document is given, with each item aligned to qualitative themes (in red).

#### **9.7.4 Aligning item selection to current literature**

In creating all items in the survey, the qualitative findings were aligned to current literature as well as to the research aims and objectives. For example, literature in this area indicates a need for further research regarding patient choice in the aesthetic environment of hospital (Lawson, 2001, Lawson and Phiri, 2003, Ulrich, 1984, Ulrich, 1991, Ulrich et al., 1991, Caspari et al., 2006, Caspari et al., 2007, Caspari et al., 2011) and a lack of research regarding the role of receptive arts (Moss et al., 2012). The few studies on aesthetics indicate a need for further research regarding the role of aesthetics in healthcare with specific patients groups and further studies on the impact of cultural participation on health and particularly for older people (Cuyppers et al., 2011b, Cohen, 2009, Caspari et al., 2007).

#### **9.7.5 Selecting demographic information**

A series of questions were asked to gather demographic information, specifically gender, age, marital status, educational level, occupation and ethnicity. These were selected from the Arts Council Survey. The research team agreed what information would be useful in answering the research objectives. Additional questions were asked specific to hospital, namely whether the patient was in shared or single room accommodation and whether a public or private patient.

The only demographic question changed from the Arts Council Survey was ethnicity. In the initial stages of review, this question was highlighted as quite out of date for modern Ireland. A review of other ethnicity questions was undertaken and the question was selected from the Irish Census 2012 (Central Statistics Office, 2012). See Appendix 15 for the ethnicity question used in the survey.

## **9.8 Conclusion**

This chapter presented the first part of designing the survey, including rationale for the use of a survey and how each item of the survey was specifically identified. The next chapter outlines the validity and reliability testing of the survey and pilot phase before the survey was fully conducted.

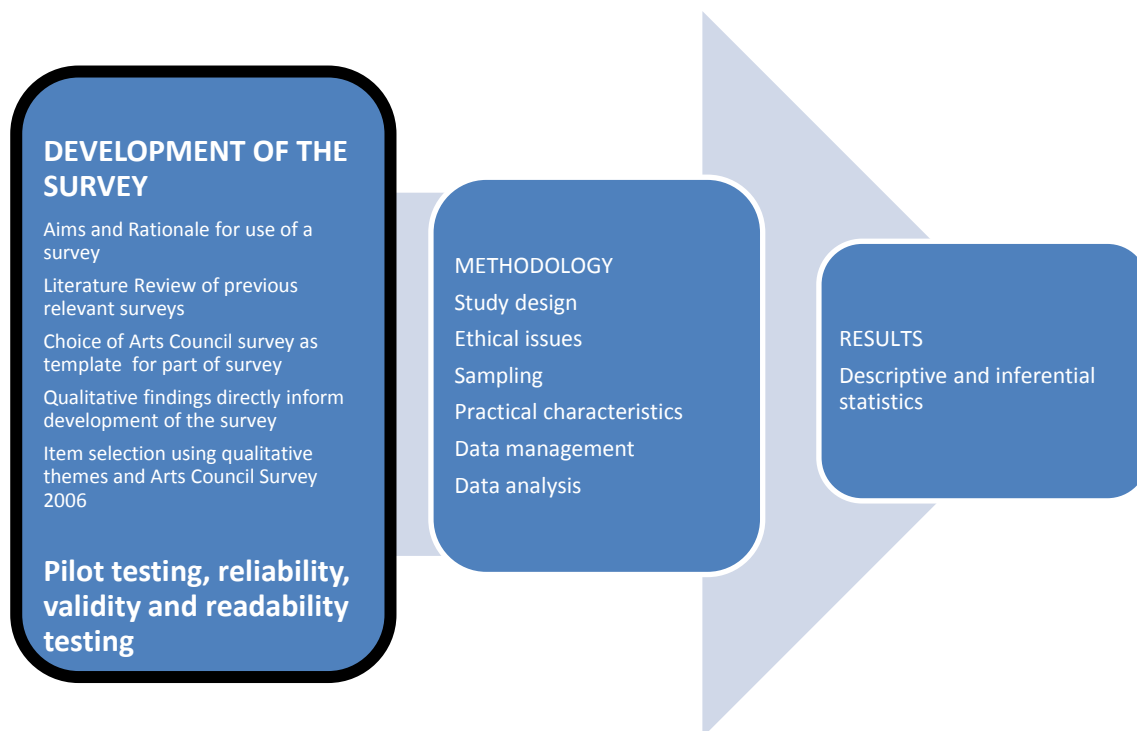
## **Chapter 10 Testing the Survey of Aesthetic and Cultural Health - Reliability, validity and pilot testing**

### **10.1 Introduction**

This chapter presents the process taken in order to assess the survey in terms of psychometric properties and also to examine the pilot use of the survey (See Figure 10.1). The process included going through the following stages:

- Creating a survey from qualitative data (Chapter 9)
- Piloting the survey
- Reliability and validity testing
- Readability testing

This chapter presents the statistical tests used to assess the psychometric properties (i.e. test-retest reliability, content validity and internal consistency) as well as readability testing and piloting the survey. The original draft version of the survey and the final revised version (following all the above stages) are presented in Appendices 12 and 13.



**Figure 10.1 Diagram of the quantitative study highlighting pilot testing, validity and reliability testing of the survey**

## **10.2 Survey pilot testing and revision**

The draft survey was initially piloted by administering it to two professionals (a nurse manager and an arts and health practitioner) and then reliability tested with ten patients. Ten experts participated in content validity testing (Bowling, 2009, Portney and Watkins, 2000).

The initial pilot with two professionals revealed some initial areas of immediate improvement, prior to reliability and validity testing. These included a need to review the questions on income and ethnicity, presentation of the survey and a need for clarity in the consent form and patient information sheet. Discussions with supervisors revealed further amendments, particularly a need to simplify the survey into two sections and clearly define the aims of the survey. The readability test revealed a need to reduce long words (three syllables or more) to make it easier to understand.



Reliability, internal consistency and content validity testing revealed further amendments. These processes are detailed in the following sections.

## **10.3 Reliability Testing of Draft Survey**

### **10.3.1 Introduction to Reliability and Internal Consistency**

Reliability is a statistical measure of whether the survey instrument can reproduce the same results in a consistent fashion (Litwin, 1995). It is concerned with the consistency of the measure and the degree to which the questions used in a survey elicit the same type of information each time they are used under the same conditions. There are three ways to assess reliability – test-retest, alternate-form and internal consistency.

Intra-rater reliability focuses on the same rater completing the same survey with the same individual on two or more occasions. This focuses on measuring the stability of responses over time with the same individual respondent. Inter-rater reliability determines the extent to which two or more raters obtain the same result when using the same instrument to measure a concept. Where the survey instrument is self-administered and designed to measure patient's own behaviours or attitudes, as in this survey, inter-rater reliability is not used (Litwin, 1995). Test-retest reliability is most commonly reported for entire survey instruments and is useful in this sort of survey, where variables are unlikely to change over time. For test-retest reliability the same group complete the survey on two separate occasions. This is a useful test where answers should not change significantly over a period of one month, for example, answers regarding which art forms patients commonly attend. Hence, the survey in this study was suitable for test-retest assessment.

To avoid the problem of respondents remembering their previous answers and answering the same way twice in a test-retest situation, alternate form reliability was also used. This involved changing the questions but keeping

the same meaning for example by changing the order of questions in the second test.

Internal consistency indicates how well different items measure the same issues. It is often better to ask a series of questions to measure one variable rather than relying on just one. If internal consistency is low, it can be improved by adding more items or by examining existing items for consistency. Internal consistency is measured by calculating the coefficient alpha statistic. This measures the consistency of a group of items combined together to form a single scale.

Reliability was thus determined in this survey by the following two methods:

- Completing the whole survey with ten patients twice, with a gap of two weeks between tests. This assesses test-retest reliability
- Internal consistency was measured in each section of the survey.

### **10.3.2 Reliability testing methods**

To test reliability of the survey, ten sample patients completed the survey on two occasions, two weeks apart. The patients met the inclusion criteria of the study, namely they were over 65 years of age with an in-patient hospital stay of 7 days or more in the last five years.

Intraclass correlation coefficients were calculated for each individual rater. In statistics, the intraclass correlation is a descriptive statistic that can be used when quantitative measurements are made on units that are organized into groups. It describes how strongly units in the same group resemble each other. It is commonly used to quantify the degree to which individuals with a fixed degree of relatedness resemble each other in terms of a quantitative trait. Another prominent application is the assessment of consistency or reproducibility of quantitative measurements made by different observers measuring the same quantity. In this case a single measure was calculated, whereby one rater's first and second tests were compared for reliability (Portney and Watkins, 2000, Salkind, 2000).

In Section 1 of the survey there were four major questions, with a series of individual items within each question. These items were grouped into a total score for each question for the purposes of analysis. The 32 items in Section 2 were also grouped together as a single score. (See Appendix 11 for details of draft survey which was used for testing reliability and validity).

### 10.3.3 Reliability testing results

Descriptive results of Test-Retest are summarised in Table 10.1. These figures suggest that generally the distribution of responses in each of the categories was similar for the original test questionnaire and the retest questionnaire.

**Table 10.1 Descriptive results of Test-Retest**

<b><i>Question group</i></b>	<b><i>Category</i></b>	<b><i>Test n (%)</i></b>	<b><i>Retest n (%)</i></b>
Q1.1	Attended 1-6 times	42 (19%)	45 (20%)
	Attended 7+ times	7 (3%)	8 (4%)
	Neither	171 (78%)	167 (76%)
Q1.2	Yes	29 (16%)	28 (16%)
	No	151 (83%)	152 (84%)
Q1.3	Yes	97 (57%)	98 (58%)
	No	73 (43%)	71 (42%)
Q1.4/1.5	Yes	11 (6%)	9 (5%)
	No	179 (94%)	181 (95%)
Q2	Strongly agree	43 (15%)	41 (14%)
	Agree	76 (26%)	81 (27%)
	Neither agree/disagree	60 (20%)	77 (26%)
	Disagree	63 (21%)	52 (18%)
	Strongly disagree	54 (18%)	46 (15%)

The kappa statistic was used to further examine the agreement between the two survey tests. A summary of the analysis results is given in Table 10.2. The figures reported are the estimated kappa values, which are the

correlation of agreement between raters, using the total responses for each question in Table 10.2.

**Table 10.2 Reliability results using Kappa**

Questions	Kappa
Q1.1	0.82
Q1.2	0.85
Q1.3	0.85
Q1.4 / Q1.5	0.68
Q2 <sup>(*)</sup>	0.76

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(\*) Analysis using weighted kappa

Kappa measures the agreement between raters over and above that which would be expected due to chance. This is measured on a scale ranging up to a maximum agreement of 1. An interpretation of kappa values is suggested in Table 10.3 (Salkind, 2000).

**Table 10.3 Kappa values**

Value of Kappa	Strength of agreement
< 0.20	Poor
0.21 – 0.40	Fair
0.41 – 0.60	Moderate
0.61 – 0.80	Good
0.81 – 1.00	Very Good

For the majority of questions the 'standard' kappa method was used. This method examines only exact agreements between repeat tests of the same rater. This works best when there are only two categories, or when the categories have no logical order. However, it is less appropriate for Question 2, where the responses are an ordinal 5-point scale, so a weighted kappa method was used for Question 2. This assesses agreement on the same scale

as the standard kappa method, but also gives some credit to near misses in preference to misses by more categories (Litwin, 1995, Salkind, 2000).

The results indicate that the kappa values were high for Q1.1, Q1.2 and Q1.3, all above 0.8. This would suggest very good agreement between initial and repeated testing. The agreement was not quite as high for Q1.4/1.5 and for Q2, but the kappa values were still reasonably high, and the agreement could still be classed as 'good'.

It is interesting to note that on reviewing question 1.4/1.5 quite a large number of the answers were marked 'no' by all reviewers. It was considered, as a result of this statistical analysis, that some of these items might be removed as they were clearly showing very little relevance to reviewers.

Individual results of intraclass correlation coefficients are set out in Table 10.4. Here, each rater's first and second tests were compared for reliability.

**Table 10.4 Results of intraclass correlation coefficients**

<b><i>Rater Number</i></b>	<b><i>Intra-class correlation r statistic</i></b>
Rater 1	.67
Rater 2	.93
Rater 3	.87
Rater 4	.97
Rater 5	.90
Rater 6	.83
Rater 7	.77
Rater 8	.62
Rater 9	.98
Rater 10	.30

The majority of the intra-class correlations are greater than 0.60, with 6 of the 10 raters scoring over .80 and 9 out of 10 scoring over .60. Rater 10 had

a very low score and her answers were quite inconsistent. The mean average of the ten results above is .78 which overall is a good result.

#### **10.3.4 Qualitative comments from reliability testing participants**

After completion of the test-retest, participants were invited to give comments about their experience of the survey. Three participants indicated that the 'strongly agree' and 'strongly disagree' choices in section 2 were irrelevant and just yes/no would be more useful. Another commented that it was difficult to listen or watch anything in hospital as it's so hard to settle down and concentrate. Another pointed out that length of stay is relevant to the study and we needed to ask about this, as well as whether the patient was in a private or shared room. Another participant felt the survey would be useful in both psychiatric and general hospitals.

Due to the high level of comments regarding Section 2 being more useful as yes/no questions (as opposed to Likert scale), this section was further piloted with two colleagues to see if this section worked better as yes/no or a sliding scale of four answers. The two colleagues, an arts office manager and a clinical nurse manager, considered that a simple agree/disagree answer would, indeed, be a better format than the four point Likert scale response.

#### **10.3.5 Internal consistency**

To determine internal consistency nine sections were identified for analysis. Items in each major question were grouped together giving nine sections - Questions 1.1, 1.2, 1.3, 1.4&1.5, 2.1, 2.2, 2.3, 2.4, 2.5 (see Appendix 11 for details of each survey question and individual items within each question). Cronbach's Alpha was used to determine internal consistency.

Cronbach's alpha is a measure of internal consistency, that is, how closely related a set of items are as a group. A high value of alpha is often used as evidence that the items measure an underlying construct. Cronbach's alpha is a test of reliability and in particular consistency. Cronbach's alpha can be

written as a function of the number of test items and the average inter-correlation among the items. The formula for the standardized Cronbach's alpha is:

$$\alpha = \frac{N \cdot \bar{c}}{\bar{v} + (N-1) \cdot \bar{c}}$$

Here N is equal to the number of items, c-bar is the average inter-item covariance among the items and v-bar equals the average variance. A reliability coefficient of .70 or higher is considered acceptable in most social science research situations (Institute for Digital Research and Education, 2012). The results for the survey questions are set out in Table 10.5.

**Table 10.5 Internal Consistency Results**

<b>Question number</b>	<b>Cronbach Alpha Result</b>	<b>Comments</b>
Q1	.325	This is a low result. Cronbach's alpha was also calculated with single items excluded and the result increased to .378 if 'circus' was left out of question 1 and .388 if 'rock and pop music' was excluded.
Q2	.597	This result rises to .664 if 'writing any music' was excluded from list of participation in arts activities.
Q3	N/A	This question was difficult to calculate due to a high number of missing answers.
Q4	N/A	Q 4 is a simple yes/no answer leading to a group of related items in Q5, so in this case Q5 items were used to calculate Alpha.
Q5	.753	This question has good internal consistency.
Q 2.1	.904	This is an excellent score for internal consistency.
Q 2.2	.746	This question has good internal consistency.
Q2.3	.753	This question has good internal consistency.
Q2.4	.768	This question has good internal consistency.
Q2.5	N/A	No result available due to relatively high number of missing items

### **10.3.6 Discussion of internal consistency results**

The results of internal consistency calculations are encouraging. Question 2 is made up of groups of statements, aiming to examine specific areas of aesthetic deprivation. It is encouraging that the internal consistency of these groups is high throughout.

Questions in Section 1 (Q1, 2 and 3) have lower scores and point to some concerns regarding internal consistency. However, these questions are taken directly from a previously used study by the Arts Council/ESRI (The Arts Council, 2006) and have thus been previously used and tested to produce results regarding public attitudes to the arts. The researcher was therefore keen to keep their groupings and items, particularly in questions 1 and 2 where art forms are listed as per Arts Council definition of art forms. Therefore, rather than excluding items such as circus or rock music, in order to raise the Alpha, we decided to keep them in but to take note to explore this issue when data is collected. A lower alpha is more likely to occur and be more acceptable in survey design than in instrument design.

However, question 3 seemed to raise issues both in this test and in the content validity testing. The content validity reviewers queried whether media use is relevant to the aims of this survey. It was reviewed and excluded as it was seen as too generalised a question for this survey.

## **10.4 Validity Testing**

### **10.4.1 Introduction to validity**

Validity is concerned with the accuracy of the survey. There are four types of validity - face validity, content validity, criterion-related validity and construct validity. Validity is concerned with whether the survey measures what it means to measure.



Face validity is about the look of the survey. This type of validity is not highly respected as a valid test (Litwin, 1995, Wynd et al., 2003).

Content validity is a subjective measure of how appropriate the items seem to a reviewer. This validity relates to the ability of the researcher to create questions that reflect the issue being researched and to make sure that key subjects are not excluded. In health services research, both patients and healthcare workers are normally included in survey validity testing (Wynd et al., 2003).

Criterion validity can be either construct or predictive. In construct criterion validity the new survey is tested against a more established 'gold standard' survey that measures the same issue. In predictive criterion validity the results of the survey can be measured against actual results at a later stage. For example, a predictive survey to measure the likely educational achievement of children registering for secondary school can be measured against actual exam results a number of years later. This validates whether the registration exams are valid predictors of future academic success. As our survey has no similar enough 'gold standard' surveys to compare with, and does not predict future behaviour, this seems an inappropriate validity measure in this case.

Construct validity is the most valuable yet the most difficult way to assess validity. It is often determined after years of performance, to assess how well a survey works in a variety of settings and populations. This validity testing was not possible within the duration of this study.

Content validity was thus used to assess the survey in this study.

#### **10.4.2 Content validity method**

Ten experts were assembled to review the survey subjectively. Each reviewer determined whether the questions reflected the aims and themes being researched and made sure that key related subjects were not excluded. The exercise asked each observer to rate each item of the survey on a 4-point

scale. The four possible responses were whether the question was relevant to the aims of the research (score 4), needs minor revisions (score 3), needs major revisions (score 2), or not relevant (or score 1). Polit's method for determining content validity was followed (Polit et al., 2007). See Table 10.6 for details of the ten experts.

**Table 10.6 Ten experts for content validity**

<b>Number</b>	<b>Expert category</b>	<b>Gender</b>	<b>Age range</b>	<b>Occupation</b>
1	One male patient in hospital in same age range as sample	Male	65 - 75	Retired distribution manager
2	One female patient in hospital in same age range as sample	Female	75 - 85	Retired teacher
3	A general lay person in same age range as sample	Male	75 - 85	Retired actor
4	A carer/family relative of someone in hospital in the patient group	Female	65 - 75	Retired nurse, husband with dementia
6	A physician with an interest in medical humanities	Male	55 - 65	Physician with medical humanities interest
7	Health professional (Allied Professional)	Female	35 - 45	Speech Therapist working with older people and researcher
8	Health professional (Allied Professional)	Female	25 - 35	Social Worker working with older people and researcher
9	Arts and Health related professionals with research background	Male	35 - 45	Music Therapist working with older people
10	Arts and Health related professionals with research background	Female	25 - 35	Music Therapist researcher
11	Nurse researcher familiar with designing surveys	Female	45 - 55	Experienced researcher, specialist interest in survey development

Details of the content validity survey questions, with instructions for reviewers are included as Appendix 16.

### 10.4.3 Measuring content validity

Content validity is defined as the extent to which an instrument adequately samples the research domain of interest when attempting to measure phenomena (Wynd et al., 2003). Evaluating a scale's content validity is a critical early step in enhancing the construct validity of an instrument (Polit et al., 2007). There are no widely agreed criteria or objective methods for determining content validity. Usually it is based on subjective judgement of experts, and through literature, representatives of the relevant population and experts in the field (Yaghmaie, 2003). Two stages are recommended in designing a valid survey, firstly the development of the survey which includes literature review and qualitative research to generate items in the survey, and then secondly the judgement/quantification stage, whereby experts review the items and evaluate using a Likert-type scale (Wynd et al., 2003, Yaghmaie, 2003).

Polit et al recommend using the content validity index (CVI) which asks reviewers to rate surveys in terms of four levels of relevancy to the survey content, with 4 being *relevant*, 3 *needs minor revisions*, 2 *needs major revisions* and 1 *not relevant*. The four item index used in this study follows Lynn and Polit's approach to content validity, whereby the first two items of the scale ('not relevant' or 'needs major revisions') are considered 'content invalid' while the other two items (needs 'minor revision' and 'relevant') are considered 'content valid' (Lynn, 1986, Wynd et al., 2003, Polit et al., 2007). This judgement phase of content validity is quantitative but is based on subjective opinions of experts. Some commentators argue that larger number of experts and the four item scale improve validity (Wynd et al., 2003, Waltz and Bausell, 1983). Items which are below acceptable levels of validity are eliminated and experts are often asked qualitative questions in addition to rating the survey items. Lynn recommends asking experts to comment on omissions in the survey. She argues that content validity, by its nature, demands rigour in its assessment and is a critical part of designing a survey instrument (Lynn, 1986).

There is no defined percentage agreement required from reviewers. Where there are five expert reviewers or less the agreement needs to be 1.00 (i.e. all experts must agree that the item is valid) whereas with more than five experts there can be a modest amount of disagreement, (so, for example, six experts are recommended to have a level of agreement of .83) (Polit et al., 2007). Davis indicates that for new instruments investigators should seek 80% or better agreement among reviewers (Davis, 1992). A rule was thus adopted for this study that if 80% of experts viewed the item as relevant it would be accepted.

To calculate CVI Polit et al state that the number of experts giving 3 or 4 as a score is divided by the number of experts (in this case 10). The result should be .80 (80%) to indicate content validity. This process was carried out for every item of the survey.

In addition to content validity index (CVI) some authors suggest statistical analysis using the Kappa statistic (Wynd et al., 2003, Polit et al., 2007). This statistic is believed to assist in providing information about degree of agreement beyond chance. However, Polit et al argue that the CVI is attractive in terms of how easy it is to compute, understand and provide information about the extent to which there is a consensus about the relevance of the item to the target theme or construct, hence less need for Kappa or other statistical analysis (Polit et al., 2007).

There is wide disagreement about the usefulness of kappa statistics to assess rater agreement. Uebersax argues that kappa statistics should not be viewed as the unequivocal standard or default way to quantify agreement, rather one should be concerned about using a statistic that is the source of so much controversy and one should consider alternatives and make an informed choice (Uebersax, 2010). Kappa is a way to test rater independence and as a way to quantify the level of agreement. The use of Kappa to quantify actual levels of agreement, however, is a source of concern. Kappa's calculation uses a term called the proportion of chance (or expected) agreement. This is interpreted as the proportion of times raters would agree by chance alone. However, the term is relevant only under the conditions of statistical

independence of raters. Since raters are clearly not independent, the relevance of this term, and its appropriateness as a correction to actual agreement levels, is very questionable (Uebersax, 2010).

#### **10.4.4 Content Validity Results**

The CVI was calculated for each item (i.e. number of answers given that were 3 or 4 divided by number of experts). Each item scored 1.00 or 0.89, no items scored lower than .80.

It was decided to group similar questions together to assist meaningful statistical analysis. Therefore, for the purposes of analyses, similar questions were grouped together and analysed together. The groupings were chosen so that there were enough questions to give a sufficient amount of data in each group, but also so that there were as many distinct groups as possible. The questions were grouped as they were structured (i.e. Question 1.1 was a group, Q1.2, Q1.3, Q1.4/1.5 and Q2) and results of each group of questions were summarised for each of the raters. These results are summarised in Table 10.7. The figures represent the number and percentage of the questions in each group where a score of 4 (question was relevant) was given.

**Table 10.7 Content validity results**

<b>Rater number</b>	<b>Q1.1 (n=22) n (%)</b>	<b>Q1.2 (n=18) n (%)</b>	<b>Q1.3 (n=17) n (%)</b>	<b>Q1.4/1.5 (n=19) n (%)</b>	<b>Q2 (n=30) n (%)</b>	<b>All Q (n=106) n (%)</b>
1	22 (100%)	16 (89%)	17 (100%)	16 (84%)	26 (87%)	97 (92%)
2	22 (100%)	18 (100%)	17 (100%)	18 (95%)	28 (93%)	103 (97%)
3	22 (100%)	18 (100%)	17 (100%)	19 (100%)	30 (100%)	106 (100%)
4	22 (100%)	18 (100%)	17 (100%)	19 (100%)	30 (100%)	106 (100%)
5	20 (91%)	17 (94%)	1 (6%)	17 (89%)	25 (83%)	80 (83%)
6	21 (95%)	18 (100%)	16 (94%)	19 (100%)	30 (100%)	104 (98%)
7	22 (100%)	18 (100%)	17 (100%)	18 (95%)	30 (100%)	105 (99%)
8	22 (100%)	18 (100%)	17 (100%)	19 (100%)	30 (100%)	106 (100%)
9	22 (100%)	18 (100%)	17 (100%)	19 (100%)	30 (100%)	106 (100%)

Table 10.7 indicates that all except rater 5 had 80% agreement for all questions. The vast majority of the raters gave the individual questions scores of 4 (question was relevant) for each block of questions. Eight of the nine raters used scores of 4 and 3 to grade the questions. The remaining rater gave some scores of 2, but no scores of 1 (not relevant) were given. It can be concluded from this analysis that there was strong agreement from the reviewers that content was valid. As most questions were rated the same between reviewers, these results also suggest that there was relatively good agreement between the observers.

It is also important to note that one of the ten reviewers did not rate the survey but gave qualitative comments. These tended to be arguing that the questions needed major or minor revisions but as these were not stated, the results could not be used in the statistical analysis. Instead, these comments

and all other qualitative remarks were collated and used to review the survey. Even if the results of the tenth rater had been included as 'needing major revision' or 'not relevant', the agreement between raters would still be sufficiently high to produce .80 results.

Finally, the agreement between the raters was assessed using a kappa statistic. (See Table 10.3 for details of Kappa scores). Two pairs of raters were studied. Firstly, Rater 5 and Rater 6 were compared, giving a Kappa of .44 (moderate). Secondly, Rater 5 and Rater 1 were compared, giving a Kappa of .108 (poor). It was not possible to calculate Kappa where one set of results were constant, so rater 5 was used as this rater had the most widely varying scores. A summary of the Kappa analysis results is given in Table 10.8. The figures reported are the estimated kappa values.

**Table 10.8 Kappa analysis results**

<b><i>Questions</i></b>	<b><i>Kappa</i></b>
Q1.1	-0.02
Q1.2	0.03
Q1.3	-0.08
Q1.4 / Q1.5	0.11
Q2	0.03
All questions combined	0.02

These results indicate that the kappa values are all very low, both when groups of questions are considered individually or when all constituent questions are combined in a single analysis. Based on the interpretation of the kappa values given earlier, the agreement could be classed as poor in all instances.

#### **10.4.5 Discussion of content validity analysis**

The two sets of analyses give slightly contradictory conclusions. On the one hand the majority of raters indicated that most individual questions were relevant. This suggests good agreement between raters, as they were mostly

happy with the content of the questionnaire. 80% agreement was found between experts. However, the kappa values suggested fairly poor agreement between the raters, with low values. This relates to a possible lack of real agreement between the raters as to which specific questions need revision.

It might be concluded that overall the results suggested that experts agreed that all questions were relevant, but that there was no real agreement between observers as to which questions were not relevant. However, as there was such high agreement between experts and such strong scores (8 out of 9 used only score 4 - relevant or 3 - needs minor revisions) it would seem that there was actually very little disagreement at all and therefore that content validity has been established. It also appears that some of the controversies surrounding use of Kappa are borne out here.

#### **10.4.6 Content validity comments by section**

As well as statistical evidence of content validity, the experts were invited to give comments. These were collated and all comments reviewed with supervisors. See Appendix 17 for full list of comments from content validity experts.

On the basis of the subjective comments, certain changes were made, namely:

- Clarifying some of the arts events, for example adding 'e.g. cinema' after the title 'mainstream film' and adding the word 'event' after some of the categories.
- Removed the category of arts participation *Helping with running arts event or organization* as this was queried by two reviewers. It was agreed that this is not really an arts activity.
- Removing a whole section of questions which looked at use of technology at home (e.g. what do you normally use at home? CD? Radio? DVD? Etc.). It was agreed that this section was not highly relevant to our study and could be confused with other activity (not arts based activity) on this equipment.



- Added a question to identify whether patients were in a ward or private room.
- Took out a question regarding dance in hospital – one reviewer felt this was upsetting, given that she could no longer dance since she had a stroke.
- Section 2 – removed the scale of 'strongly agree, agree, disagree and strongly disagree'. Feedback from reviewers indicated that these were irrelevant categories and there should just be 'agree' or 'disagree' to all statements. Also, following review with statistician we removed 'neither' so that respondents had to answer with a definite answer.
- Reviewed the questions regarding the visual art in the hospital, to ask if it was interesting for patients.
- Made the survey larger print and more spaced out to ensure it was easy to read.
- Reworded a number of questions where meaning was confusing and to ensure clarity of intention.

## 10.5 Readability testing

Readability of the survey was also checked, using the Gunning-Fog's readability index. This was to measure how easy the survey was to read and comprehend. To calculate the Gunning-Fog index the weighted average of the number of words per sentence, and the number of long words per sentence are used. The Gunning-Fog index is calculated with the following algorithm:

- Select a passage (such as one or more full paragraphs) of around 100 words. Do not omit any sentences
- Determine the average sentence length. (Divide the number of words by the number of sentences.)
- Count the "complex" words: those with three or more syllables. Do not include proper nouns, familiar jargon, or compound words. Do not include common suffixes (such as -es, -ed, or -ing) as a syllable;
- Add the average sentence length and the percentage of complex words; and

- Multiply the result by 0.4.

The complete formula is:

$$0.4 \left( \left( \frac{\text{words}}{\text{sentences}} \right) + 100 \left( \frac{\text{complex words}}{\text{words}} \right) \right)$$

For this survey, three sections of text were used. The ideal score for readability is a score of 7 or 8, with anything above 12 being too hard for most people to read. A fog index of 12 requires the reading level of an 18 year old, texts for a wide audience need a fog index of less than 12 and texts requiring near-universal understanding generally need an index less than 8. The test was developed by Robert Gunning, an American businessman, in 1952 (Gunning, 1952).

The three sections of text reviewed are as follows:

Section 1: Text from very start of survey title to end of question 1.1.17.

Gunning Fog index was initially 10.12 but with revision the readability became 8.37.

Section 2: Qu 1.1.18 – Qu 1.2.18.

Initially Gunning Fog index was 10.7 but again with revisions this reduced to 8.15.

Section 3: Question 2 Arts in hospital.

Gunning fog was initially 10.3 and second time 9.1. Although this was still a little high, the text uses the word 'hospital' frequently, which is classed as a complex word as it has 3 syllables. It was impossible to remove all these references; hence the score is slightly higher than ideal.

For details of text and readability calculations for each section see Appendix 18.

## **10.6 Additional changes as a result of validity and reliability findings, comments and recommendations:**

Five changes were made to the survey, taking on board the results of the reliability and validity testing, qualitative comments received during the testing phase and discussion with research supervisors:

- Removal of question 1.3 – not relevant enough to the mapping of arts interests. Also slightly out of date with being taken from Arts Council 2006 survey,
- Removal of one item from Q1.5 '*Not very interested in these kind of things*' – not relevant in this survey which identified which art forms patients were interested in
- Section 2 changed from Likert scale to 'Agree/Disagree' – Reliability and validity testing both indicated this change would improve the survey and statisticians also recommend not offering the option to not answer, as a simple agree/disagree would encourage participants to commit to a definite answer (Salkind, 2000, Waltz and Bausell, 1983).
- 2.3.4 '*I danced while I was in hospital*' was removed; four reviewers and 2 test-retest participants felt this was a strange question as it is so rare to dance in hospital. It was not felt that this question would capture useful information from a large population.
- Section 2.5 was improved. This section was controversial during validity testing as it contained several general overview statements that could be taken in many ways and might be ambiguous. These questions were improved to ensure clarity and it was decided to remove two of these questions to leave only 4 unambiguous questions in this section.

## **10.7 Final changes to the survey**

Once the survey was implemented further issues arose which needed to be addressed. Designing one's own survey is difficult and the researcher became aware during implementation of two major changes needed.

Firstly, during the first 50 surveys, it became clear that most patients had not engaged in arts activities or attended events in the last year, due to illness. Thus, questions 1 and 2 in section 1 were not gaining relevant answers. A review of these questions was undertaken by the researcher and her two supervisors. A decision was made to make these questions two part questions, asking what arts the person had attended or engaged in during the last year and in the last ten years. This was hoped to give a better flavour of the normal aesthetic interests of the patients. It was decided to use the data from the first 50 but also to collect a further 100 with both questions used.

The new question was piloted with 5 patients. Here we asked about their arts interests in the last twelve months, the last 2 years and in the last 10 years. Ten years was then agreed as most useful marker question for the survey.

Secondly, the question of income level of patients was deleted after the first 10 surveys. It became clear that this question was difficult to administer as it was so private, but also because there was confusion as to whether people should answer what they earned at their peak working life or now, as a retired person. It was decided to delete this question as adequate socio-demographic information could be deduced, for the sake of this survey, from educational level achieved and occupation.

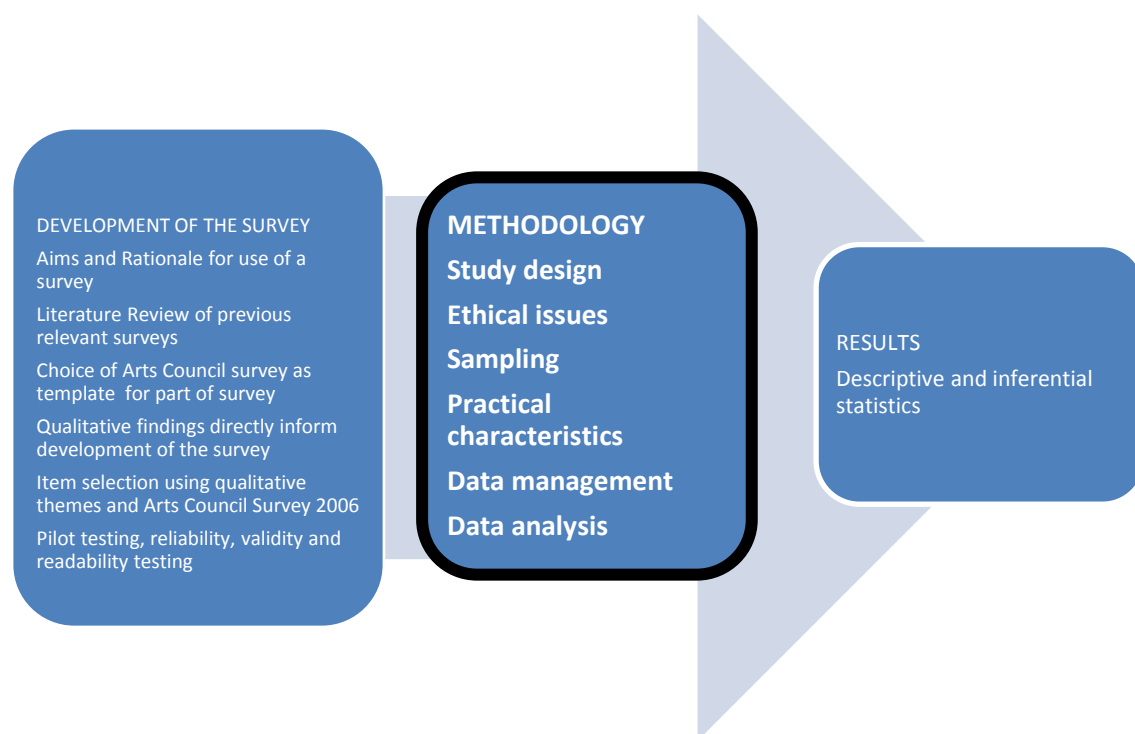
## **10.8 Conclusion**

This chapter presented the reliability, validity and readability testing of the quantitative study, a survey. The next two chapters present the methodology and results of the survey, as conducted with 150 patients from January – September 2013.

## Chapter 11 Methodology – Quantitative Study

### 11.1 Introduction

This chapter presents the methodology for the quantitative study (See Figure 11.1) using the final tested version of the survey (See Appendix 12). The study protocol is included as Appendix 19.



**Figure 11.1 Diagram of the quantitative study highlighting Methodology**

### 11.2 Study Design

#### 11.2.1 Recruitment specific to quantitative study

150 patients were surveyed for the study. Patients were selected from two ambulatory care services in geriatric medicine on specific dates between

January and September 2013. It was recognised that the patients selected for the qualitative study may have over represented a more articulate group of patients so in this survey it was important to gain a cross section of the hospital population. This was done by sampling all patients aged over 65 attending the day hospital at Tallaght Hospital and the Royal Hospital Donnybrook.

### **11.2.2 Ethical approval, Inclusion and Exclusion criteria**

As per General Methodology (See Section Two, 4.4 – 4.5 for further details of methodology for the overall study).

### **11.2.3 Sampling**

Every patient attending the day hospital on a given day of study, who met the inclusion criteria, was eligible for the study. All eligible patients left were surveyed, unless they did not attend or were busy with other appointments.

There are several strategies for sampling patients. In this case convenience sampling was the method used. This approach is common in health service studies, where, for convenience sake, the study units that happen to be available at the time of data collection are selected in the sample (for example, patients attending a clinic or health centre). In this case, all the older people attending the Age Related Day Hospital were surveyed on a particular day. This is not a purely random sample of people; however it gives a useful first impression and does not overly control the sample. A limitation of this type of sampling is that the sample may be quite biased - some types of people may be over-selected, others under-selected or missed altogether. In this example, the interactions observed were biased because the patients were surveyed on specific days that the researcher could attend and work on the research (Fink, 1995b).

### **11.2.4 Practical characteristics**

The following decisions were made when planning collection of the survey:

- The instrument was to be self-administered where possible (assistance given where people have cognitive, physical or literacy problems)
- The survey would not be too long and would be simple to complete

### **11.2.5 Measures used alongside survey**

Three standard measures were used to assess mental, cognitive and physical health levels. The Barthel physical function index (Wade and Collin, 1988), the 3DY Cognitive Test (Molnar et al., 2008) and the Geriatric Depression Scale (GDS) were used (see Section Two, 4.5.5 – 4.5.8).

### **11.2.6 Data Management**

Data management is an important part of any study design. Consistency of data collection was ensured through careful design and testing of the survey (See Chapter 10). Questions were limited to yes/no and agree/disagree to keep the survey as objective as possible. A study specific data collection instrument was designed, in this case a survey, to facilitate consistent collection of participant data by investigators. This was thoroughly piloted and tested prior to use.

Once the survey was completed, the researcher checked for any missing items and returned to the patient to ensure every section of the survey was complete. Data was entered into SPSS software. To ensure the data was clean, sections were taken at random on four separate occasions and data re-entered to check for errors. The researcher entered all data. Original paper versions of the surveys were kept filed so that electronic records could be checked for accuracy. Standard operating procedures were used to ensure consistency in data collection – for example, instructions were given for each question in the survey, every entry on SPSS was checked and then random surveys were double checked to ensure accuracy of data inputting. Decisions were made about how to enter missing data, but as the researcher returned to participants to complete missing entries there were no blanks.



A data dictionary was designed. This is a repository of information about the data in a database. This catalogues important and agreed information for each variable (Fink, 2003b, Fink, 2003a). The data dictionary was the blueprint for the study. See Appendix 20 for the data dictionary. To maintain levels of security of data, the original handwritten surveys were kept locked in a filing cabinet on the hospital premises. The SPSS version was coded so that no personal details were recorded. The computer used to store data was also encrypted to ensure safety of any patient information. Statistical analysis was carried out using SPSS software.

### **11.2.7 Data Analysis**

In this study, descriptive results were important, namely frequency counts and averages. To meet the research objectives the descriptive statistics were first presented. Specifically, frequency of participation in aesthetic events and activities were measured amongst the sample in the last ten years and the last 12 months. Similarly, descriptive statistics were important for questions relating to barriers to current participation in aesthetic and cultural interests and the experience of the aesthetic environment.

Further analysis was then conducted to explore comparisons and relationships between variables – specifically whether gender, age, educational level, type of hospital accommodation (shared room or single), public/private status of patient, physical functioning and depression levels affected engagement in arts events and activities before, during and after hospital stay (Boynton, 2004b, Boynton, 2004a, Fink, 1995a, Scott and Mazhindu, 2005, Salkind, 2000, Waltz and Bausell, 1983).

Table 11.1 presents the process of data analysis, starting with survey aims and objectives, linked to survey questions which specifically answer the objectives, hypotheses (where applicable) and statistics used to answer the research questions and to and test hypotheses.

**Table 11.1 Survey aims, objectives, specific items that address the objectives, hypotheses and statistical tests used**

<b><i>Survey aim</i></b>	<b><i>Survey objective</i></b>	<b><i>Final survey questions specific to this aim and objective</i></b>	<b><i>Comments</i></b>	<b><i>Hypotheses</i></b>	<b><i>Statistics used</i></b>
To create a significant observational survey of patients before, during and after hospital stay that provides information about the aesthetic and cultural interests of patients	Identify the most frequently attended arts activities and events in the population of older people in hospital	Question 1.1 and 1.2 <i>How often in the last 12 months/10 years have you attended arts events and activities?</i>	List of every art form used, as per Arts Council 2006.	Arts events and activities are frequently attended by sample in the last 10 years and last 12 months. There will be a drop off in activity levels in last year due to hospital stay	Descriptive statistics - frequencies
To develop and explore further the themes presented in the qualitative study	To identify if there is loss of access and engagement in arts activities post hospital stay	Q1.3 and 1.4 <i>Do you currently find it difficult to access arts activities you enjoyed prior to hospital stay?</i>	Question lists possible reasons for reduced access to arts activities including a series regarding the theme of loss (specifically loss of confidence, physical difficulties causing barriers to attendance, loss of motivation)	The majority of sample will reduce attendance and activity post hospital stay Loss of confidence is a major reason for reducing attendance and participation in arts events following hospital stay	Descriptive statistics - frequencies
To develop and explore further the themes presented in the qualitative study	To identify which noises were most frequently described as a problem by patients in hospital	Q2.2 Specific questions regarding noise pollution	Each item addresses a different potential noise pollution, as named in qualitative interviews (e.g. noise from staff, noise from machines, noise from other patients)	Patients are disturbed by noises during hospital stay	Descriptive statistics - frequencies
To develop and	To identify which art forms	Q 2.3 and 2.1	Q2.3 The most frequently	Music, film and dance will	Descriptive statistics -

explore further the themes presented in the qualitative study	patients had access to in hospital		cited art forms in qualitative study are listed here to gather data on how frequently they are engaged in by this sample during hospital. Q2.1 identifies how many of sample had choice and control over access to these art forms in hospital	be the most popular art forms in hospital Patients will not have choice over their use of art forms and whether the TV/radio is on or off	frequencies
To develop and explore further the themes presented in the qualitative study	To provide further data as to whether patients had enough quiet spaces in hospital	Q2.2.9		The majority of patients will not have access to quiet spaces when they need them.	Descriptive statistics - frequencies
To develop and explore further the themes presented in the qualitative study	To gather data on 4 general statements related to perceived importance of arts in hospital	Q2.5	Miscellaneous items arising from qualitative study, specifically regarding aesthetics of hospital. These warranted further attention but did not fit into any other section. Specifically these collect data on whether patients expected to be able to continue their arts activities in hospital, if they were able to and if they felt arts are important in hospital.	Patients think arts are important in hospital.  Patients did not expect arts in hospital.  Some, but not all, patients were not interested in pursuing their arts interests in hospital due to ill health and more pressing physical concerns	Descriptive statistics - frequencies
To explore the role of aesthetics in older patients' lives, in the context of what changing health does to one's aesthetic infrastructure	Identify which art forms are most frequently accessed in hospital	Q2.1 and 2.3		Music, film and dance will be the most popular art forms in hospital	Descriptive statistics - frequencies
To explore the role of aesthetics in older patients' lives, in the	To identify barriers to engagement in hospital	Q2.1 and 2.2		Loss of physical ability and loss of confidence are major reasons for not attending	Descriptive statistics - frequencies

context of what changing health does to one's aesthetic infrastructure				arts events post hospital	
To explore the role of aesthetics in older patients' lives, in the context of what changing health does to one's aesthetic infrastructure	To identify whether patients can still attend the art activities of their choice post hospital stay	Q1.3		The majority of sample will reduce attendance and activity post hospital stay	Descriptive statistics - frequencies
To explore the role of aesthetics in older patients' lives, in the context of what changing health does to one's aesthetic infrastructure	To provide data on reasons for lower attendance post hospital (if this is the case)	Q1.4		Loss of physical ability and loss of confidence are major reasons for not attending arts events post hospital	Descriptive statistics - frequencies
To explore the extent to which the hospital environment is aesthetically-deprived or enriched for each patient	Identify how frequently patients can access specific art forms in hospital	Q2.3		Patients cannot access art forms they enjoy in hospital	Descriptive statistics - frequencies
To explore the extent to which the hospital environment is aesthetically-deprived or enriched for each patient	Identify how frequently patients have control over their aesthetic environment	Q2.1 and 2.2		The majority of patients will not have control over TV and radio	Descriptive statistics - frequencies
To explore the	Provide data regarding the	Q2.4		Visual art in hospital is	Descriptive statistics

extent to which the hospital environment is aesthetically-deprived or enriched for each patient	impact of visual art in the hospital and whether patients decorate their own room or ward space			important to patients Patients do not decorate their own rooms with their own art	- frequencies
<p>To provide a foundation for further study to determine whether promotion of aesthetics in healthcare provides benefits to health and quality of life for patients in hospital.</p> <p>To develop a survey to begin to map patients engagement in aesthetics and to catalogue the possibility of aesthetic deprivation in hospital, with a view to developing a Survey of Aesthetic and Cultural Health</p>	Provide descriptive data on a range of items regarding aesthetics in hospital	Q2		<p>Patients do not engage in art forms in hospital</p> <p>Patients do not have control over their aesthetic environment</p>	Descriptive statistics - frequencies
As above	Provide descriptive data on a range of items regarding barriers to attending arts post hospital stay	Q3		Patients do not attend arts events post hospital as frequently as prior to hospital	Descriptive statistics - frequencies
As above	Identify whether arts are frequently accessed prior to hospital stay	Q1.1 and 1.2		Arts are frequently accessed prior to hospital	Descriptive statistics - frequencies

As above	Identify descriptive results that warrant further attention	Q1 and 2		n/a	Descriptive statistics - frequencies
As above	Explore relationship between age and attendance at arts activities and events before, during and after hospital stay	Statistics to determine if there is a relationship between age and all questions in Section 1 and 2		Higher age will affect attendance at arts events	Inferential statistics (see Section 12.5.2 for details)
As above	Explore relationship between gender and attendance at arts activities and events before, during and after hospital stay	Statistics to determine if there is a relationship between gender and all questions in Section 1 and 2		Women will attend and participate in arts events more frequently than men.	Inferential statistics (see Section 12.5.2 for details)
As above	Explore relationship between education level achieved and attendance at arts activities and events before, during and after hospital stay	Statistics to determine if there is a relationship between educational level achieved and all questions in Section 1 and 2		Level of attendance at arts events before and after hospital stay will be lower with lower educational level.  Patients with lower education level are less likely to continue arts activities in hospital.	Inferential statistics (see Section 12.5.2 for details)
As above	Explore relationship between Barthel score of physical functioning and attendance at arts activities and events before, during and after hospital stay	Statistics to determine if there is a relationship between Barthel score of physical functioning and all questions in Section 1 and 2		Higher physical disability levels will result in lower attendance at arts events prior to and post hospital stay.  Patients with higher physical disability levels are less likely to have control over their aesthetic	Inferential statistics (see Section 12.5.2 for details)

				environment.	
As above	Explore relationship between Geriatric Depression Scale and attendance at arts activities and events before, during and after hospital stay	Statistics to determine if there is a relationship between Geriatric Depression Scale and all questions in Section 1 and 2		<p>Higher depression levels will result in lower attendance at arts events prior to and post hospital stay.</p> <p>Patients with higher depression levels are less likely to have control over their aesthetic environment.</p>	Inferential statistics (see Section 12.5.2 for details)
As above	Explore relationship between type of hospital accommodation and attendance at arts activities and events before, during and after hospital stay	Statistics to determine if there is a relationship between type of hospital accommodation and all questions in Section 1 and 2		<p>Patients in shared rooms will experience more noise pollution and less control over their aesthetic environment in hospital.</p>	Inferential statistics (see Section 12.5.2 for details)
As above	Explore relationship between status of patient (i.e. private or public) and attendance at arts activities and events before, during and after hospital stay	Statistics to determine if there is a relationship between status of patient (i.e. private or public) and all questions in Section 1 and 2		<p>Private patients will experience less noise disturbance and are more likely to have control over their aesthetic environment in hospital.</p> <p>Private patients are more likely to continue arts activities in hospital.</p>	Inferential statistics (see Section 12.5.2 for details)

### **11.3 Conclusion**

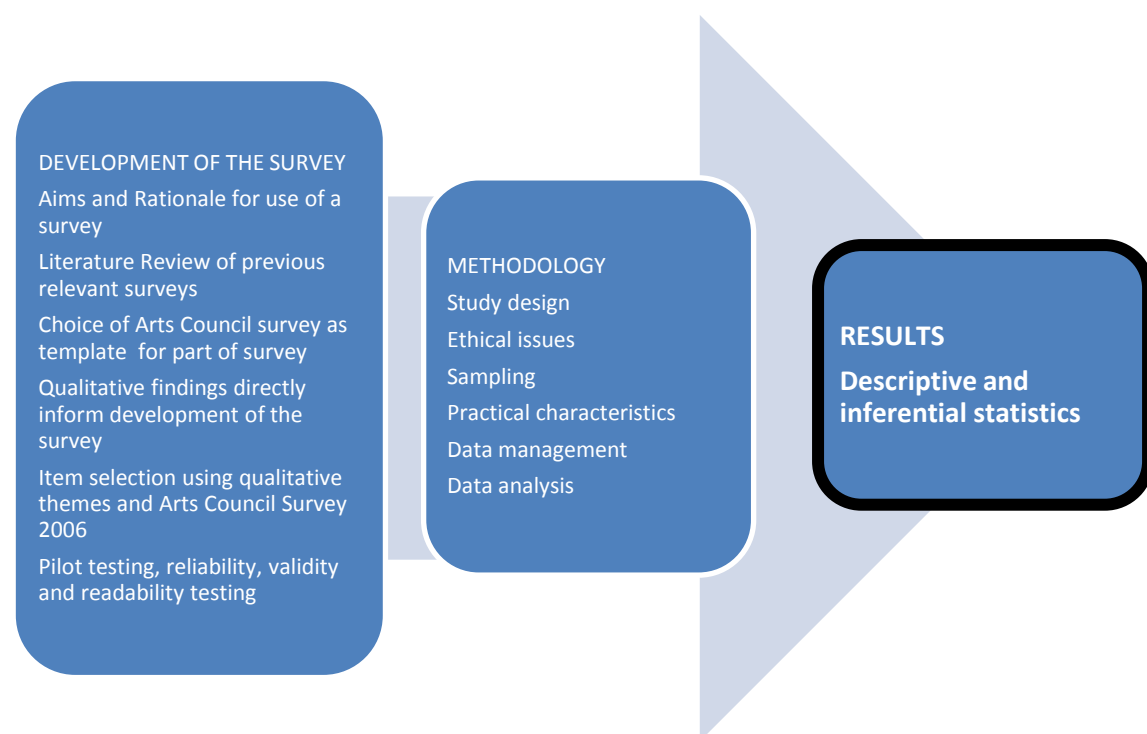
This chapter set out the methodology for the quantitative study, including inclusion and exclusion criteria, ethical approval, data management and plans for analysis. The next chapter sets out the results of the survey.



## Chapter 12 Results of the Quantitative Study

### 12.1 Introduction

This chapter presents the results of the quantitative study (see Figure 12.1). 150 patients completed the Survey of Aesthetic and Cultural Health. Descriptive statistics are presented first, followed by inferential statistics. This section contains multiple analyses of all possible variables of interest, but it must be noted that determining significance is limited due to the difficulties involved in making and trying to interpret multiple comparisons.



**Figure 12.1 Diagram of the quantitative study highlighting Results**

### 12.2 Patients sampled

The survey was completed over 51 days, with 431 new patients available for the survey. Of these, 104 were ineligible due to length of stay and 58 due to

cognitive difficulties. Another 101 patients were unavailable on the day of survey, due to either non-attendance or attendance at other therapies and appointments which took them from the day hospital on the day of survey. 18 patients refused to participate, leaving a total of 150 patients who participated in the survey.

## **12.3 Descriptive results of the survey**

Results are given for the full 150 patients, except in two instances:

- (1) An additional question was added to Q 1.1 and 1.2. This was added after the first 42 patients had completed the survey (see chapter 11). The first 42 surveys only gave answers regarding arts events and activities attended in the last 12 months. The other 108 completed an extra question to record their arts activities and interests in the last 10 years.
- (2) Q1.3 asked if patients currently experienced problems attending arts events and only those who answered 'yes' answered a series of questions regarding their reasons for this. 106 answered yes to this question.

### **12.3.1 Demographic characteristics of patients completing survey**

The majority of patients (83%) were over age 75. The population was all white, with extremely little mix of ethnicity. The results show quite a high level of educational disadvantage. 81% had attended education as far as second level. The majority of respondents were public patients (65.3%) and had been in shared rooms (78% had experience of shared rooms).

The majority (62%) showed low probability of depression, although one third showed probable clinical pattern of mild depression: this was signalled to the clinicians in charge of each Day Hospital.

See Table 12.1 for demographic characteristics of patients completing the survey.

**Table 12.1 Demographic characteristics of patients completing survey (n=150)**

<b><i>Demographic characteristic</i></b>	<b><i>n (%)</i></b>
Age	
- 65 – 74	27 (18)
- 75 – 84	69 (46)
- 85 – 94	50 (33.3)
- >95	4 (2.7)
Gender	
- Male	57 (38)
- Female	93 (62)
Marital status	
- Single	14 (9.3)
- Married	69 (46)
- Divorced/separated	7 (4.7)
- Widowed	60 (40)
Working status	
- Retired	138 (92)
- Unemployed	4 (2.7)
- Full-time Homemaker	3 (2)
Education level completed	
- No formal education	6 (4)
- Primary level	37 (24.7)
- 2 <sup>nd</sup> level	80 (53.3)
- 3 <sup>rd</sup> level undergraduate	10 (6.7)
- 3 <sup>rd</sup> level postgraduate	10 (6.7)
- Still at 3 <sup>rd</sup> level	1 (0.7)
Dependents under the age of 18?	
- Yes	4 (2.7)
- No	146 (97.3)
Ethnic background	
- White Irish	146 (97.3)
- White Irish Traveller	1 (0.7)
- Any other white	2 (1.3)

- All other	1 (0.7)
Accommodation during hospital stay	
- Private room	32 (21.3)
- Shared ward	96 (64)
- Both	21 (14)
- Don't know	1 (0.7)
Recruiting hospital:	
- Royal Hospital Donnybrook	35 (23%)
- Tallaght Hospital	115 (77%)
Barthel Index of Activities of Daily Living (score out of 20, with 20 being most physically disabled)	
- <10	11 (7.3)
- 10 – 15	22 (14.7)
- 16 – 20	117 (78)
Geriatric Depression Score	
- 0 -4 (low probability of depression)	93 (62)
- 5 – 9 (probability of mild depression)	44 (29.3)
- 10 – 15 (probability of severe depression)	13 (8.7)

### 12.3.2 Arts Events - attendance at individual arts events

Attendance at all arts events indicated a reduction from the number attending in the last ten years to the number attending in the last 12 months. The most popular events attended in the last twelve months were film, play, musicals, classical music, art exhibitions, readings and traditional Irish music events, as well as variety shows. However, the most popular event was film, with 21% attendance rate, followed by classical music (12.7 %) which indicates that 1 in 5 of the older hospital patients sampled watch films at the cinema and 1 in 10 attend classical music events in the year before hospital stay.

Looking at attendance during the last ten years, the most popular events were film, musical, play, variety show/pantomime, classical music and opera, art exhibitions and traditional Irish events. There was much higher attendance in the last ten years (as opposed to the last 12 months) with 47% attending films, 40% attending musicals and 40% attending plays. 32% attended classical music and opera. The same events were as popular in both last year and last ten years, and attending arts events was still a minority interest but much more popular in last ten years than in the last year. See Table 12.2 for attendance at individual arts events.

It is important to note, however, that all results related to the question of arts participation in the last ten years need to be treated with caution. The researcher intended to ask patients two separate questions: what arts activities patients participated in during the last year and what arts activities they participated in ten years ago. However, there is a lack of clarity in the question as patients may have included the last year's activity in their quantification of the last ten years activity, hence the past ten years would logically *include* the last year's figure. Thus, conclusions based on these figures need to be drawn with caution. However, whilst the emphasis of these results may be reduced, they are still of interest and are thus all results regarding activity ten years ago are included in this results section in full.

**Table 12.2 Arts Events - attendance at individual arts events (n=150 for 12 months, n=108 for ten years)**

<b>Item Number</b>	<b>Activity</b>	<b>Attended &gt; 12 months n (%)</b>	<b>Did not attend &gt; 12 months n (%)</b>	<b>Attended &gt; 10 years n (%)</b>	<b>Did not attend &gt; 10 years n (%)</b>
1	Mainstream film (e.g. cinema)	32 (21.3)	118 (78.7)	51 (47)	57 (53)
2	Play	22 (14.7)	128 (85.3)	45 (41.7)	63 (58.3)
3	Rock or Popular Music event	4 (2.7)	146 (97.3)	7 (6.5)	101 (93.5)

4	Traditional Irish or Folk Music event	15 (10)	135 (90)	25 (23)	83 (77)
5	Stand-up Comedy	4 (2.7)	146 (97.3)	9 (8.3)	99 (91.7)
6	Musical	21 (14)	129 (86)	40 (37)	68 (63)
7	Variety show/Pantomime	13 (8.7)	137 (91.3)	37 (34.3)	71 (65.7)
8	Art exhibition (for example, paintings, sculpture, photographs)	15 (10)	135 (90)	30 (28)	78 (72)
9	Circus	2 (1.3)	148 (98.7)	10 (9)	98 (91)
10	Country and Western music event	5 (3.3)	145 (96.7)	15 (14)	93 (86)
11	Traditional/Folk Dance event	8 (5.3)	142 (94.7)	15 (14)	93 (86)
12	Jazz/Blues Concert	5 (3.3)	145 (96.7)	11 (10.2)	97 (89.8)
13	Classical Music Concert or Recital	19 (12.7)	131 (87.3)	35 (32.4)	73 (67.6)
14	Readings (e.g. literature or poetry)	15 (10)	135 (90)	19 (17.6)	89 (82.4)
15	Art house film	3 (2)	147 (98)	4 (3.7)	104 (96.3)
16	Opera	8 (5.3)	142 (94.7)	35 (32.4)	73 (67.6)
17	Modern dance event	6 (4)	144 (96)	8 (7.4)	100 (92.6)
18	Ballet	6(4)	144 (96)	18 (16.7)	90 (83.3)

### 12.3.3 Arts activities – participation in individual arts activities

Participation in arts activities again showed a reduction in every category over a 10 year period. For example, 18.5% of the sample played a musical instrument or painted ten years ago and this dropped to 4% and 12.7% respectively in the last twelve months. Similarly 25% (1 in 4) sang in a choir ten years ago but dropped to 4.7% in the last year.

Participation in art classes was popular, even in the last twelve months. Dancing was also a popular activity – combining responses to set dancing, Irish dancing and other dancing, there was a total of 52 (48%) who participated in dancing in the last 10 years, with this dropping to 15 (9.9%) in the last 12 months. Hospital stays and ill health were cited anecdotally as the main cause of this drop in participation. When grouping musical and singing activities together, 59 of the 109 patients (54.6%) had participated in some sort of singing or musical activity in the last 10 years, with this dropping to 19 (12.7%) in the last 12 months. Musical interests, dancing and photography were the most popular activities. A large percentage (51%) noticed public art on the street, 36% in the last 12 months.

See Table 12.3 for participation in individual arts activities.

**Table 12.3 Arts activities – participation in individual arts activities  
(n=150 for last 12 months, n= 108 for last ten years)**

<b>Item Number</b>	<b>Activity</b>	<b>Participated &gt; 12 months n (%)</b>	<b>Did not participate &gt; 12 months n (%)</b>	<b>Participated &gt; 10 years n (%)</b>	<b>Did not participate &gt; 10 years n (%)</b>
1	Play a musical instrument for your own pleasure, rehearse or for an audience	7 (4.7)	143 (95.3)	20 (18.5)	88 (81.5)
2	Painting/drawing/sculpture	18 (12)	132 (88)	20 (18.5)	88 (81.5)

3	Sing in a choir	7 (4.7)	143 (95.3)	27 (25)	81 (75)
4	Set dancing	5 (3.3)	145 (96.7)	17 (15.7)	91 (84.3)
5	Perform or rehearse in play/drama	1 (0.7)	149 (99.3)	11 (10.2)	97 (89.8)
6	Other dancing (not fitness class)	8 (5.3)	142 (94.7)	25 (23)	83 (77)
7	Other Irish traditional/folk dancing	2 (1.3)	148 (98.7)	10 (9.3)	98 (90.7)
8	Photography	15 (10)	135 (90)	8 (7.4)	100 (92.6)
9	Writing (e.g. poems, stories or plays)	8 (5.3)	142 (94.7)	8 (7.4)	100 (92.6)
10	Writing any music	1 (0.7)	149 (99.3)	1 (0.9)	107 (99.1)
11	Making artworks or animations on a computer	3 (2)	147 (98)	3 (2.8)	105 (97.2)
12	Perform or rehearse in light opera/musical	2 (1.3)	148 (98.7)	7 (6.5)	101 (93.5)
13	Making films as an artistic activity	2 (1.3)	148 (98.7)	1 (0.9)	107 (99.1)
14	Perform or rehearse in opera	1 (0.7)	149 (99.3)	2 (1.9)	106 (98.1)
15	Other singing to an audience or rehearsing (not karaoke)	5 (3.3)	145 (96.7)	12 (11.1)	96 (88.9)
16	I have stopped to look at any art (i.e., a sculpture) in a public place (e.g. in a park, on a street etc.) within the last 12 months	54 (36)	96 (64)	55 (51)	53 (49)

In both Questions 1.1 and 1.2 there was a box for 'other' in case any activities were missed. This was in line with the original survey used by the Arts Council (The Arts Council, 2006). Where patients said yes to 'other' activities or events these were recorded with qualitative notes taken as to



what activities were listed. In total 39 of the 150 patients (n=39, 26%) cited 'other' activities with 41 activities listed. These were grouped into similar activities. Whilst these are not analysed quantitatively, this small sample give a strong flavour of the variety of interests amongst the 150 patients (see Table 12.4).

**Table 12.4 'Other' activities cited by patients**

<b><i>Activity</i></b>	<b><i>Number of patients</i></b>
Crafts (knitting, sewing, tapestry)	10
Sports	9
Walking	6
Reading	5
Gardening	2
Computer	1
Playing cards	1
Political action	1
Horse racing	1
Mountain climbing	1
Book binding	1
Bingo	1
No details given	5

#### **12.3.4 Arts Events and Activities - number attending at least one arts events/activity**

These figures were created by counting how many arts events each patient attended (whatever the art form) in the last ten years and twelve months. Each patient then had a total number of arts events attended. The same was created regarding participation in arts activities. This allowed analysis based on the total number of arts activities or events attended rather than specifying individual art forms (see Table 12.5).

47.3% of respondents had attended some sort of arts event in the last twelve months and 78.7% in the last ten years. Participation in events was lower, with 27% participating in last twelve months, rising to 58.3% in last ten years. The most striking result here is the drop in activity in the last year from previous levels of arts engagement. Also the vast majority of patients did engage in at least one arts event or activity in the last ten years.

**Table 12.5 Arts Events and Activities - attendance at arts events and participation in arts activities, total numbers (n=150 for 12 months, n=108 at 10 years)**

<b>Attendance at ANY arts events or activities</b>	<b>Total number</b>	<b>n (%)</b>
Attendance at ANY Arts Events <b>in last 12 months</b> (i.e. total number of all arts activities attended in last 12 months)	0	79 (52.7)
	1	32 (21.3)
	2	10 (6.7)
	3	9 (6)
	4	7 (4.7)
	5	4 (2.7)
	6	3 (2)
	7	2 (1.3)
	8	2 (1.3)
	11	1 (0.7)
	16	1 (0.7)
Attendance at ANY Arts Events <b>in last 10 years</b>	0	23 (21.3)
	1	13 (12)
	2	7 (6.5)
	3	11 (10)
	4	7 (6.5)
	5	17 (16)
	6	12 (11)
	7	5 (4.6)
	8	3 (2.8)
	9	3 (2.8)
	10	3 (2.8)
	11	1 (0.9)
	12	1 (0.9)

	13	111 (0.9)
	16	1 (0.9)
Participation in ANY Arts Activities in last 12 months	0	110 (73)
	1	21 (14)
	2	10 (6.7)
	3	4 (2.7)
	4	3 (2.0)
	5	1 (0.7)
	15	1 (0.7)
Participation in ANY Arts Activities in last 10 years	0	45 (41.7)
	1	23 (21.3)
	2	16 (14.8)
	3	11 (10.2)
	4	4 (3.7)
	5	2 (1.9)
	6	2 (1.9)
	10	1 (0.9)
	11	1 (0.9)
	15	1 (0.9)

### 12.3.5 Current attendance at Arts Events and Activities

106 patients (71% of sample) currently found it hard to attend arts activities. 86% of those who were no longer able to attend arts events cited physical health issues such as too much pain as the main cause for non-attendance. Transport issues and access to venues were the next major issues for those who had stopped attending arts events. 20 (19%) of those not attending had nobody to go with. Loss of confidence and lack of motivation were the next most significant reasons for non-attendance. 20% (1 in 5) of the sample cited being afraid to go out and low mood as reasons for not attending arts events currently. See Table 12.6 for current attendance at arts events and activities and Table 12.7 for barriers to current attendance.

**Table 12.6 Current attendance at Arts Events and Activities (n=150)**

Survey question	Yes n (%)	No n (%)
Do you find it difficult to take part in the arts activities which interest you?	106 (70.7)	44 (29.3)

**Table 12.7 Barriers to current attendance (n=106)**

Reason for non- attendance at arts activities and events	Yes n (%)	No n (%)
Physical health issues (for example, too much pain, physical difficulties)	91 (86)	15 (14)
Transport difficulties	44 (42)	62 (58)
Access to venue	34 (32)	72 (68)
Lack of motivation	32 (30)	74 (70)
Loss of confidence	30 (28)	76 (72)
Fear of going out	22 (21)	84 (79)
Low mood	22 (21)	84 (79)
Too far away	20 (19)	86 (81)
Nobody to go with	20 (19)	86 (81)
I might feel uncomfortable or out of place	18 (17)	88 (83)
Cost	13 (12)	93 (88)
Inadequate information on event	11 (10)	95 (90)
Family commitments	9 (8)	97 (92)
Difficult to find time	6 (6)	100 (94)

## 12.4 Descriptive results - Section 2 Arts in Hospital

### 12.4.1 Receptive arts in hospital

42% of patients watched TV of their choice in hospital and 56.7% of patients listened to radio programmes of their choice during their hospital stay. 47.3% listened to music of their choice. The majority of patients did not have choice over these activities. Anecdotally, many commented that although the

TV was on, it did not show what they wanted and they had no control over it. The issue of choice was important in this question.

Given that going to see films was the most popular art event in question 1, it is notable that only 29.3% of patients watched films of their choice in hospital. However, 55% of patients read in hospital and more than one in 20 used e-reading devices (6.7%). Low numbers of this population used a computer (1.3%). See Table 12.8 for engagement in receptive arts in hospital.

**Table 12.8 Receptive arts in hospital (n=150)**

Item number	Survey question	Agree n (%)	Disagree n (%)
1	In hospital I watched TV/DVD of my choice	63 (42)	87 (58)
2	In hospital I used a computer	2 (1.3)	48 (98.7)
3	In hospital I listened to radio programmes of my choice	85 (56.7)	65 (43.3)
4	In hospital I watched films of my choice	44 (29.3)	106 (70.7)
5	In hospital I listened to music of my choice	71 (47.3)	79 (52.7)
6	In hospital I read for pleasure	83 (55.3)	67 (44.7)
7	In hospital I used e-reading devices	10 (6.7)	140 (93.3)

#### 12.4.2 Noise in hospital

As far as sound disturbance is concerned, the largest problem recorded was sounds from other patients, with 36 (24%) citing this as a problem. Just over 1 in 10 patients were disturbed by staff (14%) and machines (11%). Results in this section about noise pollution and the aesthetic environment, are, however, inconclusive. Concern arises that the vast majority of patients had no control over the TV (n=99, 66%) or radio (n=97, 64.6%). However, when asked if noises from the TV and music disturbed them, patients recorded lower numbers. 124 (82.7%) stated that sounds from the TV *did not* disturb

them and 136 (90.7%) stated that music being played on the ward *did not* disturb them.

The vast majority of patients (n=108, 72%) were not able to choose whether to be in a private room or shared ward. The majority of patients had access to a quiet place when they needed it (n=92, 61.3%) and access to conversation and companionship when they needed it (n=126, 84%). It is notable, however, that whilst 61.3% had access to quiet space when they needed it, this percentage could be improved as it still left nearly 40% without quiet spaces in hospital.

See Table 12.9 for responses to survey questions concerning noise in hospital.

**Table 12.9 Noise in hospital (n=150)**

Item number	Survey question	Agree n (%)	Disagree n (%)	Other n (%)
1	I had control over whether the TV was on or off while in hospital	50 (33.3)	99 (66)	1 (0.7%)
2	Sounds from TV or radio disturbed me when I was in hospital	26 (17.3)	124 (82.7)	0 (0%)
3	I had control over whether the radio was on or off while in hospital	52 (34.7)	97 (64.6)	1 (0.7)
4	Music being played on the ward disturbed me when I was in hospital	14 (9.3)	136 (90.7)	0 (0%)
5	Sounds from other patients disturbed me when I was in hospital	36 (24)	114 (76)	0 (0%)
6	Sounds from machines or equipment disturbed me when I was in hospital	17 (11.3)	133 (88.7)	0 (0%)
7	Sounds from staff disturbed me when I was in hospital	21 (14)	129 (86)	0 (0%)
8	I was able to choose whether to share a room with other patients while in hospital	42 (28)	108 (72)	0 (0%)
9	I had access to a quiet place when I needed it in hospital	92 (61.3)	58 (38.7)	0 (0%)
10	I had access to company and conversation when I needed it in hospital	126 (84)	24 (16)	0 (0%)

### **12.4.3 Most popular art forms**

58.7% of patients listened to music in hospital; this was the most popular arts activity of the group listed. Next highest was watching films in hospital (33.3%). These receptive arts were more popular than participative arts listed in this section (e.g. writing in hospital, playing an instrument or painting). This links with the qualitative findings, where patients indicated that they preferred receptive arts in hospital when sick.

There was a drop-off in the numbers of patients who participated in any art forms in hospital, compared to the numbers who participated in the same art forms prior to attending hospital. This was the case in all art forms listed except writing. Given that just under 1 in 5 (18%) patients painted or drew in the last ten years, this dropped to 1 in 20 (5%) in hospital. Similarly, whilst playing a musical instrument was a minority interest - 20 (18%) in last ten years and 7 (4.7%) in last 12 months - this dropped again in hospital to 2 (1.3%). Nonetheless, it is perhaps notable that 2 people in the sample were able to play their musical instrument in hospital. These were both in the Tallaght Hospital site.

One in six, (n=21, 14%), listened to live music in hospital: of these 15 were from Tallaght Hospital where there is an active music in the hospital programme and 6 from the Royal Hospital Donnybrook site.

With regard to films, links can be made between Q 2.3.6, Q 1.1.1 and Q 2.1.4. The majority did not watch films of their choice in hospital (n=106, 70.7%). There was a drop in viewing films when patients attended hospital. Although 47% attended films in the last 10 years, only 33.3 % watched films in hospital and 29.3% said they could watch films of their choice in hospital.

One area which reversed the general trend was writing, with 8 patients writing in the last ten years or 12 months, rising in hospital to 12.

See Table 12.10 for engagement in popular art forms in hospital

**Table 12.10 Popular art forms – music, dance, art, writing, film  
(n=150)**

Item number	Survey question	Agree n (%)	Disagree n (%)
1	I listened to music while in hospital	88 (58.7)	62 (41.3)
2	I listened to live music when I was in hospital	21 (14)	129 (86)
3	I played a musical instrument in hospital	2 (1.3)	148 (98.7)
4	I wrote in hospital	12 (8)	138 (92)
5	I painted or drew in hospital	8 (5.3)	142 (94.7)
6	I watched films in hospital	50 (33.3)	100 (66.7)

#### 12.4.4 Visual art in hospital

The questions in Section 2.5 are challenging to interpret, despite reliability and validity testing. 32.7% continued the arts activities they enjoy in hospital, which indicates a deficit in hospital regarding access to arts activities and 49.3% felt that their arts interests were important in hospital. A large number (62%) stated that arts programmes are important in hospital. However, 39% did not access arts in hospital because they were too ill. See Table 12.11 for responses to visual art in hospital and Table 12.12 for responses to questions regarding access to arts activities in hospital.

**Table 12.11 Visual art in hospital (n=150)**

Item number	Survey question	Agree n (%)	Disagree n (%)	Don't know n (%)
1	I noticed the visual art, pictures or photographs on the wall in my room or ward	84 (56)	63 (42)	3 (2)
2	I put my own art, pictures or photographs on the wall in my room or ward	12 (8)	135 (90)	3 (2)
3	I was satisfied with the visual art on display in the hospital	84 (56)	61 (40.7)	5 (3.3)
4	The visual art in hospital was interesting and varied.	78 (52)	67 (44.7)	5 (3.3)



**Table 12.12 Access to arts activities in hospital (n=150)**

Item number	Survey question	Agree n (%)	Disagree n (%)	Don't know n (%)
1	I continued the arts activities I enjoy while in hospital	49 (32.7)	101 (67.3)	0 (0%)
2	My arts interests were important to me when I was in hospital	74 (49.3)	76 (50.7)	0 (0%)
3	Arts programmes are important in hospital	93 (62)	53 (35.3)	4 (2.7)
4	I did not access arts in hospital because I was too ill	59 (39.3)	90 (60)	1 (0.7)

## 12.5 Inferential statistics<sup>4</sup>

### 12.5.1 Introduction

The aim of this analysis was to examine whether there was any association between responses to the survey and patient demographics, specifically gender, education level, type of accommodation (single/shared room), public/private status of patient, age, physical function and depression levels. However, it is important to note that whilst comparison is made in all instances between two groups, the significance of p values at <0.05 should be treated with caution due to multiple comparisons which may weaken any generalisations that could be taken from these results.

### 12.5.2 Statistical Methods

The statistical methods used for the analysis were dependent on the nature of the patient demographics. Some of the demographics were categorical in nature (i.e. gender, education level, accommodation, public/private status), whilst others were continuous variables (i.e. age, Barthel index score and Geriatric Depression Scale (GDS) score). Of the continuous variables, age was found to be approximately normally distributed, whilst the Barthel index and GDS were found to have skewed distributions.

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<sup>4</sup> These results were completed with the assistance of a Statistician, Paul Bassett.

Table 12.13 shows how each question was examined.

**Table 12.13 Statistical analysis**

<b>Dependent variable - Survey question</b>	<b>Independent variable - Demographic item</b>	<b>Statistical analysis used</b>	<b>Description of statistic</b>
Q1.1 (Total score <sup>5</sup> ) & Q1.2 (Total score)	Barthel, GDS and Age	Spearman's rank test	This non-parametric test is used to determine whether a change in one variable tends to be associated with a change in another.
Q1.1 (Total score) & Q1.2 (Total score)	Gender, accommodation and public/private status	Mann-Whitney test	A non-parametric test for differences in the median of 2 independent samples.
Q1.1 (Total score) & Q1.2 (Total score)	Education level	Kruskal-Wallis	A non-parametric test of significance used when there are more than 2 independent samples and when alternative parametric tests cannot be used. Can be used with data measured on the ordinal, interval or ratio scale.
Q1.3 (Each item tested individually)	Gender, education level, accommodation and public/private status	Fisher's exact test	This test is useful for categorical data that result from classifying objects in two different ways; it is used to examine the significance of the association between the two kinds of classification. Fisher's test is useful when interested in whether there is an association between two variables rather than a difference.
Q1.3 (Each item tested individually)	Age	Unpaired t-test	Tests for differences between the means.
Q1.3 (Each item tested individually)	Barthel and GDS	Mann-Whitney test	See above
Q2 (Each item tested individually)	Gender, education level, accommodation and public/private	Fisher's exact test	See above

<sup>5</sup> For details of how total score was calculated see Section 12.3.4

	status		
Q2 (Each item tested individually)	Age	Unpaired t-test	See above
Q2 (Each item tested individually)	Barthel and GDS	Mann-Whitney test	See above

In Q1.1 and 1.2 the scores were found to have positively skewed distributions. Spearman's rank correlation was used to examine the size of the association between this variable and the continuous patient demographics. Due to skewed distribution of the scores, the Mann-Whitney test was used to compare between demographics with only two categories, whilst the Kruskal-Wallis test was used to compare between categorical variables with more than two categories.

Q 1.3 concerned the difficulty in taking part in arts events (yes or no). The association between this variable and the categorical demographics was assessed using Fisher's exact test. The unpaired t-test was used to compare age between the two response groups, whilst the Mann-Whitney test was used to compare between response groups for continuous variables not found to be normally distributed (Barthel and GDS).

Individual questions from Section 2 of the survey were analysed. Each of these items had binary responses, with patients either agreeing or disagreeing to the statements. As such, these measures were of a similar type to question 1.3, and thus identical analysis methods were used. That is, Fisher's exact test for the categorical variables, and either the unpaired t-test or Mann-Whitney for the continuous demographics (depending on distribution).

## 12.5.3 Results

### 12.5.3.1 Age

The first set of analyses examined associations between age and the various survey responses. Initially the association between age and the responses to Q1.1 and Q1.2 were examined, and the analysis results are summarised in the Table 12.14. The figures reported the correlation coefficients indicating the size of the relationship between variables, and p-values indicating the significance of the results. The results suggest some evidence that the number of arts events attended varied by age. There was a negative correlation between the two variables, suggesting that older patients attended fewer arts events than younger patients. There were no other significant associations with age.

See Table 12.14 for association between age and Q1.1 and 1.2.

**Table 12.14 Association between Age and Q1.1 and 1.2**

Question group	N	Correlation Coefficient	P-value
Q1.1a - Attended in last 12 months	150	-0.20	<b>0.01</b>
Q1.1b - Attended in the ten years prior to hospital	108	-0.14	0.16
Q1.2a - Taken part in last 12 months	150	-0.03	0.70
Q1.2b - Taken part in the ten years prior to hospital	108	0.09	0.33

The association between age and difficulty in taking part in arts events post hospital stay (Q1.3) were next examined. The results of the analysis are summarised in Table 12.15. The figures reported are the mean and standard deviation in each response category. The age of patients who did and didn't find it difficult to take part varied significantly. Those who had difficulty were generally older, on average almost 3 years older than those without difficulty.

**Table 12.15 Association between Age and Q1.3**

<b>Q1.3 - Difficult to take part in arts activities and events</b>	<b>n</b>	<b>Mean age (SD)</b>	<b>P-value</b>
No	44	79.5 (7.1)	<b>0.03</b>
Yes	106	82.2 (6.8)	

The association between age and the 32 items in Section 2 responses are summarised in Table 12.16. The figures reported are the mean and standard deviation age for those who agreed and disagreed with each of the various statements. P-values indicating the statistical significance of the results are also given. The results suggest that for the majority of questions, there was no difference in age between those who agreed and disagreed with the statements. A borderline statistically significant difference was found for Q2.2.4 which asked about music disturbance. Those who were disturbed tended to be older, with a mean age of 85 compared to 81 in the group not disturbed by music.

**Table 12.16 Association between Age and Section 2**

<b>Question</b>	<b>Disagree</b>		<b>Agree</b>		<b>P-value</b>
	<b>n</b>	<b>Mean (SD)</b>	<b>n</b>	<b>Mean (SD)</b>	
<b>Q2.1</b>					
2.1.1 Watched TV/DVD	87	81.9 (7.0)	63	80.7 (6.9)	0.32
2.1.2 Used a computer	148	81.4 (6.9)	2	76.4 (12.3)	0.31
2.1.3 Listened to radio	65	80.6 (7.6)	85	82.0 (6.4)	0.22
2.1.4 Watched films	106	81.9 (6.9)	44	80.0 (7.0)	0.13
2.1.5 Listened to music	79	80.5 (7.4)	71	82.4 (6.3)	0.10
2.1.6 Read for pleasure	67	80.3 (7.2)	83	82.2 (6.7)	0.10
2.1.7 Used e-reading devices	140	81.6 (7.0)	10	78.1 (5.3)	0.13
<b>Q2.2</b>					
2.2.1 Control over TV	99	81.8 (6.8)	50	80.5 (7.2)	0.26
2.2.2 TV/radio disturbed me	124	81.3 (6.8)	26	81.8 (7.7)	0.75
2.2.3 Control over the radio	97	81.2 (7.6)	52	81.7 (5.8)	0.67
2.2.4 Music disturbed me	136	81.0 (7.0)	14	85.3 (5.2)	<b>0.03</b>

2.2.5 Other patients disturbed me	114	81.0 (6.7)	36	82.7 (7.6)	0.20
2.2.6 Machines disturbed me	133	81.2 (6.8)	17	83.0 (8.5)	0.30
2.2.7 Staff disturbed me	129	81.2 (6.8)	21	82.3 (8.3)	0.51
2.2.8 Choose to share a room	108	81.0 (7.4)	42	82.4 (5.8)	0.25
2.2.9 Access to quiet place	58	81.5 (6.4)	92	81.3 (7.3)	0.82
2.2.10 Access to company	27	79.6 (6.6)	126	81.7 (7.0)	0.17
<b>Q2.3</b>					
2.3.1 Listened to music	62	81.3 (6.8)	88	81.4 (7.1)	0.94
2.3.2 Listened to live music	129	81.2 (0.6)	21	82.4 (6.6)	0.47
2.3.3 Played musical instrument	148	81.4 (7.0)	2	78.5 (10.1)	0.55
2.3.4 Wrote	138	81.6 (6.7)	12	78.2 (9.5)	0.10
2.3.5 Painted or drew	142	81.3 (6.8)	8	83.0 (9.4)	0.51
2.3.6 Watched films	100	81.9 (6.7)	50	80.3 (7.5)	0.19
<b>Q2.4</b>					
2.4.1 Noticed art/pictures on wall	63	81.1 (6.9)	84	81.5 (7.0)	0.74
2.4.2 Put own art on the wall	135	81.2 (7.0)	12	82.6 (6.6)	0.50
2.4.3 Satisfied with visual art	61	81.9 (7.1)	84	80.9 (7.0)	0.40
2.4.4 Visual art was interesting	67	81.3 (7.3)	78	81.3 (6.8)	0.99
<b>Q2.5</b>					
2.5.1 Continued arts activities	101	81.2 (7.2)	49	81.7 (6.4)	0.67
2.5.2 Arts interests important	76	81.0 (7.7)	74	81.8 (6.1)	0.46
2.5.3 Arts programmes important	53	80.6 (7.6)	93	81.6 (6.5)	0.36
2.5.4 Did not access arts	90	82.0 (6.4)	59	80.3 (7.7)	0.14

### 12.5.3.2 Gender

The next set of analyses examined the association between gender and the survey responses. Firstly the association between gender and the scores obtained from Q1.1 and Q1.2 were examined, with the analysis results summarised in Table 12.17. The figures reported are the median and inter-quartile range score for each gender. The results indicate no differences in scores between genders.

The response to Q1.3 was also compared between genders, with the results summarised in Table 12.18. The figures reported are the number and percentage of patients who did and didn't have difficulty taking part in arts activities for each gender. The results suggested no statistically significant difference between genders.

**Table 12.17 Association between Gender and Q1.1and 1.2**

Question group	Males		Females		P-value
	n	Median (IQR)	N	Median (IQR)	
Q1.1a - Last 12 months	57	0 (0, 2)	93	0 (0, 2)	0.93
Q1.1b – Attended in the ten years prior to hospital	39	4 (1, 5)	69	3 (1, 6)	0.92
Q1.2a - Last 12 months	57	0 (0, 1)	93	0 (0, 1)	0.91
Q1.2b – Participated in the ten years prior to hospital	39	1 (0, 2)	69	1 (0, 2)	0.88

**Table 12.18 Association between gender and Q.3**

Q1.3 - Difficult to take part	Males n (%)	Females n (%)	P-value
No	21 (37%)	23 (25%)	0.14
Yes	36 (63%)	70 (75%)	

The responses to Section 2 were also compared between genders, and the responses to all items were not found to differ significantly between genders.

### 12.5.3.3 Education

The next set of analyses examined differences in responses depending on education level. To reduce the number of categories, and to increase the sample size in each category, patients were grouped into three categories, either no/primary education, 2nd level education or any 3rd level education.

The responses to Q1.1 and Q1.2 were compared between groups and the results are summarised in Table 12.19. The figures reported are the median and inter-quartile range in each education group, along with p-values indicating the difference between the three groups (see Table 12.19). Responses to Q1.1 and Q1.2 were not found to significantly vary by the education level of the patients.

**Table 12.19 Association between Educational level and Q1.1 and 1.2**

Question group	None /primary		2nd level		3rd level		P- value
	N	Median (IQR)	n	Median (IQR)	N	Median (IQR)	
Q1.1a - Last 12 months	43	0 (0, 2)	80	0 (0, 1)	27	1 (0, 2)	0.26
Q1.1b – Ten years prior to hospital	29	3 (1, 5)	62	3 (1, 6)	17	5 (4, 7)	0.24
Q1.2a - Last 12 months	43	0 (0, 1)	80	0 (0, 1)	27	0 (0, 1)	0.97
Q1.2b – Ten years prior to hospital	29	1 (0, 1)	62	1 (0, 2)	17	2 (0, 3)	0.16

The next analysis compared between education groups for the response to Q1.3, with no statistically significant difference between education groups was observed.

The responses to Section 2 were also compared between the three education groups, with the analysis results summarised in Table 12.20. The figures reported are the number and percentage of patients in each category who



agreed with the statements. The analyses suggested that only two of the survey questions were found to vary significantly between education groups.

Those with a lower level of education (none/primary) were more likely to watch films than those with higher levels of education. 44% of none/primary education patients watched films compared to around 25% in the two other education categories. Patients in the highest level of education were more likely to write in hospital. 22% of the level 3 group wrote, compared to only around 5% of patients in the other two groups.

See Table 12.20 for details of association between educational level and Section 2.

**Table 12.20 Association between Educational level and Section 2**

<b>Question</b>	<b>None /primary (n=43) n (%)</b>	<b>2nd level (n=80) n (%)</b>	<b>3rd level (n=27) n (%)</b>	<b>P- value</b>
<b>Q2.1</b>				
2.1.1 Watched TV/DVD	22 (51%)	32 (40%)	9 (33%)	0.30
2.1.2 Used a computer	0 (0%)	1 (1%)	1 (4%)	0.41
2.1.3 Listened to radio	22 (51%)	46 (58%)	17 (63%)	0.63
2.1.4 Watched films	19 (44%)	18 (23%)	7 (26%)	<b>0.04</b>
2.1.5 Listened to music	18 (42%)	39 (49%)	14 (52%)	0.69
2.1.6 Read for pleasure	24 (56%)	44 (55%)	15 (56%)	1.00
2.1.7 Used e-reading devices	4 (9%)	3 (4%)	3 (11%)	0.25
<b>Q2.2</b>				
2.2.1 Control over TV	14 (33%)	27 (34%)	9 (33%)	1.00
2.2.2 TV/radio disturbed me	6 (14%)	11 (14%)	9 (33%)	0.07
2.2.3 Control over the radio	16 (37%)	24 (30%)	12 (44%)	0.39

2.2.4 Music disturbed me	2 (5%)	8 (10%)	4 (15%)	0.33
2.2.5 Other patients disturbed me	13 (30%)	15 (19%)	8 (30%)	0.28
2.2.6 Machines disturbed me	7 (16%)	7 (9%)	3 (11%)	0.48
2.2.7 Staff disturbed me	6 (14%)	8 (10%)	7 (26%)	0.13
2.2.8 Choose to share a room	15 (35%)	20 (25%)	7 (26%)	0.54
2.2.9 Access to quiet place	27 (63%)	47 (59%)	18 (67%)	0.75
2.2.10 Access to company	35 (81%)	69 (86%)	22 (81%)	0.72
<b>Q2.3</b>				
2.3.1 Listened to music	24 (56%)	48 (60%)	16 (59%)	0.90
2.3.2 Listened to live music	3 (7%)	13 (16%)	5 (19%)	0.27
2.3.3 Played musical instrument	0 (0%)	1 (1%)	1 (3%)	0.41
2.3.4 Wrote	3 (7%)	3 (4%)	6 (22%)	<b>0.02</b>
2.3.5 Painted or drew	4 (9%)	2 (3%)	2 (7%)	0.21
2.3.6 Watched films	19 (44%)	24 (30%)	7 (26%)	0.21
<b>Q2.4</b>				
2.4.1 Noticed art/pictures on wall	25 (60%)	41 (52%)	18 (69%)	0.28
2.4.2 Put own art on the wall	4 (10%)	6 (8%)	2 (8%)	0.92
2.4.3 Satisfied with visual art	26 (63%)	43 (55%)	15 (58%)	0.73
2.4.4 Visual art was interesting	26 (63%)	39 (50%)	13 (50%)	0.36
<b>Q2.5</b>				
2.5.1 Continued arts activities	13 (30%)	27 (34%)	9 (33%)	0.95
2.5.2 Arts interests important	19 (44%)	42 (53%)	13 (48%)	0.67
2.5.3 Arts programmes important	28 (68%)	50 (64%)	15 (56%)	0.57
2.5.4 Did not access arts	19 (45%)	27 (34%)	13 (48%)	0.29

#### 12.5.3.4 Barthel score

The association between the Barthel score and the survey responses was also examined. The association between Barthel score and the arts events attended and taken part in was first examined, with the results summarised in Table 12.21. Figures reported are the correlation coefficients and their associated p-values.

The results suggest some evidence of an association between Barthel score and both parts of Question 1.1. However, the results were of borderline statistical significance in both cases. The positive correlations suggests that those with a higher Barthel score attended more events in the last 12 months and during the last ten years, than those with lower scores. The Barthel score was not significantly correlated with the responses to Q1.2.

**Table 12.21 Association between Barthel score and Q1.1 and 1.2**

Question group	n	Correlation Coefficient	P-value
Q1.1a - Attended in last 12 months	150	0.17	<b>0.04</b>
Q1.1b - Attended ten years prior to hospital	108	0.19	0.05
Q1.2a - Taken part in last 12 months	150	0.08	0.34
Q1.2b - Taken part ten years prior to hospital	108	0.13	0.16

The association between Q1.3 and the Barthel score were next examined. The results are summarised in Table 12.22. The figures reported are the median and inter-quartile range Barthel score in each response category. No significant association between question response and Barthel score was observed.

**Table 12.22 Association between Barthel score and Q1.3**

<b>Q1.3 - Difficult to take part</b>	<b>n</b>	<b>Barthel Median (IQR)</b>	<b>P-value</b>
No	44	18 (17, 20)	0.72
Yes	106	18 (15, 20)	

The association between the Barthel score and all items in Section 2 was next examined and there was no evidence that the Barthel score was associated with any aspect of Section 2.

### **12.5.3.5 GDS**

The GDS score was the next variable examined. The correlation between this score and responses to Q1.1 and Q1.2 were examined, and the results are summarised in Table 12.23. The results suggested strong evidence of an association between GDS score and the number of arts events attended in the last 12 months. There was a negative correlation between variables, suggesting that those with higher GDS scores attended fewer arts events. There was also slight evidence of a negative associated with the number of arts participated in during the last 12 months, but this result was not quite statistically significant. There was no significant association between GDS and arts events attended or participated in during the last ten years.

**Table 12.23 Association between Geriatric Depression Scale and Q1.1.and 1.2**

<b>Question group</b>	<b>n</b>	<b>Correlation Coefficient</b>	<b>P- value</b>
Q1.1a - Attended in last 12 months	149	-0.29	<b>&lt;0.001</b>
Q1.1b - Attended ten years prior to hospital	107	-0.02	0.87
Q1.2a - Taken part in last 12 months	149	-0.15	0.07
Q1.2b - Taken part ten years prior to hospital	107	-0.10	0.29

The association between GDS score and the response to Q1.3 was next examined, with the results summarised in 12.24. The GDS was not found to vary between patients who did and did not find it difficult to take part in arts events.

**Table 12.24 Association between Geriatric Depression Scale and Q1.3**

<b>Q1.3 - Difficult to take part</b>	<b>n</b>	<b>GDS Median (IQR)</b>	<b>P-value</b>
No	44	4 (2, 6)	0.16
Yes	105	4 (3, 6)	

The next analyses examined how the GDS varied between those who agreed and disagreed with each statement in Section 2. The figures reported in Table 12.25 are the median and inter-quartile range GDS score in each group, along with p-values indicating the significance of the results. There was no significant association between the GDS and the responses to most of the section 2 questions. However, borderline statistically significant associations were observed for two questions and statistical significance was observed for one item ('Did not access arts').

Those who had access to a quiet place had lower GDS scores than those without access. There were only small numbers of patients who played a musical instrument, but these were found to have lower GDS scores. Patients who disagreed with the statement 'I did not access the arts in hospital' (Q2.5.4) had higher GDS scores compared to patients who did access the arts.

**Table 12.25 Association between Geriatric Depression Scale and Section 2**

Question	Disagree		Agree		P-value
	n	Median (IQR)	n	Median (IQR)	
<b>Q2.1</b>					
2.1.1 Watched TV/DVD	86	4 (3, 6)	63	4 (3, 6)	0.82
2.1.2 Used a computer	147	4 (3, 6)	2	5 (4, 6)	0.50
2.1.3 Listened to radio	65	4 (3, 7)	85	4 (3, 6)	0.29
2.1.4 Watched films	105	4 (3, 6)	44	4 (3, 7)	0.43
2.1.5 Listened to music	79	4 (3, 6)	70	4 (3, 6)	0.70
2.1.6 Read for pleasure	66	4 (3, 7)	83	4 (3, 6)	0.14
2.1.7 Used e-reading devices	139	4 (3, 6)	10	4 (4, 5)	0.85
<b>Q2.2</b>					
2.2.1 Control over TV	98	4 (3, 6)	50	4 (3, 7)	0.43
2.2.2 TV/radio disturbed me	123	4 (3, 6)	26	6 (3, 7)	0.07
2.2.3 Control over the radio	96	4 (3, 6)	52	4 (3, 7)	0.67
2.2.4 Music disturbed me	135	4 (3, 6)	14	3 (3, 7)	0.97
2.2.5 Other patients disturbed me	114	4 (3, 6)	35	4 (3, 8)	0.62
2.2.6 Machines disturbed me	132	4 (3, 6)	17	3 (3, 7)	0.88
2.2.7 Staff disturbed me	128	4 (3, 6)	21	5 (3, 8)	0.29
2.2.8 Choose to share a room	107	4 (3, 7)	42	4 (3, 5)	0.14
2.2.9 Access to quiet place	58	4 (3, 7)	91	3 (3, 6)	<b>0.03</b>
2.2.10 Access to company	24	5 (3, 8)	125	4 (3, 6)	0.06
<b>Q2.3</b>					
2.3.1 Listened to music	62	4 (3, 7)	87	3 (3, 6)	0.05
2.3.2 Listened to live music	128	4 (3, 6)	21	4 (3, 7)	0.29
2.3.3 Played musical instrument	147	4 (3, 6)	2	1 (1, 1)	<b>0.02</b>
2.3.4 Wrote	137	4 (3, 6)	12	4 (2, 5)	0.38
2.3.5 Painted or drew	141	4 (3, 6)	8	6 (3, 9)	0.26
2.3.6 Watched films	99	4 (3, 6)	50	4 (3, 6)	0.64
<b>Q2.4</b>					

2.4.1 Noticed art/pictures on wall	63	4 (3, 6)	83	4 (3, 6)	0.35
2.4.2 Put own art on the wall	134	4 (3, 6)	12	5 (4, 9)	0.10
2.4.3 Satisfied with visual art	60	4 (3, 6)	84	4 (3, 6)	0.57
2.4.4 Visual art was interesting	66	4 (3, 6)	78	4 (3, 6)	0.29
<b>Q2.5</b>					
2.5.1 Continued arts activities	100	4 (3, 6)	49	4 (3, 6)	0.53
2.5.2 Arts interests important	76	4 (3, 6)	73	4 (3, 7)	0.13
2.5.3 Arts programmes important	52	4 (3, 6)	93	4 (3, 6)	0.72
2.5.4 Did not access arts	90	3 (2, 5)	58	5 (3, 7)	<b>0.005</b>

### 12.5.3.6 Type of accommodation

The next analyses compared the section 2 survey responses between patients of differing accommodation types. A summary of the results is given in Table 12.26. The figures are the number and percentage of patients in each of the three categories who agreed with the various statements. P-values indicating the significance of the overall difference in outcome between groups are also reported. A number of differences in response between the three accommodation groups were observed.

Those in a private room (or who had both shared/private) rooms were more likely to watch a TV, and also more likely to watch films. Additionally these groups were more likely to have control over the TV. Patients who were in a private room were more able to choose if they shared a room, compared to those in shared accommodation. The results regarding whether patients found arts programmes important in hospital suggested that patients in private rooms and shared rooms had similar responses. However, patients who had a mix of shared/private rooms were less likely to consider the arts to be important.

**Table 12.26 Association between accommodation (single or shared room) and items in Section 2**

Question	Private (n=32) n (%)	Shared (n=96) n (%)	Both (n=21) n (%)	P- value
<b>Q2.1</b>				
2.1.1 Watched TV/DVD	20 (63%)	30 (31%)	13 (62%)	<b>0.001</b>
2.1.2 Used a computer	1 (3%)	1 (1%)	0 (0%)	0.59
2.1.3 Listened to radio	19 (59%)	54 (56%)	11 (52%)	0.89
2.1.4 Watched films	13 (41%)	21 (22%)	10 (48%)	<b>0.02</b>
2.1.5 Listened to music	18 (56%)	41 (43%)	12 (57%)	0.26
2.1.6 Read for pleasure	22 (69%)	52 (54%)	8 (38%)	0.09
2.1.7 Used e-reading devices	4 (13%)	5 (5%)	1 (5%)	0.38
<b>Q2.2</b>				
2.2.1 Control over TV	18 (56%)	24 (25%)	8 (40%)	<b>0.005</b>
2.2.2 TV/radio disturbed me	5 (16%)	16 (17%)	5 (24%)	0.73
2.2.3 Control over the radio	16 (50%)	31 (32%)	5 (25%)	0.13
2.2.4 Music disturbed me	4 (13%)	7 (7%)	3 (14%)	0.45
2.2.5 Other patients disturbed me	4 (13%)	24 (25%)	8 (38%)	0.10
2.2.6 Machines disturbed me	3 (9%)	10 (10%)	4 (19%)	0.44
2.2.7 Staff disturbed me	1 (3%)	16 (17%)	4 (19%)	0.10
2.2.8 Choose to share a room	21 (66%)	13 (14%)	8 (38%)	<b>&lt;0.001</b>
2.2.9 Access to quiet place	25 (78%)	53 (55%)	14 (67%)	0.07



2.2.10 Access to company	24 (75%)	85 (89%)	16 (76%)	0.11
<b>Q2.3</b>				
2.3.1 Listened to music	21 (66%)	54 (56%)	13 (62%)	0.65
2.3.2 Listened to live music	4 (13%)	15 (16%)	2 (10%)	0.83
2.3.3 Played musical instrument	1 (3%)	1 (1%)	0 (0%)	0.59
2.3.4 Wrote	4 (13%)	8 (8%)	0 (0%)	0.26
2.3.5 Painted or drew	3 (9%)	4 (4%)	1 (5%)	0.50
2.3.6 Watched films	16 (50%)	26 (27%)	8 (38%)	0.06
<b>Q2.4</b>				
2.4.1 Noticed art/pictures on wall	16 (50%)	54 (57%)	13 (65%)	0.58
2.4.2 Put own art on the wall	2 (6%)	6 (6%)	4 (20%)	0.13
2.4.3 Satisfied with visual art	18 (56%)	52 (57%)	13 (65%)	0.83
2.4.4 Visual art was interesting	17 (53%)	49 (53%)	11 (55%)	1.00
<b>Q2.5</b>				
2.5.1 Continued arts activities	10 (31%)	33 (34%)	6 (29%)	0.90
2.5.2 Arts interests important	20 (63%)	46 (48%)	7 (33%)	0.12
2.5.3 Arts programmes important	21 (68%)	64 (68%)	7 (35%)	<b>0.02</b>
2.5.4 Did not access arts	11 (34%)	36 (38%)	11 (52%)	0.40

### 12.5.3.7 Type of patient

The final set of analyses examined differences between two types of patient, private and public. There were a small number of patients who were classed as both private and public, and these were omitted from the analyses.

Analyses were performed to compare the responses to section 2 between these two patient groups, and the analysis results are summarised in Table 12.27. The figures reported are the number and percentage of patients in each group who agreed with each of the statements. The analysis results suggested a difference between patient groups in the ability to choose a room. Private patients were more able to choose a room, with almost half (48%) being able to choose a room, compared to only 17% of public patients. There was also a difference between groups in terms of noticing art/pictures on the hospital walls. This was more common in the public group than in the private group. No other statistically significant differences between groups were observed.

**Table 12.27 Association between Public/Private patient status and Section 2**

<b>Question</b>	<b>Private (n=44) n (%)</b>	<b>Public (n=98) n (%)</b>	<b>P-value</b>
<b>Q2.1</b>			
2.1.1 Watched TV/DVD	23 (52%)	37 (38%)	0.14
2.1.2 Used a computer	2 (5%)	0 (0%)	0.09
2.1.3 Listened to radio	27 (61%)	53 (54%)	0.47
2.1.4 Watched films	16 (36%)	27 (28%)	0.33
2.1.5 Listened to music	21 (48%)	46 (47%)	1.00
2.1.6 Read for pleasure	28 (64%)	49 (50%)	0.15
2.1.7 Used e-reading devices	5 (11%)	5 (5%)	0.29
<b>Q2.2</b>			
2.2.1 Control over TV	18 (41%)	30 (31%)	0.25
2.2.2 TV/radio disturbed me	10 (23%)	14 (14%)	0.23
2.2.3 Control over the radio	13 (30%)	33 (34%)	0.70
2.2.4 Music disturbed me	5 (11%)	7 (7%)	0.52
2.2.5 Other patients disturbed me	8 (18%)	25 (26%)	0.40
2.2.6 Machines disturbed me	7 (16%)	9 (9%)	0.26
2.2.7 Staff disturbed me	5 (11%)	15 (15%)	0.61
2.2.8 Choose to share a room	21 (48%)	17 (17%)	<b>&lt;0.001</b>
2.2.9 Access to quiet place	27 (61%)	60 (61%)	1.00

2.2.10 Access to company	34 (77%)	86 (88%)	0.13
<b>Q2.3</b>			
2.3.1 Listened to music	27 (61%)	56 (57%)	0.71
2.3.2 Listened to live music	6 (14%)	15 (15%)	1.00
2.3.3 Played musical instrument	1 (2%)	1 (1%)	0.53
2.3.4 Wrote	5 (11%)	7 (7%)	0.52
2.3.5 Painted or drew	2 (5%)	6 (6%)	1.00
2.3.6 Watched films	15 (34%)	33 (34%)	1.00
<b>Q2.4</b>			
2.4.1 Noticed art/pictures on wall	18 (41%)	60 (63%)	<b>0.03</b>
2.4.2 Put own art on the wall	4 (9%)	7 (7%)	0.74
2.4.3 Satisfied with visual art	23 (52%)	55 (59%)	0.58
2.4.4 Visual art was interesting	22 (50%)	50 (53%)	0.86
<b>Q2.5</b>			
2.5.1 Continued arts activities	12 (27%)	33 (34%)	0.56
2.5.2 Arts interests important	21 (48%)	51 (52%)	0.72
2.5.3 Arts programmes important	26 (62%)	64 (67%)	0.70
2.5.4 Did not access arts	21 (48%)	35 (36%)	0.20

## 12.6 Summary of quantitative results

Key conclusions from the quantitative study are as follows:

Film, play, musicals, classical music, art exhibitions, readings and traditional Irish music events were the most popular arts events attended prior to hospital stay and film featured as highly popular in all categories of the survey. Musical interests, dancing and photography were the most popular participative arts activities prior to hospital stay. Arts activities are very popular in this population, with 47.3% of respondents attending some sort of arts activity in the last twelve months and 78.7% in the last ten years.

The majority of patients find it difficult to attend art events and activities post hospital stay, citing physical difficulties and loss of confidence and motivation as key reasons. A large percentage of the older hospital patients sampled found it difficult to re-engage in their artistic and cultural activities post illness. Older patients appeared to attend less arts events than younger patients both pre and post hospital stay, while patients with more severe physical difficulties attended less arts events post hospital. Older patients (age 85 – 95) and those with physical limitations may therefore require increased support to attend arts events and activities.

Within the aesthetic environment of hospital it was found that the majority of patients did not have control over TV and radio. Quiet places were indicated as important for patients with a large number not able currently to access such quiet places. Many patients had no choice over private or shared ward accommodation. Reading and listening to music were popular receptive activities for patients in hospital and need to be made available. There was a very low expectation of continuation of arts activities in hospital and patients generally did not put up photographs in their room, listen to favourite music or play musical instruments in hospital.

Technology use (computers and e-readers) was relatively low in hospital, however perhaps not such a low result when one considers expectations of e-reader use in this age group. Older people may need support to access healthcare-related technology (Stephenson et al., 2012).

The strongest association in the statistical results was between GDS score and attendance at arts events and activities in the year pre hospital. Also, those who participated in the hospital arts programme had lower levels of depression than those who did not. Interestingly, the few people who played musical instruments while in hospital had lower depression scores. However, any statistical significance in these results are borderline statistically significant at best, given the number of statistical tests performed. Whilst statistical results are interesting, statistical significance is weak.

Writing was an activity that appeared to increase in hospital. Those with higher education were more likely to write in hospital. Further research in this area is indicated.

The survey indicates issues around the extent of choice and control patients have in hospital and which arts are recommended in hospital. Receptive arts are strongly indicated. The results provide rich information for arts managers to ensure their programme is meeting the interests and preferences of patients. It is hoped this survey might be the beginnings of a more robust tool to assess aesthetic needs, interests and deficits. There are very few available to use at present in the health sector.

A full discussion of the quantitative results is contained in Chapter 13, where the two studies are triangulated and discussed in full.

## **12.7 Comparison to Arts Council 2006 survey results**

The original survey (from which Section 1 was adapted) was a survey of 1210 people in 2006. This was a representative sample of Irish population. 90% of population felt that arts play an important and valuable role in a modern society such as that of Ireland. 85% of people had attended at least one arts event in the last 12 months. In this sample 47.3% of patients had attended at least one arts event in the last 12 months, but this figure rose to 78.7% if the last ten years were taken into account.

Film was the most popular art form, followed by plays, rock/pop music, street theatre, traditional music and comedy. This was a similar finding to this sample, except that dancing and classical music was more popular activities in the hospital sample. Participation rates were lower, however, than attendance at arts events in the ESRI sample, with 8% playing a musical instrument, 6% participating in painting or drawing and 8% dancing. The hospital research showed similarly low participation rate, when compared to attendance at arts events, with 27% participating in arts activities in the last 12 months and 48.3% doing so in the last 10 years.

In this study, however, participation was generally higher than in the ESRI sample. 18.5% played a musical instrument in the last ten years, with this figure dropping to 4.7% in the last 12 months. 18.5% participated in painting or drawing in the last ten years, with 12% in the last 12 months. 23% took part in 'other dancing (not fitness class)' in the last ten years, dropping to 5.3% in the last twelve months.

Over half, 55%, had stopped to look at public art in the last 12 months. This was similar to the hospital research, with 51% noticing public art in the last 10 years and 36% in the last year. 64% of people had read a book in the last year and the survey found a link between education advantage and attendance/participation in arts.

The report found a disparity between public preference and the official policy of the Arts Council. It also indicated that currently the Arts Council gave priority to support for individual artists, whereas the public saw this as a low priority.

*The arts as practiced in Ireland... are often a mark of social exclusiveness rather than an instrument of social inclusion* (Lunn and Kelly, 2008) p. 107.

## **12.8 Conclusion**

The purpose of this chapter was to present the results of a survey of 150 patients aged over 65 who had a stay in hospital of 7 days or more. This survey succeeded in providing information regarding the aesthetic interests of older people in hospital, one of the key aims of the research. It also allowed verification and elaboration of themes from the qualitative study. The next chapter gives a full discussion of the findings of both this study and the qualitative study, brought together in a mixed methodology analysis (see Section 5).

## ***Section Four Conclusion***

This section detailed the quantitative study, the second arm of the overall research project. The aims, methodology, design of the survey, reliability and validity testing and results were presented. This quantitative study evolved directly from themes that arose in the qualitative study. As the whole research is a mixed methodology design (sequential-exploratory), the findings from the qualitative study were used directly to inform and design this quantitative study and the two arms of the research are combined in the final discussion and analysis.

This survey provided information on the relationship between health and the aesthetic infrastructure of patients and the main barriers to going out to arts events or activities. It mapped patients' arts interests prior to and during hospital stay and points to the possibility of aesthetic deprivation in hospital and begins to provide a template for assessing this for patients. It provided useful information for arts programmers and managers in hospitals and healthcare facilities and a possible template for use when consulting patients about the aesthetic environment of hospital.

A full discussion of these results is given in the next section, Section 5.



## ***Section Five Discussion - Overview***

The purpose of this section is to bring together and discuss the results from the full research (see Figure 13.1). This is done by returning to the seven themes of the qualitative study and discussing these in relation to key findings from the quantitative study, as well as referencing international literature relevant to the conclusions.

This section also presents how this research makes an original contribution to the field, makes recommendations for future research and limitations of this research. The process of mixed method analysis was presented in Section 2 (4.5.11) and the two parts of the research, the qualitative and quantitative findings, are brought together here in a final discursive analysis. Finally, this section returns to the original research question and theoretical framework and discusses these in relation to the findings of this research. See Figure 13.1 for overall thesis diagram highlighting the discussion section.



**Figure 13.1 Overall thesis design highlighting Discussion Section**

## Chapter 13 Discussion

### 13.1 Mixed Method Analysis

This mixed-method research has yielded significant new insights into the role and importance of aesthetic issues in health and healthcare, with pointers towards both practical and research developments to engage with the threat of aesthetic deprivation. The qualitative and quantitative studies found a numbers of areas of concordance, but also some apparently significant areas of difference. This discussion will explore the potential implications and significance of these similarities and differences, using the framework of the seven key themes of the qualitative analysis, relating each to the quantitative study and also to the relevant academic literature.

The reason for mixing methods is to expand the scope of inquiry by accessing a wider range of data (Pope and Mays, 2006). This research followed a sequential-exploratory mixed method design, whereby one part of the research leads into the next. In this research, exploratory qualitative data created attributes or themes which were used directly to create categories for the survey, in order to further analyse the data and carry out confirmatory statistical analysis. Section 4 (Chapter 9) outlined in detail how the qualitative study informed the quantitative study.

Triangulation is a method used to combine and compare multiple data sources, bringing together knowledge from the separate studies with reference to international literature (Tashakkori and Teddlie, 1998). *Theoretical triangulation* was used here; the purpose of this triangulation method is to provide broader and deeper understanding of the research problem in hand and to view it through multiple lenses. Triangulation for completeness purposes, as in this research, is used mainly in researching unexplored research problems such as this topic, namely the aesthetic interests of patients in hospital (Hussein, 2009).

This discussion section represents the fusing of the qualitative and quantitative study findings, with reference to international literature. The research questions in each section were related to each other and strands of one approach led into the research of the other. As per recommendations from mixed method theorists, a narrative, qualitative style discussion section is presented here (Teddlie and Tashakkori, 2009).

## **13.2 Discussion of Key Findings**

### **13.2.1 Theme 1: Interests and passions**

This research illustrates, for the first time, the aesthetic interests of older patients attending hospital and complements research from studies among the public. In addition, it provides linkages between aesthetic interests and health and well-being in a novel fashion. Patients in the qualitative study had a key passion or interest (be that arts or other interests), with music, dancing, theatre and reading being most popular. Music, singing, dancing and films were the most popular cited participative activities in the 150 patients surveyed in the quantitative study, with reading and listening to music being the most popular receptive activities for patients in hospital. This illustrates the commonality of the findings between the two studies.

Patients in both the qualitative and quantitative studies indicated specific interests and passions that are important to them. Data from both studies indicate that the arts are popular interests and that watching films, listening to music, singing, reading and dancing might be most relevant to this population in hospital. However, the quantitative study indicated a high degree of heterogeneity in interest in the arts, with some forms of arts a relatively minority interest in the population surveyed at Tallaght Hospital, particularly stand-up comedy, circus, art house film and modern dance, as well as participative activities that include writing music, creating artwork or animations on computer and making films. The two studies, however, confirm the theme that individual interests and some art forms are important to patients.

The findings in this research build on a broader context, including a number of international policy documents regarding the investment in, and value of, the arts to the general public (Hill, 2010, Lunn and Kelly, 2008). Similarly, a number of papers report the importance of participation in and attendance at arts and cultural activities in terms of health and social benefits (Bygren et al., 2009a, Bygren et al., 1996, Cuypers et al., 2011a, Cuypers et al., 2011b, Konlaan et al., 2000, Fisher and Specht, 1999). An additional significant body of Governmental reports suggest perceived benefits of arts on health, quality of life and well-being (The Arts Council England, 2007, Coats, 2004, Francis et al., 2003, Galloway, 2006, National Endowment for the Arts, 2013, Philipp et al., 1999). The recent US National Endowment for the Arts Report (2013) alludes to potential health benefits of participation in arts interventions for older people, including improved cognitive function, memory, general self-esteem, increased social interaction and reduced stress. Music was found to be the most common participatory art form for older people in the USA (National Endowment for the Arts, 2013). Similarly, a UK report on the arts in nursing homes identified four essential elements of excellence, namely maintaining choice and control over day-to-day and significant life decisions; maintaining good relationships with family, partners, friends, staff and others; spending time purposefully and enjoyably; doing things that bring pleasure and meaning. The arts are seen, by this report, to be a key component of achieving these elements (Cutler et al., 2011).

The heterogeneity of patient interests and engagement shone through this research. It was impossible to describe a compact shared cohort regarding the most popular arts and leisure activities as a wide range of arts activities and events were attended. An awareness of this heterogeneity has significant implications when planning the arts in healthcare services, as well as indicating that continued links with the arts sector regarding trends in public interest and engagement in the arts might be helpful (The Arts Council England, 2007, The Arts Council, 2006).

The finding that many patients had little experience of, or expectations from, arts in the hospital also point to a need to balance curating arts for people in

hospital (in other words opening up a world of arts as yet undiscovered) and meeting the aesthetic needs directly identified by people themselves (in other words, providing the more popular art forms rather than high art). This links the qualitative and quantitative studies – in the qualitative study every interviewee had a passion or interest, whereas in the quantitative study a considerable number had not attended arts events in the last ten years. This leaves an important research question: what is the impact of this reduced participation on well-being and health, given that loss was a marked feature in the qualitative study?

Given the variety of leisure interests listed as important in the qualitative study, further research is indicated to explore what leisure activities people actually want in healthcare and to provide them. Studies of leisure interests of older people in hospital are relatively scarce, with two useful studies providing examples of the importance of leisure activities post stroke (O'Sullivan and Chard, 2010, Reynolds and Priora, 2011) and a large Finnish study indicating a robust association between participation in leisure activities and better health (Hyypä et al., 2005). The broad palette of interests outlined in both the quantitative and qualitative arms of this research should prompt hospitals to consider the aesthetic environment rather than neglect this need as is currently often the case (Caspari et al., 2006, Caspari et al., 2007, Caspari et al., 2011).

### **13.2.2 Theme 2: Loss and the impact of illness on my leisure activities**

One of the most significant findings of this research was the drop-off in activities due to illness and/or post hospital stay. In almost every category in the quantitative study the numbers attending arts in the last ten years was higher than that attended in the last year, indicating a drop-off in attendance and participation during a time of hospital stays and ill-health. This confirms previous literature, including a relevant study indicating marked decline in participation in leisure activities for patients with stroke (Sjögren, 1982).

A large percentage of patients in the survey sample also found it difficult to re-engage in their artistic and cultural activities post illness, with physical difficulties being the predominant reason cited for this. In the qualitative study, loss appeared to be a significant issue, particularly for patients with chronic illnesses, for whom a gradual decline in health impaired their ability to engage in the activities they enjoy. Loss of confidence was also cited in both studies as a reason for reducing attendance and participation in arts activities and events.

There is also a clear link in this research between lower levels of attendance at arts events post hospital stay and difficulties in accessing venues. This may indicate an aesthetic deficit, caused either by physical health issues or barriers to access following hospital stay. These findings may resonate with arts managers in the community who may need to focus on improved access for those with health problems who face barriers to access of venues. Active retirement groups, for example, who appear to keep these activities possible for older, physically frail adults are very important and should be encouraged. The findings should also prompt an awareness of the large percentage of older hospital patients who find it difficult to re-engage in their artistic and cultural activities post illness, a finding in both the quantitative and qualitative studies. It may be relevant for health and social professionals to increase support for older people to enable them to overcome their fears following illness and hospital stay and to continue to engage in cultural life despite poorer health, perhaps through models such as outreach Day Centres and Day Hospitals. The findings indicate that patients found it difficult to access arts events due to their physical difficulties. Interesting programmes at the Museum of Modern Art, New York and the Irish Museum of Modern Art highlight the increasing attention given to outreach and access programmes for older people and people with chronic health problems (Museum of Modern Art, 2013, Irish Museum of Modern Art, 2006). These findings are borne out in a major study by The Department for Culture, Media and Sport in England in 2005 which collected information from 29,000 adults. They found that a marked decline is visible in both arts attendance and participation from ages around 64, resulting in very low levels of engagement among the oldest age groups. Over the age of 65, primary barriers to attendance are poor health,

lack of social networks, and transport. Those aged 75 and older who are living alone are significantly less likely to have attended the arts than those living with other adults (Keaney and Oskala, 2007).

It could be hypothesised that, in addition to ill health causing patients to stop arts activities, hospitals and healthcare facilities may unwittingly neglect continuation of these activities in, and after, hospital. Hospitals are often aesthetically deprived environments and staff could play a role in promoting the continuation of arts and leisure activities. It is also possible that patients are passing through a phase when they are too ill to be interested in this area of their lives. Qualitative results indicated that patients were happy to 'park' their arts interests while they got well and would simply not have been interested in pursuing these activities while acutely ill, as per Maslow's hierarchy of needs (Maslow, 1970). However, an important study indicated that where patients were offered access to their five favourite CDs to listen to while recovering in hospital, there were significant benefits on a range of health measures (Sarkamo et al., 2008). This may point to the deprivation occurring where patients do not have access to their favourite music or other simple aesthetic pleasures and the possible negative effect on health and well-being.

While it may be appropriate for patients in the acute phase of illness to 'park' their aesthetic interests, this research suggests that strategies for meeting aesthetic, cultural and leisure interests in acute care remain exploratory and warrant further research. It is possible that these results have a clearer significance for longer stay patients in all health services, where a need for control of their aesthetic environment is important. Identification of aesthetic interests and potential areas of injury may be more readily delineated by instruments such as the Survey for Cultural and Aesthetic Health (SACH) or other useful tools such as the Pleasant Events Schedule.

In the qualitative research patients indicated a sense of loss following hospital stay – loss of physical abilities, loss of confidence and loss of motivation. This was enough to warrant a whole theme, which at times seemed out of place in this sort of research. However, in the quantitative



study this loss of confidence was verified and given a high rating. The losses encountered by patients include a loss of engagement in activities enjoyed prior to hospital, as well as loss of social life and stimulation that comes with attendance at events normally enjoyed. Arts therapists have long identified the arts as a vehicle for emotional expression and as part of helping older people to recover and cope with illness, for example in reducing anxiety and promoting mobility (Adsit and Lee, 1986, Beard, 2011, Burack et al., 2002, Dolgan et al., 2011, Hartley et al., 2010, Kim and Koh, 2005, Vink Annemiek et al., 2003, Yamaguchi et al., 2012). There is also literature to support adaptation of activities when health or problems associated with aging threaten continuation of activities (Donnellan and O'Neill, 2013, Reynolds and Priora, 2011). In addition, a loss of cultural capital may in turn diminish social capital and thereby well-being (Lizardo, 2006).

### **13.2.3 Theme 3: Low expectation of arts in hospital**

The qualitative study found a very low expectation of continuation of arts activities in hospital. The quantitative study confirms that arts are often not continued in hospital, with relatively low rates of patients, for example, putting up photographs in their room, listening to favourite music, playing musical instruments in hospital, writing and reading. Given the popularity of these arts in the sample prior to hospital stay, this finding suggests the need to explore how such low-cost and potentially readily accessible artistic engagement can be encouraged, especially as there are strong indications in the literature and in the qualitative study that maintaining engagement in the arts can improve quality of life and individuality in hospital (Särkämö et al., 2009, Sarkamo et al., 2008).

There is little experience amongst patients in this research of engaging in formal arts programmes in hospital and yet lower depression scores indicated in those who did. This research indicates the need for a nuanced and skilled approach from curators and arts programmers in hospitals and healthcare services, in order to offer arts that will meet the individual needs of patients. Sensitivity is also required regarding which arts are of interest at different

phases of hospital care. Further research on the effect of participation in arts in hospital on depression rates may also be useful.

The survey prompts consideration of the extent of patient choice and control in hospital and which arts are recommended in hospital. This resonates with significant literature regarding the impact of choice of hospital accommodation on recovery rates and pain management (Lawson, 2001, Lawson and Phiri, 2003, Cutler et al., 2011).

#### **13.2.4 Theme 4: Arts activities vary according to stage of illness – participative and receptive arts**

An important finding was that patients are not sure if they want arts during the acute phase of illness and some arts programmes may be indicated for rehabilitation and recovery phases only. Awareness of the most popular activities, namely dancing, music, reading, singing and film, is important here.

Writing was the only activity that appeared to increase in hospital. Further research in this area is important as there are currently only a few papers on the benefit of writing for patients in hospital, with most focusing on therapeutic benefits as opposed to writing as a creative leisure activity (Baikie, 2005, Bolton, 1999, Pennebaker, 1997).

Whilst patients generally did not expect arts nor necessarily want them in the acute phase of illness, the current literature points to the benefit of carefully selected arts interventions in acute settings and this area warrants further attention. For example, a number of studies indicate that listening to pre-recorded music may have benefits including pain management, sedation and reduction of anxiety for various clinical procedures and within Intensive Care Units, although results are inconclusive to date and sample sizes too small to ensure significance (Bradt and Dileo, 2009, Szeto and Yung, 1999, Chlan et al., 2013, Jafari et al., 2012, Ozer et al., 2013, Su et al., 2013, Yeo et al., 2013).

### **13.2.5 Theme 5: The positive impact of arts in hospital**

There were a large number of positive comments in the qualitative study regarding the personal benefits of engaging in the hospital arts programme, predominantly benefits that countered the losses experienced by patients, for example re-building self-confidence, making new social connections, stimulation, distraction from worries, opportunities for self-expression, feeling cared for in hospital and discovering a new arts activity to replace lost activities. This is consistent with findings in the literature whereby engagement in hospital arts programmes was strongly associated with improved quality of life and sense of individuality (Baumann et al., 2013, Sadler and Ridenour, 2009, Scher and Senior, 2000, The Arts Council, 2010, Coats, 2004, Hume, 2010). Arts programmes may also play a role in supporting patients to get out and about, to re-engage with the outside world and to make venues friendly. A number of community arts and health initiatives are documented in the current literature which confirm the role of arts as part of community health programmes and coping with chronic illness (Bedding and Sadlo, 2008, Beesley et al., 2011, Carson et al., 2007, Everitt and Hamilton, 2003, Greaves and Farbus, 2006, Huxley, 1997, Johnson and Stanley, 2007, Makin and Gask, 2012).

The survey did not focus on the area of positive benefits of engaging in the arts and this area may warrant further investigation. Nonetheless, this research did attempt to address the need for quantitative studies, as identified in the arts and health literature, as well as the call for further in-depth qualitative studies to understand the experience of hospital and the role of the arts (Stuckey and Nobel, 2010, Daykin et al., 2008a, Daykin et al., 2010, Dileo and Bradt, 2009, Cuypers et al., 2011b, Royal Society for Public Health UK, 2013, Sadler and Ridenour, 2009).

### **13.2.6 Theme 6: Aesthetics of hospital – in particular, noise, sharing rooms and lack of choice**

Results from the quantitative study prompt consideration of improvements in the aesthetic environment of hospital. TV and radio noise pollution and lack of control over this noise was identified as a significant problem. In the qualitative study, the aesthetics of hospital was given relatively little attention; however noise and disturbance of other patients were identified as the predominant issue when prompted.

Overall, the results on noise pollution indicate that lack of control over aesthetic injury was important to patients. Given that these noxious stimuli can be managed by relatively simple changes, such as providing quiet spaces and offering more control and consultation over TV and radio, this should be a focus for action by hospitals to improve their aesthetic environment. More complex issues such as choice of private room and less disturbance from other patients might be relevant for hospital designers. Generally, continuation of arts activities dropped off during hospital stay, with low levels of engagement. For example, the small sample who played musical instruments were generally unlikely to continue this in hospital, and the larger numbers who enjoy watching films again reduced this activity during hospital stay. It was interesting to note the lower depression scores in the very few patients who did continue to play their musical instruments in hospital.

Contradictory results were discovered in the survey - although large numbers stated that they had no control over TV or radio, the majority said they were not disturbed by the TV or radio that other people were watching or listening to. It is possible that patients are unwilling to complain and may be willing to watch or listen to whatever is played on TV/radio without choice. However, when given an opportunity, as in the qualitative study, some patients did indicate that noise from TV disturbed them. The issue of powerlessness or lack of control over aesthetic environment and lack of expectation regarding control may be relevant issues here and may guide hospital staff in encouraging patients to take some control over their aesthetic environment.

For example, in the survey (Q2.4.2) patients were asked if they put their own art, photographs or pictures on the wall in their room or ward. Only 12 (8%) had done so. Further research on the relationship between locus on control in hospital and aesthetic engagement is recommended, particularly as aesthetics is a neglected area of healthcare research and this finds an echo in our results (Caspari et al., 2006, Caspari et al., 2007). Similarly, further exploration of the role of the curator in hospital would be useful, as this person may play a pivotal role in encouraging patients to continue their aesthetic interests.

### **13.2.7 Theme 7: Recommendations for improvements to the aesthetic environment of hospital**

A common theme across qualitative and quantitative studies was the need for a quiet space in hospital. While the qualitative study identified this need in terms of a recommendation for improvements to the aesthetic environment, the quantitative study indicated that most people had quiet space in hospital when they needed it. However, the percentage of those without a quiet space in the quantitative study was significant enough to support this issue as a major finding and to recommend improvements in this area.

Another key recommendation arising from the qualitative study was the need for arts programmes to be linked closely to clinical teams and referrals. This was not explored with the survey sample, as the aim was to map the aesthetic interests of patients rather than explore the clinical and therapeutic value of the arts in this particular research. However, the qualitative findings here reflect many studies regarding the role of arts therapies as a clinical intervention as part of a multi-disciplinary team approach to treatment, especially music therapy which is well represented in the literature (Adsit and Lee, 1986, Ansdell and Meehan, 2010, Bradt and Dileo, 2010, Bradt et al., 2011b, Bradt et al., 2010b, Gold et al., 2006, McArdle and Byrt, 2001, Miettinen, 1995).

### **13.3 Bringing together the whole research**

There are strong links between the qualitative and quantitative studies, as evidenced in section 13.2. In addition to the themes and issues discussed above, a number of additional themes arise when bringing together the whole research.

#### **13.3.1 Receptive versus participative arts**

The receptive arts in hospital were strongly signalled as important by the participants in this research but are given less attention in the current literature on arts in hospitals. There is sparse literature regarding receptive arts and little evidence of benefit to date (Cruise et al., 1997, Davis and Thaut, 1989, Forsblom et al., 2010).

This research highlighted the interest in, and need for, receptive arts, both during hospital stay and when adapting to limited physical abilities. A significant percentage of the sample were also interested and engaged in dancing, singing in choirs and attending painting classes and these participative interests might be important to notice and attend to in healthcare services.

If listening to music, for example, is a key interest prior to hospital and in hospital, it would seem a simple step to enhance the aesthetic environment of hospital with more live music made accessible to patients, as well as opportunities to listen to music at the bedside. Similarly, reading and writing are some of the most accessible arts activities when in bed. These could be made readily available to patients with minimal intervention or support. The benefit of reading in hospital is a very under researched area. A recent systematic review of the benefit of reading on health and well-being of people with neurological conditions found only twelve studies and no randomised controlled trials. All but one of the quantitative studies reported that the reading interventions had a positive effect; however the results should be viewed with caution due to the lack of randomisation, the small numbers of

participants involved, and the limited and heterogeneous evidence base. A study of the benefit of reading groups for people with dementia showed similarly weak evidence of benefit (Billington et al., 2013, Latchem and Greenhalgh, 2014).

### **13.3.2 Cultural impoverishment with ageing/illness**

Relatively few patients played a musical instrument or attended traditional 'high art' venues such as ballet, opera, concert halls or art galleries in the last ten years. These art forms may, in current society, be an activity for the elite (Alexander, 2003). However, traditional music and dancing scored highly and there may be an argument for curators and arts managers to programme popular arts activities that patients enjoy rather than imposing their own ideas onto patients. The results provide a reminder that arts managers must provide patients with activities that meet their own identified aesthetic needs. The role of the curator has evolved from being an elite art expert, to a specialised educationalist, to an outreach officer for disadvantaged groups attending museums and galleries. Further research as to the role of the arts curator in hospital may be of benefit (Anderson and Karczmar, 1990, Aston, 2009, Grehan, 2005, The Arts Council, 2010, Association of Art Museum Curators, 2007, Overduin, 1986, Nanda et al., 2011).

The findings from this overall research give concrete pointers to arts curators in health contexts. For example in Tallaght Hospital there are no dance or film activities and there is no choir for patients, despite these being key activities of interest in the sample. The mobile library is an important feature of the hospital and should be developed. The results also point to a general lack of artistic engagement in the population and perhaps a need to generate a sense of cultural entitlement and to offer new opportunities.

Hospital may, in fact, be a first point of call for many in terms of engaging in arts activities. For example, at Tallaght Hospital a group of patients from the Cardiac Rehabilitation Unit attended a creative writing group. For many this was their first experience of the art form. Some continue to attend writing groups in the community, having cited this new experience in hospital as the starting point for an engagement in this art. Simple aesthetic improvements

to the ward environments are also clearly indicated, such as ensuring listening to music is possible in hospital.

Another relevant issue is that a healthy sample of older people who have not experienced health problems in the last twelve months might have a very different profile as regards aesthetic interests and engagement in arts activities. The sample in this research is probably not representative of healthy older people living in the Tallaght Hospital area, as their attendance levels might be higher across art forms. Studies in Nordic countries indicate higher levels of engagement in older people in cultural activities and suggest associated benefit (Bygren et al., 2009a, Bygren et al., 2009b, Bygren et al., 1996, Cuypers et al., 2011a, Cuypers et al., 2011b, Konlaan et al., 2000). Further research would be recommended in this area.

### **13.3.3 Technology and e-readers**

Technology use was relatively low in hospital (2% of the survey sample used computers); however 6.7% used e-readers which may be a surprisingly high result in a sample who were predominantly over 75. This may be of interest to managers who aim to make hospital processes electronic. Those involved in introducing technology in hospital and health care may benefit from awareness of this low level of usage and either support older people to access technology or ensure it is possible to continue to navigate the hospital without using technology (Stephenson et al., 2012).

### **13.3.4 Educational disadvantage**

Participation and attendance at some forms of the arts is a relatively minority interest in this population, although significant interest is signalled in music, film, reading and dancing. This sample perhaps indicates the low level of access to, and education in, some forms of arts in this particular sample. Several studies indicate a relationship between education level and attendance and participation in the arts. An American study found people with arts education were four times more likely to attend arts performances and education was found to be the primary factor affecting attendance (Bergonzi and Smith, 1996). Similarly, the ESRI report on a survey of public attitudes to the arts found a link between education level and attendance at



arts events (Lunn and Kelly, 2008). It is possible that the arts education level of this sample (majority finished school at second level) affected the levels of attendance and participation in the arts.

This research provides rich information for arts managers providing arts programmes for patients and raises questions and possible new priorities for those funding and providing arts in healthcare settings. The results also prompt appreciation for educational outreach and access programmes for this population and a revised approach to the importance of aesthetics and arts educational opportunities for older people (Bedding and Sadlo, 2008, Wikstrom, 2004, Wolf, 1998).

### **13.3.5 Visual art**

The relevance of public art placed in the hospital received attention in this research. It was notable that a high percentage of the sample had stopped and noticed public art but a low percentage engaged in making art themselves. Receptive art, in this instance, seems again more relevant to patients than participation. Research indicates that art placed in health settings is viewed differently than in galleries, and the importance of context cannot be underestimated (Grehan, 2005). Again, this is an area that tends to be neglected in healthcare settings, with curators often struggling to prove their worth as a useful investment in making hospitals better places to stay (Caspari et al., 2011).

## **13.4 Limitations of the research**

This research focused on a broad topic. The concepts of aesthetics, culture and arts are difficult to define and the area is relatively unexplored. Conceptually, this research is new and original and literature reviews were broad. Defining the research question was complex. Through conducting this research, it was clear that further research in this area was recommended and perhaps limiting the areas of study to one art form or one specific clinical group might be useful.

This research was conducted in an Irish hospital situated in a relatively disadvantaged area of Dublin. The sample was predominantly white and Irish, and relatively small, hence the results may not be translatable to other contexts. A group of older people with higher education and who were more regular attendees of arts activities might give very different results, as well as those from other cultures. Also, it is notable that relatively few people had attended arts in the last year, and this may be a false representation of the normal arts interests of older people who are healthy.

Two further sampling issues arose. Firstly, it is not possible to determine whether the sample in this research are representative of older, white Irish subjects in the hospital catchment area and this is a limitation of this study. Attempts were made to select participants as randomly as possible from the Age Related Health Care Unit but further work would have ensured a representative sample. Secondly, sampling of the qualitative study could have been improved, with those engaged in the arts and those not engaged being more closely matched. For example, it is possible that those who had chosen to engage in the arts programme were of a particular educational level or diagnosis group, although attempts were made to select participants at random.

This survey was of patients over the age of 65. Younger people are engaging much more with technology and this will be an increasingly useful tool for patients to access their arts interests and their social life while in hospital. Thus, results will be very different for other age groups. There is a need for similar studies with younger people, especially the aesthetic and cultural needs of young adults in hospital. Also, there is a need for research into how technology may be used to increase access to the arts in the older population in hospital, for example through art-making apps and opportunities to live stream arts events into healthcare facilities. This current research may become less relevant as technology develops and changes the way we receive and engage in arts.

All patients were surveyed without reference to their specific illness. Some differences in answers were indicated in the qualitative study, for example

patients attending hospital with an acute illness such as a heart attack were less likely to want to engage in arts in the hospital whereas those with a chronic disease such as rheumatoid arthritis viewed arts as a potential therapy in coping with their illness. In this particular research, however, the aim was to broadly map aesthetic interests and experience of aesthetic deprivation in older people in hospital, rather than focus on specific illness groups. Research on the aesthetic needs of specific illness groups would be recommended for future research.

Further work would be recommended to refine this tool and to test it with other populations. Inter-rater reliability testing would have been useful during the survey design. At the outset it was assumed that only one researcher would deliver all the surveys and help patients complete them, or that the survey would be self-administered. Therefore only intra-rater reliability testing was undertaken. However, most of the sample needed assistance to complete the survey (for example, due to poor eyesight or writing ability) so inter-rater reliability testing might have been a useful addition. However, as the survey was strictly quantitative there was little room for interpretation on the part of the researcher collecting the survey from participants.

A limitation of the survey was the question regarding arts participation in the last year and the last ten years. Whilst it was intended to ask patients two separate questions: what arts activities patients' participated in during the last year and what arts activities they participated in ten years ago. However, the survey did not build a clear picture of the participation of patients exactly ten years prior to hospital stay and this could be improved in future surveys. Also, it would be interesting to find out how often patients attended their favoured art forms rather than simply identify which arts they prefer.

Finally, it is important to note a limitation with regard to the inferential statistics conducted. Whilst making multiple comparisons is acceptable in a new and exploratory survey, in retrospect it would have been helpful to pre-define comparisons of particular interest. Further refining of the survey tool

and more detailed planning of the statistical results process is recommended before conducting such a study in future.

### **13.5 Recommendations for future research**

Further research is indicated in a number of areas, including the aesthetic interests of the general healthy population of older people living in the Tallaght Hospital area (to provide comparison and further information on aesthetic interests of the older population), issues of locus of control over the aesthetic environment of hospital and studies with other age groups, illness groups and health service populations.

Further research is also indicated to explore what leisure interests, other than the arts, are important to patients and how arts, cultural and leisure interests can most effectively be provided in hospital and healthcare facilities. More research on receptive arts in hospital would also be recommended, as well as attention to the role of everyday aesthetics in hospital. Barriers to attendance at arts events are a significant issue in the older population and increased understanding of access needs is important.

It was found that whilst the research certainly did produce rich, valuable data, conclusions could not be generalised outside this particular population due to small numbers in both parts of the research. Larger studies on arts and health are indicated in both the literature and in this research.

It is possible that patients are just too ill to be interested in their arts and leisure interests in hospital. Further research on the differences in aesthetic needs during acute hospital stay and for patients living with chronic illnesses would be recommended. The arts may also have considerable significance in other health settings, for example nursing homes (Cutler et al., 2011) and research on the aesthetic preferences and possible deprivation of these populations would be welcome.

To what extent is becoming ill or entering the hospital building a key factor in automatically reducing aesthetic involvement and interest? Did patients not expect to be able to play their musical instrument or paint in hospital or did they actively choose not to continue their arts activities? Were they uninterested due to ill health? Or would they have continued if the facilities to do so were available? A debate around these issues and further research would be welcome.

Further research on the positive benefits of engaging in arts would be helpful. It is important to note the strong qualitative findings regarding the benefits of arts on social, emotional and psychological health. Whilst this is a consistent finding within much of the literature regarding the benefits of arts in healthcare, there is a lack of rigorous quantitative evidence, for example Cochrane reviews.

## **13.6 Original contribution to the field**

This research makes an original contribution by understanding the aesthetic needs of older people before, during and after hospital stay and their importance to these patients. It highlights the neglected area of aesthetics in hospital and contributes a rigorous study to this field. This research provides information regarding how patients perceive the aesthetic environment of hospital and has created a survey that could be shared and used for this purpose.

The research is the one of few studies internationally to catalogue the aesthetic interests of patients in hospital and the first Irish survey available for assessing patients' satisfaction with their aesthetic environment. It is one of the first studies, internationally, to rigorously review which qualitative methodology is best used for arts and health studies and to set out an interview process for in-depth patient interviews regarding the aesthetic environment of hospital. This research is one of very few in the literature that sought to map the aesthetic interests of patients - most arts and health studies have focused on providing evidence of the benefit of participation in arts activities within healthcare contexts. This research is also rare in highlighting the role of receptive arts in hospital. This is one of the most original contributions of this research: to map the baseline arts interests of patients before attempting to prove benefit of arts on health and well-being and to focus on receptive arts.

The research contributed knowledge to the field – specifically, patients' views regarding the aesthetic environment of acute hospitals and importance of arts benefits as well as considerations regarding design of a survey in this field. Originality appears in the concept of aesthetic deprivation and in the highlighting of the importance of receptive arts, a section of aesthetic engagement which is rarely explored in the healthcare literature. Originality also appears in the data surrounding noise pollution, again a neglected area in the field. Also, the drop-off rates of both attendance at arts events and

participation in arts activities during hospital stay and post hospital are significant findings.

This research is one of the only mixed method studies in this field, as well as the only study of aesthetic deprivation. It highlights the role of managers and curators in developing appropriate aesthetic and cultural programmes for older patients.

Older people are proportionately the largest demographic group using health services and a better understanding of the interaction between aesthetics and health in this group was hoped to inform investigative strategies for the whole population. This research highlighted issues for older people in accessing arts post hospital stay and it is now indicated, completing this research, that further study is warranted with other age groups and patient populations. It is hoped that the survey and interview designs here will be useful to others and might be the beginnings of a more robust tool to assess aesthetic needs, interests and deficits. There are very few available to use at present in the health sector.

There is a relatively limited amount of evidence based research undertaken as to the nature of, and potential benefit from, aesthetics in health care and a limited number of studies with rigorous methodology. This research has contributed peer reviewed papers in this area of work and has contributed knowledge to this field of study.

### **13.7 Reviewing the theoretical framework**

The theoretical framework identified at the start of the research was that of Maslow's Hierarchy of Needs (Maslow, 1969, Maslow, 1970). This gives a much needed presence to aesthetics as one of our human needs, albeit a need with lower importance than more basic survival needs. It is one of few models of human psychological health to include aesthetics as an integral element of human needs. It gives strength to the assertion that aesthetic

needs are part of the full human being and cannot be ignored in health service environments.

This research confirmed that aesthetic needs are of importance to patients but also indicated a possible receding of this interest during acute phase of illness. This research points to the losses experienced when aesthetic needs are not addressed or become difficult to fulfil, for example, post hospital stay.

John Green gives a strong argument against Maslow's hierarchy, in his novel *The Fault in our Stars*. The main character in the book is a teenager with terminal cancer. However, in arguing that the *order* of needs is wrong, his character actually makes a strong argument *for* aesthetic needs as part of our human condition, even when we are ill. The teenage protagonist says:

*Maslow became famous for his theory that certain needs must be met before you can even have other kinds of needs. Once your needs for food and water are fulfilled, you move up to the next set of needs, security and then the next and the next, but the important thing is that, according to Maslow, until your physical needs are satisfied, you can't even worry about security or social needs, let alone 'self-actualization' which is when you start to, like, make art and think about morality and quantum physics and stuff.*

*According to Maslow, I was stuck on the second level of the pyramid, unable to feel secure in my health and therefore unable to reach for love and respect and art and whatever else, which is, of course, utter horseshit: The urge to make art or contemplate philosophy does not go away when you are sick. Those urges just become transfigured by illness (Green, 2012) p. 211.*



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# Appendices

## Appendix 1 Ethical Approval Documentation

THIS NOTE/PAPER MUST NOT BE USED FOR  
PRESCRIPTIONS OR INVOICING PURPOSES  
SJH/AMNCH Research Ethics Committee Secretariat  
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SJH/AMNCH  
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Ms. Hilary Moss  
Arts Officer  
Department of Allied Health Professionals  
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Tallaght  
Dublin 24

April 26<sup>th</sup> 2010

*Please quote this reference in any follow up to this letter: 2010/04/06 Chairman's Action*

**Re: The Benefits of the Arts for Patients in an Acute Hospital.**

Dear Hilary,

Thank you for your recent submission of the above proposal to the SJH/AMNCH Research Ethics Committee.

The Chairman, having reviewed the proposal, has given ethical approval on behalf of the Committee.

Yours sincerely,

Ms. Ursula Ryan  
Secretary  
SJH/AMNCH Research Ethics Committee.

17<sup>th</sup> September 2012

**Re: Ethical Approval for The Benefits of the Arts for Patients in an Acute Hospital**

**Reference: 2010/04/06 Chairman's Action**

Dear Ms Ryan,

The Research Ethics Committee gave ethical approval to the above study in 2010. This project is ongoing and the first part is complete. In the application we stated that the methodology would be as follows:

*Qualitative methodology would be in-depth interviews using an ethnographic/ grounded theory approach to the lived experience of hospital patients of arts in healthcare.*

The aims of the study approved currently approved are:

- To explore the role of arts in patients' lives, in the context of coping with illness, and in terms of potential health benefits.
- To improve patient care by making recommendations based on this research for arts input in hospitals and for people with chronic conditions.
- To map patient preferences and perceived benefits regarding the arts, particularly while in hospital
- Determine which art forms patients engage with, find of benefit and prefer when coping with illness and to explore how patients most effectively interact with these arts.

I am writing as we would now like to extend this study very by carrying out interviews with patients from the Age Related Health Care Unit (100 patients). The research would take the form of a questionnaire (based mainly on the survey on public attitudes to the arts used by the Arts Council 2006) and would be used with patients from the Age Related Health Care Unit during late 2012 – July 2013. This would be part 2 of the study, to compliment the qualitative study which is now complete, and as a whole this will form my PhD on this topic.

All details of the original proposal are still being carried out exactly as requested in the original application and there are no changes to this. The aims of the study remain exactly the same (as do all other details of the original application).

I am writing to enquire whether I need to submit a further application for ethical approval or whether the original approval will suffice? We submitted for a supplementary study in Dec 2010 which was approved by letter. I would be grateful for your advice on the matter. I attach the latest draft of the survey for your information.

Many thanks again,

Hilary Moss  
PhD Researcher, School of Medicine, TCD  
Director of Arts and Health, Tallaght Hospital

THIS NOTEPAPER MUST NOT BE USED FOR  
PRESCRIPTIONS OR INVOICING PURPOSES

SJH/AMNCH Research Ethics Committee Secretariat  
Ursula Ryan Ph: 4142342 email: [Ursula.Ryan@amnch.ie](mailto:Ursula.Ryan@amnch.ie)  
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Ms. Hilary Moss  
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TELEPHONE: 4353 1200  
November 3<sup>rd</sup> 2012

**Re: Qualitative methodology would be in-depth interviews using an  
ethnographic/grounded theory approach to the lived experience of hospital  
patients of arts in healthcare**

*Please quote this reference in any follow up to this letter: 2012/41/02*

Dear Ms. Moss,

Thank you for your letter dated September 17th 2012 and enclosures in which you  
request ethical approval of an amendment to the above referenced studies.

The Chairman, on behalf of the Research Ethics Committee, has reviewed this  
proposed amendment and has given ethical approval.

The following amendments were approved:

2. Extending Study to carry out interviews

Yours sincerely

**Ms. Ursula Ryan**  
Secretary,  
SJH/AMNCH Research Ethics Committee

## **Appendix 2 Information and Consent Forms**

### **Patient Information and Consent form – Qualitative study**

Title of study: The benefit of the arts for patients in acute hospital

Introduction: The aim of this research is to explore the role of arts in patients' lives, in the context of coping with illness, and in terms of potential health benefits and to improve patient care by making recommendations based on this research for arts input in hospitals. The study will involve interviewing you about the arts you enjoyed before you were ill, while you were ill and during recovery.

#### **Procedures:**

Those selected for participation in this study are patients at this hospital and half of those interviewed will have attended the hospital arts programme. Patients who are excluded are those who are unable to participate in a thirty minute interview due to difficulties with speech, hearing or understanding. You will take part in an in-depth interview regarding what arts you enjoyed or used before you were ill, during hospital and while recovering from illness after being in hospital. The interview will be recorded for research purposes but all answers will be kept confidential.

#### **Benefits:**

You may find that participating in the study helps you to identify how the arts improve your health help you to cope with your health needs.

#### **Risks:**

There is no pressure to participate in the study if you do not want to. Occasionally talking about music or art or your hospital experience can evoke sad or difficult memories but you will be given an opportunity to discuss this with a member of the team after the session or advised of suitable support agencies should you need to talk through any issues after the interview.

Exclusion from participation: You cannot be in the study if you have difficulties with speech, hearing or understanding which mean you will be unable to participate in a twenty minute interview. You must have stayed in the hospital for more than 1 week in the last 5 years.

Alternative treatment:

You do not have to be a part of this study to be treated and your participation or refusal to participate will not affect the other treatments you receive in the hospital.

Confidentiality:

Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the hospital. Quotes from your interview may be used but your name will not be used.

Compensation:

Your doctors are covered by standard medical malpractice insurance. Nothing in this document restricts or curtails your rights.

Voluntary Participation: You have volunteered to participate in this study. You may quit at any time. If you decide not to participate, or if you quit, you will not be penalised and will not give up any benefits which you had before entering the study.

Stopping the study: You understand that your doctor or the sponsoring company may stop your participation in the study at any time without your consent.

Permission: This trial has hospital Research Ethics Committee approval.

Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the hospital Arts Officer Ms Hilary Moss Tel 014142076 or email [hilary.moss@amnch.ie](mailto:hilary.moss@amnch.ie). You can also discuss this with any member of your healthcare team in the hospital.

## **Consent form – Qualitative Study**

Title of research study: The benefit of the arts for patients in acute hospital

This study and this consent form have been explained to me. The interviewer has answered all my questions to my satisfaction. I believe I understand what will happen if I agree to be part of this study.

I have read, or had read to me, this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I have received a copy of this agreement and I understand that, if there is a sponsoring company, a signed copy will be sent to that sponsor.

Name of sponsor:

PARTICIPANT'S NAME:

PARTICIPANT'S ADDRESS:

PARTICIPANT'S TELEPHONE NUMBER:

DATE OF BIRTH:

PRIMARY DIAGNOSIS:

PARTICIPANT'S SIGNATURE:

Date:

Date on which the participant was first furnished with this form:

Where the participant is incapable of comprehending the nature, significance and scope of the consent required, the form must be signed by a person competent to give consent to his or her participation in the research study

(other than a person who applied to undertake or conduct the study). If the subject is a minor (under 18 years old) the signature of parent or guardian must be obtained:-

NAME OF CONSENTOR, PARENT or GUARDIAN:

SIGNATURE:

RELATION TO PARTICIPANT:

Where the participant is capable of comprehending the nature, significance and scope of the consent required, but is physically unable to sign written consent, signatures of two witnesses present when consent was given by the participant to a registered medical practitioner treating him or her for the illness.

NAME OF FIRST WITNESS:

SIGNATURE:

NAME OF SECOND WITNESS:

SIGNATURE:

Statement of investigator's responsibility: I have explained the nature, purpose, procedures, benefits, risks of, or alternatives to, this research study. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

(Keep the original of this form in the research file, give one copy to the participant, keep one copy in the investigator's records, and send one copy to the sponsor (if there is a sponsor).

Signature of researcher\_\_\_\_\_

Signature of patient's doctor (or designated member of the team)

\_\_\_\_\_

*IF YOU NEED SUPPORT FOLLOWING THIS INTERVIEW:*

CONTACT HILARY MOSS TEL: 0876105553

CONTACT YOUR DOCTOR OR NURSE AT TALLAGHT HOSPITAL 01 414 2000

## **Patient Information and Consent Form – Quantitative Study**

Title of study: The benefit of the arts for patients in acute hospital

This research aims to find out more about the arts and leisure interests of patients in this hospital. We hope this survey will help us to improve the range of arts and leisure facilities available for patients in hospitals. The study will involve you completing a survey about your arts interests and whether you could continue your arts interests in hospital.

To be in this study you must have stayed in the hospital for at least one week in the last five years. You cannot be in the study if you have difficulties with speech, hearing, writing or understanding which mean you will be unable to complete a survey.

Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the hospital. Answers from your survey will be used but your name will never be used. Your answers will help us to improve the arts and leisure services we offer to patients in this hospital.

There is no pressure to participate in the study if you do not want to. You do not have to be a part of this study to be treated and your participation or refusal to participate will not affect the other treatments you receive in the hospital.

You have volunteered to participate in this study. You may quit at any time. If you decide not to participate, or if you quit, you will not be penalised and will not give up any benefits which you had before entering the study.

Occasionally thinking about music or art or your hospital experience can evoke sad or difficult memories but you will be advised of suitable support agencies should you need to talk through any issues after completing the survey. You may find that taking part in the study helps you to identify the role your arts and leisure interests play in your life.



Nothing in this document restricts or curtails your rights. Your doctor may stop your participation in the study at any time without your consent.

This trial has hospital Research Ethics Committee approval. If you wish to verify this, please contact Ursula Ryan at the Research Ethics Office at Tallaght Hospital for further information (Tel: 01 414 2000).

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the hospital Arts Officer Hilary Moss Tel 014142076 or email [hilary.moss@amnch.ie](mailto:hilary.moss@amnch.ie). You can also discuss this with any member of your healthcare team in the hospital. If you need support following this survey please contact Hilary Moss Tel: 01 414 2076 or contact your doctor or nurse at Tallaght Hospital.

## **Consent form – Quantitative Study**

If you are happy to complete this survey, please sign your consent below:

This study and this consent form have been explained to me. The researcher has answered all my questions to my satisfaction. I believe I understand what will happen if I agree to be part of this study. I have read, or had read to me, this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I have received a copy of this agreement.

NAME:

ADDRESS:

TELEPHONE NUMBER:

EMAIL ADDRESS:

DATE OF BIRTH:

SIGNATURE:

DATE:

Statement of investigator's responsibility: I have explained the nature, purpose, procedures, benefits, risks of, or alternatives to, this research study. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Signature of researcher\_\_\_\_\_

Did the participant need assistance completing the survey?      Yes/No

If so, name of researcher who assisted the participant

\_\_\_\_\_

(Keep the original of this form in the research file; give one copy to the participant)

## **Appendix 3 Approval from Arts Council for use of parts of survey**

### **Permission from Arts Council to use their survey**

---

From: Ann O'Connor  
To: Des O'Neill  
Sent: Wed Dec 08 17:14:33 2010  
Subject: RE: Use of questionnaire  
[Hello Des,](#)

[Thank you for your email.](#)

[There is no difficulty in using the questionnaire, full acknowledgement is appreciated.](#)

[Best wishes,](#)  
[Ann](#)

[Ann O'Connor](#)  
[Arts and Health Adviser](#)  
[Arts Council](#)

From: Des O'Neill [<mailto:Des.ONeill@amnch.ie>]  
Sent: 07 December 2010 15:48  
To: Ann O'Connor; Orla Moloney  
Subject: Use of questionnaire

Dear Ann/Orla

Just checking - we hope that there would be no difficulties using the questionnaire in "The Public and the Arts (2006)", the study performed by the ESRI for the Arts Council - full attribution would be given...

Kind regards

Desmond O'Neill MA MD FRCPI AGSF FRCP(Glasg)  
President, European Union Geriatric Medicine Society, [www.eugms.org](http://www.eugms.org)

Associate Professor, Dept of Medical Gerontology, Adelaide and Meath Hospital, Dublin 24, Ireland  
Tel +353 1 414 3215; Fax +353 1 414 3244; [www.ageandknowledge.ie](http://www.ageandknowledge.ie)

## Appendix 4 Barthel Scale of Physical Function

BARTHEL ADL INDEX		PATIENT'S NAME:						
		HOSPITAL NUMBER:						
DATE								
BOWELS	0 = Incontinent 1 = Occasional accident ( 1 per week) 2 = Continent							
BLADDER	0 = Incontinent or catheterised & unable to manage 1 = Occasional accident (max 1 x per 24 hours) 2 = Continent for over 7 days							
GROOMING	0 = Needs help 1 = Independent, face, hair, teeth, shaving.							
TOILET USE	0 = Dependent 1 = Needs some help but can do something. 2 = Independent (on and off, dressing, wiping).							
FEEDING	0 = Unable 1 = Needs help cutting, spreading butter etc. 2 = Independent.							
TRANSFER	0 = Unable 1 = Major help (1-2 people, physical). 2 = Minor help (verbal or physical). 3 = Independent							
MOBILITY	0 = Immobile 1 = Wheelchair independent including corners etc. 2 = Walks with help of 1 person (verbal or physical). 3 = Independent (but may use any aid, eg. stick).							
DRESSING	0 = Dependent 1 = Needs help but can do half unaided. 2 = Independent							
STAIRS	0 = Unable 1 = Needs help (verbal, physical, carrying aid). 2 = Independent up and down.							
BATHING	0 = Dependent 1 = Independent							
TOTAL								

## Appendix 5 3DY Cognitive Test

*Can you tell me the:*

1. Day
2. Date
3. Year
4. *Please spell the word 'WORLD' backwards*

Score (maximum 4) \_\_\_\_\_

## Appendix 6 Geriatric Depression Scale

### Geriatric Depression Scale (short form)

**Instructions:** Circle the answer that best describes how you felt over the past week.

- |   |     |    |
|---|-----|----|
| 1. Are you basically satisfied with your life?                            | yes | no |
| 2. Have you dropped many of your activities and interests?                | yes | no |
| 3. Do you feel that your life is empty?                                   | yes | no |
| 4. Do you often get bored?  | yes | no |
| 5. Are you in good spirits most of the time?                              | yes | no |
| 6. Are you afraid that something bad is going to happen to you?           | yes | no |
| 7. Do you feel happy most of the time?                                    | yes | no |
| 8. Do you often feel helpless?  | yes | no |
| 9. Do you prefer to stay at home, rather than going out and doing things? | yes | no |
| 10. Do you feel that you have more problems with memory than most?        | yes | no |
| 11. Do you think it is wonderful to be alive now?                         | yes | no |
| 12. Do you feel worthless the way you are now?                            | yes | no |
| 13. Do you feel full of energy?   | yes | no |
| 14. Do you feel that your situation is hopeless?                          | yes | no |
| 15. Do you think that most people are better off than you are?            | yes | no |

**Total Score** \_\_\_\_\_

**Appendix 7 Patients' perceptive of arts in healthcare: Summary of findings from relevant studies organised by qualitative methodology**

Study first author and methodology	Description of study	Mixed method (M), Single study (S) or no method given (NM))	Methodology	Primary data collection tool I (interview) F (focus group) OB (observation) O (Other) N (no detail given)	Brief findings	Sample size (where available)	Client group
Grounded theory	Grounded theory (GT) has the goal of developing a theory which explains and provides insights into the phenomenon and the study. GT means progressive focusing on particular concepts and ideas important for the emerging theory. Grounded theory is ... a creative process that is appropriate to use (where there is) a lack of knowledge of the theory of the topic (or) when the existing theory offers no solution to problems (or) when modifying existing theory (Holloway 2005).						
(Torkelson Lynch and Chosa, 1996)	Examines the relationship between participation in a community based expressive art programme for individuals with disabilities	M	GT	I	Benefits of arts included improved self-esteem, opportunities and social interactions	44	Adults with disabilities
(Lazzari et al., 2005)	Art programme for incarcerated young women	S	GT	I	Some evidence that art making supported women to improve self-esteem and identity. Less clear link between this and reduction of violence.	31	Young women in locked facilities, age 11 - 17



Beesley (Beesley et al., 2011)	Experience of stroke survivors participation in arts health group programmes possible benefits to health and wellbeing	S	GT	I and F	Arts contributed to improvements in patients' confidence, self-efficacy, quality of life and community participation.	16	Stroke, aged 43 – 81
(Barry et al., 2010)	Effect of music therapy CD creation on distress of paediatric oncology patients and coping during first radiation treatment	M	GT	I	Contributed to knowledge of how to support children when receiving radiation. Music therapy was experienced a positive experience and aided their coping	11	Children, oncology patients
(O'Callaghan, 2001)	A music therapy study aimed at understanding patients, visitors and staff experience of a music therapy programme at a cancer hospital	S	GT	O (written responses to brief open ended questions)	A partial, textual insight into the benefit of music therapy in a cancer hospital.	128	Adult cancer patients
(O'Callaghan, 2007)	Interpretive subgroup analysis on modified grounded theory research of music therapy in oncology	S	GT	I	Music Therapy had some social and emotional effects on participants. The number of sessions of Music Therapy had scant effect and gender and age of participants affected results.	128	Adult cancer patients
(Odell-Miller et al., 2006)	Investigates the arts therapies as a treatment for adults with mental health difficulties	M	GT	I	The numerical results were not conclusive owing to high variability and small sample size. Qualitative results indicate value of arts	10	Adult mental health

					therapies. Recommend larger quantitative studies.		
(Symons et al., 2011)	Aims to understand the experience of participation in visual art from the perspective of adults undergoing outpatient physical rehab	S	GT	I	Art contributed to clients meeting their rehabilitation goals, gaining confidence, enjoyment, planning for future	9	Adults neurology
(Coholic et al., 2009)	Exploring the helpfulness of arts-based group work for the development of self-awareness and self-esteem in children in foster care	S	GT	I and data from group therapy sessions	Findings indicate that children learned new skills, improved coping skills	35	Children in foster care
(Perry et al., 2008)	Creative arts group for parents of toddlers under 2, brief intervention	S	GT	I	Benefit of arts as complementary to other treatments for post natal depression. Benefit only observed during short term therapy, no longer term benefits noted.	18	Parents (9) and professionals (9)
(Eggenberger et al., 2004)	Giving voice to family caring in cancer: integrating visual art and research findings	S	GT	N	Visual art plays a role in making a phenomenon understandable and explaining experience	21	Family members of people with cancer

Phenomenology	Aims to describe interpret and understand the meanings of experiences at both a general and unique level. The research question centres on What it is like to be in or experience a particular situation? This approach focuses on the depth of a particular experience, to describe the qualities of experiences that were lived through. Thematic analysis is undertaken, moving back and forth between whole meanings and part meanings (Holloway 2005)						
(Bedding and Sadlo, 2008)	Retired people's experience of participation in an art class	S	PH	I	Benefit of painting was linked to challenge, a sense of achievement, productivity, boosting confidence	6	Retired adults
(Kennett, 2000)	Exploring the experiences of terminally ill patients taking part in an exhibition of their art work	S	PH	I	Main themes identified as enjoyment, enthusiasm, excitement, pride, achievement, satisfaction, sense of purpose, mutual support and permanence. Hope was identified as the essence of the phenomenon.	21	Terminally ill patients (10) and facilitators (11)

(Sinding et al., 2002)	To explore the experience of women with breast cancer involved in creating a drama Handle With Care? Living With Metastatic Breast Cancer	S	PH	I	A performance of the final script was crafted following dialogue and focus group meetings. The experience of living with metastatic breast cancer was analytically, imaginatively, and personally engaged. Ethical issues and this new research method are explored.	2	Women with cancer (with artistic director, theatre company and volunteers)
(Ansdell and Meehan, 2010)	Effectiveness of music therapy in mental health settings, user perspective	S	PH	I	Music Therapy can help to re-establish patients' on-going use of music as a health promoting resource and coping strategy in their lives	19	Adult mental health
(Reynolds and Priora, 2011)	Exploring older peoples account regarding strategies for adapting to their participation in visual art making in context of arthritis	S	PH	I	A detailed analysis of the experience of creative occupation. Participants described the flow of art-making, which help to banish intrusive thoughts about cancer, engage in positive journeys and alleviate some stress.	10	Women with cancer aged 62 – 81

(Lane, 2005)	To examine the lived experience of hospitalised patients of arts and healing of 63 participants over a 4-year period.	S	PH	I	The spiritual dimension of arts experience emerged as a key theme for patients. Implications for nursing care are discussed.	63	Adults in hospital
(Van Lith et al., 2011)	Studies mental health consumers' lived experiences of art making within psychosocial rehabilitation services	S	PH	I	Art making is a highly valued activity who suggest that methods such as art making can facilitate recovery and self-expression. A key challenge is to better integrate such methods into mental health service delivery.	18	Adult mental health
(O'Sullivan and Chard, 2010)	To illuminate the experiences of older adults returning to leisure activities, following rehabilitation post-stroke	S	PH	I	Post-stroke interventions need a more occupation-focussed approach, including return to leisure at an earlier stage of stroke rehabilitation.	5	Older adults with stroke
(de Guzman et al., 2011)	Traditional Filipino arts among elders in institutionalized care settings	S	PH	I	Recreational therapies helped patients overcome the challenges of depression and offered hope for more positive views of themselves	3	Women, aged 60 + living in residential care
Ethnography	Ethnography studies people						

	in natural surroundings to develop theories about behaviours and culture.						
(Howells and T, 2009)	Effect of an integrated art studio on the lives of participants	S	E	I and OB and D and O (journal keeping)	Art helped people build new identities and roles, a meaningful activity and a bridge back into the community	20	Adult mental health
(Spaniol, 1998)	Towards an ethnographic approach to art therapy research: people with psychiatric disability as collaborators	S	E	I and OB		unavailable	Adult mental health
(Ferrara Montreal, 2004)	Anthropological study of art therapy with the Northern Quebec Cree people	S	E	OB	A comprehensive analysis of the nature of patients' experiences, examining the role of arts and the narrative of individual experience of trauma by Cree individuals.		Adults living in Northern Quebec
Content analysis or thematic analysis	These approaches include a number of techniques for organising and analysing textual data thematically. Content analysis and thematic methods of analysis are general qualitative approaches to identifying themes, rather than in-depth specific methodologies. These approaches are mentioned in a number of studies.						
(Gunnarsson et al., 2010)	Investigating clients' experiences of taking part in the Tree Theme arts method	S	TA	I	Overarching theme - the client made a journey, engaged in difficult process,	20	Adult mental health

					the creative interventions offered new life perspectives		
(Magill, 2009)	The role of music in palliative care music therapy sessions is analysed	S	TA	I	4 themes - music is a conduit, music is love, music makes a difference and music gets inside us	7	Bereaved caregivers
(Robb and Ebberts, 2003)	To compare patient perceptions regarding the effectiveness of 6 week music sessions with no music sessions.	S	TA	O (song lyrics and post study questionnaire)	Themes include hope, positive coping, control, time (this paper accompanies another reporting on the quantitative results)	6	Bone marrow transplant patients
(Bartel et al., 2011)	Evaluate the arts for life project for patients and residents with long term illness in nursing homes, using digital artist or music therapy interventions	S	TA	I	Opportunities to express creativity and individuality.	7	5 patients, 2 relatives, long term care in nursing homes
(Lloyd et al., 2007)	Exploring how visual arts programme in Australia contributes to recovery in mental health services	S	TA	I	Arts programmes are a medium of expression and self-discovery, with spiritual and self-empowerment roles	8	Adult mental health
(Reynolds and Prior, 2006)	Reflecting on experience of visual art making for women living with cancer	S	TA	I	Themes - creative adventures, distraction from worries, control, achievement, mastery, positive journeys, alleviating stress	10	Women with cancer

(Greaves and Farbus, 2006)	Effects of creative and social activity on the health and well-being of socially isolated older people (various art forms)	M	TA	I and F	Qualitative data showed the programme was well received by participants, reporting social activity, self-worth, optimism, positive changes in health behaviour	264	Socially isolated older people
(Demecs et al., 2011)	Women's experience of attending a creative arts program during their pregnancy, singing, dancing, storytelling and weaving	S	TA	I and O (questionnaires)	Themes included seeking support, sharing together, connecting with each other, myself and the baby, finding balance	7	Pregnant women
(Wikstrom, 2004)	The importance of aesthetic forms of expression in later life - dance, music, literature, pictures	S	TA	I	Arts were found to be intellectual activities, giving a feeling of timelessness, spacelessness and interaction with others	166	Adults over age 65
(Secker et al., 2007b)	Empowerment and arts participation for people with mental health needs.	M	TA	O Qualitative case studies	Arts and mental health initiatives could make an essential contribution to the future of mental health and social care provision, in the context of a growing emphasis on recovery orientated mental health services.	34	Adult mental health
(Beaven et al., 2008)	Perceptions of participants in a cancer patient support art group	NM	TA	I	Art therapy contributed to positive attitude to life and to	25	Cancer patients



					coping more effectively		
(Kincaid and Peacock, 2003)	Study of repeated door testing behaviour in a nursing home for people with dementia (with art used to disguise the door)	M	TA	OB and quantitative pre-post testing	Wall murals can be an effective way of cueing residents away from a situation that may evoke agitation and a situation of potential harm and litigation	12	Older adults with dementia
(Schofield, 2003)	To investigate the use of the Snoezelen multisensory environment in palliative day care	M	TA	I	Qualitative data suggested Snoezelen may promote relaxation. Recommendations are made for further research. Scant details of method of data analysis.	26	Older adults (mean age 66.3)
(Chen et al., 2009)	To explore the perceptions of group music therapy among elderly nursing home residents in Taiwan	S	TA	F	Benefits of music therapy revealed two major themes: (1) strength derived from the group dynamic and (2) enhanced quality of life	17	Older adults (wheelchair users)
(Dooris, 2005)	To describe the context, process and findings of a qualitative review of Walsall Arts into Health Partnership, UK	M	TA	I, F and O (documentary analysis)	Findings point to the value of community arts and health work and to the importance of a partnership approach. However, current debates regarding evaluation approaches within	27	Adults, various community arts and health programme participants

					the field point to the need for clarification regarding values, the use of multiple methodologies and engagement with a diversity of stakeholders		
(Caspari et al., 2011)	This study aimed to describe experts' evaluation and wishes for aesthetics in hospitals.	S	TA	I	The aesthetic surroundings are very important for the health and well-being of the patients	16	Adults with expertise in aesthetics
(Spandler et al., 2007)	The contribution of arts initiatives to recovery approaches in mental health services	S	TA	I and O (questionnaires)	Some evidence of benefit of arts in mental health recovery	34	Adult mental health
(Burton and Stevenson, 2010)	Assessing the value of offering art therapy activities to patients and carers.	S	TA	I	Arts helped patients relax, socialise - although more research needed, the benefits reported should not be ignored.	8	Adults with cancer (5) and carers (3)
(Shaw and Wilkinson, 1996)	Role of sculpture for patients with advanced cancer in palliative care services	S	TA	I	The patients' perceptions of the study suggest that this approach to art in palliative care is of value. Art has intrinsic value even without being used as a therapy or diversion	9	Adults cancer

(Feen-Calligan and Nevedal, 2008)	Evaluation of an art therapy program	M	TA	O (evaluations consisted of self-reports by participants to open ended questions)	This brief report presents a practical strategy for evaluating art therapy programmes based on participant evaluations	120	Adults and children receiving art therapy
Arts based methodologies	Arts based methodologies emphasise the visual rather than the verbal (for example children may be able to paint to express their views more easily than using words) (Rapport, Wainwright et al. 2005) as well as new methodologies such as drama based action research.						
(Broadbent et al., 2009)	Investigating whether drawings could be a useful way to assess patients perceptions of headaches	S	O (survey instrument plus drawings of pain)	O (mainly statistical analysis of questionnaire plus analysis of drawings)	Drawings offer an additional way to assess peoples' experience of their headaches and reflect illness perceptions and distress. Drawings may be a useful way for clinicians to understand patients' experience of pain. Limited information about process of analysing drawings.	65	University students who experience persistent headaches

(Lee and De Finney, 2008)	Examines the use of popular theatre as a methodology when investigating experiences of exclusion for racialised minority girls	S	T (popular theatre as a research methodology )	O (Various methods such as discussion, arts and theatre were used to develop a narrative of the experience. The performance of theatre before an audience of peers is a way of validating and making visible experiences)	Popular theatre is developing as an alternative and promising research methodology. However, many methodological dilemmas arose during this project.	10	Girls age 14 – 18
(Mitchell et al., 2006)	A team of researchers, artists, and actors create a research based drama about living with dementia, based on data from service users	S	T	O (Discussions, observations, improvisation by playwright, actors and researchers. 6 performances were evaluated, these were given to 100 people with dementia and their families	The experience of viewing the play illuminated the experience of people with dementia	100	Adults with dementia and their families
(Foster, 2007)	To reflect on participatory, arts based research project carried out at a Sure Start programme in North West England.	S	O (using arts, drama, creative writing over 2 year period to tell the narrative of participants experience)	O (Through creating art work, poems and short films, participants are able to construct their stories for themselves)	The arts offer a way for researchers and research participants to examine their lived experience, to reflect creatively upon this, and to know themselves more deeply. A very different practice from that of the researcher selecting snippets from various interviews and piecing them together to tell a particular tale	6	Women, parents participating in a support programme for mothers of children under 5

					from his or her own perspective. The arts process validated findings from more conventional research methods.		
(Lind et al., 2010)	Describes a research project studying the strengths of adolescent girls in an open custody treatment group home	S	T	OB and O (theatre techniques)	Arts-based research and participatory action research offer new ways of accessing marginalized populations' strengths and challenging harmful societal assumptions	1	Adolescent girl in an open custody treatment group home.
Narrative approach	Describing an account of a person's experience in the form of a story or narrative account						
(Stuckey and Tisdell, 2010)	Role of creative expression in diabetes, visual digital art	S	TA	I and O (analysis using art processes)	3 key themes emerged - putting a positive spin on illness to make meaning, meaning making in patient care and experiencing negative emotions	8	Women with type 1 diabetes
No method given							
(Forzoni et al., 2010)	To assess whether patients perceive art therapy as helpful during chemotherapy sessions	S	N	I	Art therapy may be useful to support patients during the stressful time of	54	Cancer patients

					chemotherapy treatment		
(Griffiths, 2003)	Arts and creativity qualitative study of mental health promotion tool for young African and Caribbean men	S	N	I and F	Arts may be useful as a health promotion tool for this client group	unavailable	Young African and Caribbean men with mental health issues
(Gallagher, 2008)	Evaluating project for patients and residents with long term illness in nursing homes, using music therapy and digital art interventions	NM	N	I	Findings of benefit should be interpreted with caution given the small sample, larger scale research recommended	7	Patients/residents of long term nursing homes (5) and their families (2)
(Twardzicki, 2008)	Role of performing arts in challenging stigma around mental illness	M	N	O (qualitative questionnaire and attitude questionnaire)	3 years of data shows a successful approach to influencing attitudes and empathy around mental health and feelings of service users' achievement, mood, confidence and inclusion.	126	Young adult students (34) Mental health clients (43) audiences (57) tutors (4)
(Philipp and Robertson, 1996)	Research into the health benefits of writing poetry.	S	N	O (written comments invited from general public)	Writing poetry was reported to provide a useful outlet for their emotions, to manage anxiety, depression, dying and bereavement, post-traumatic stress, eating disorders, and sexual abuse.	218	Adults, general public

Notes: GT- Primary Methodology GT (Grounded theory), PH - Phenomenology, E – Ethnography, T - Theatre action research based methods, TA - Thematic or content analysis, O- Other, N - No method given

## Appendix 8 Published paper of literature review of qualitative methodologies used in arts and health studies (Moss et al., 2012)

Downloaded from [mh.bmj.com](http://mh.bmj.com) on April 27, 2013 - Published by group.bmj.com

### Original article

## A review of qualitative methodologies used to explore patient perceptions of arts and healthcare

Hilary Moss,<sup>1</sup> Claire Donnellan,<sup>2</sup> Desmond O'Neill<sup>3</sup>

► An additional table is published online only. To view this file please visit the journal online (<http://dx.doi.org/10.1136/medhum-2012-010196>).

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### ABSTRACT

Although the importance of the arts in healthcare is increasingly recognised, further research is needed to investigate the mechanisms by which arts and health programmes achieve their impact. An overview of the qualitative methods used to explore patients' perceptions of these interventions is lacking. We reviewed the literature to gain insights into the qualitative methods used to explore patients' perceptions of the role of arts in healthcare with a view to identifying the most common methodologies used and to guide researchers embarking on research regarding patients' perceptions of arts in healthcare. Our results indicate a paucity of qualitative studies, a variety of methods used and variability of methodological rigour. Grounded theory and phenomenology were the most common approaches adopted, mixed methods approaches were relatively frequent, and versions of 'thematic' or 'content' analysis were commonly cited. Semi-structured interviews were the most popular data collection method. The emphasis of all of the studies was on active or participative arts engagement, with no focus on receptive engagement with the arts and aesthetics. It was concluded that careful consideration of appropriate methodology is important when researching such an exploratory and sensitive area. Individual interviews were most popular and might be appropriate when exploring personal, sensitive experiences. Mixed method studies possibly provide a comprehensive approach which might satisfy both the arts and healthcare settings need for evidence. It seems important to pay attention to rigour in any methodology chosen and a greater focus on receptive engagement with the arts might be encouraged in future research.

### INTRODUCTION

The impact of arts in healthcare is increasingly recognised but the level of research is modest compared with other factors associated with health and well-being.<sup>1–3</sup> Current research on arts and health falls broadly into five areas—the role of aesthetics in design and the healthcare environment, the role of arts as a therapeutic intervention, medical humanities, treatments for medical issues arising from work as a performing musician and the role of cultural participation on health and well-being. Although we have some measures of the temporal and financial engagement of the general population in arts and cultural activities, much remains to be determined about the role of these activities in the lives of those who attend health services, the impact of illness on their access to, and participation in, arts and cultural activities, and on the possible impact of artistic and cultural enrichment of healthcare environments.<sup>1,2,4–14</sup>

Patients' participation in arts in healthcare settings is a relatively under-researched area, with many studies indicating benefits such as boosting self esteem, sense of achievement and positivity at a time of ill-health.<sup>15–16</sup> However, much of the evidence available lacks rigour.<sup>2,17–19</sup> The arts attract a significant portion of government spend in many societies and with this funding comes a responsibility to evaluate the appropriateness of arts programmes within healthcare contexts.<sup>13,14,20</sup> An important aspect of health service delivery is consumer satisfaction and thus arts programmes in healthcare need to be based on patients' preferences and their perception of arts programmes rather than curatorial notions of what is best for the patient.<sup>7,21</sup>

Qualitative research represents the best initial approach to such a complex and under-documented aspect of health and well-being, through exploring the relative priorities, needs and wishes of those attending health services, and setting the parameters for future research, including quantitative research. There is a growing interest in describing the range of qualitative methodologies used in healthcare research in general,<sup>22</sup> and such analyses can help to determine the strengths and weaknesses of current knowledge and approaches.

A review of 135 published qualitative studies (not just arts and health studies) in the *Journal of Qualitative Health Research* found that 106 studies used grounded theory and 67 used phenomenology. Ninety-five of these studies did not credit any particular methodologist for the qualitative method used. Of the 67 phenomenological studies, 38% were identified as purely phenomenology, 31% interpretative phenomenology and 29% hermeneutic phenomenology and it was found that within any one type of qualitative methodology, there can be a variety of data analysis processes. The authors found key fundamental principles across studies to be constant comparison of data, cyclical analysis (ie, returning to data to check coding as the analysis proceeds) and emphasis on early analysis. It was found that a certain detachment from the 'rules' will help qualitative researchers to maintain reflective insight into data.<sup>22</sup> Given the relatively undeveloped research field of arts and health, researchers might gain insight from other disciplines and more generic studies of methodology.

The aim of this review, therefore, was to identify studies that used qualitative methodology in arts and healthcare or health-related studies and to explore which qualitative methodology was used. Specifically, this review aimed to identify research on patient perceptions of arts and health in order

to inform debate on the optimum methodologies for research in this area.

## METHODOLOGY

A computer search was conducted using the following databases: PsycINFO (1872–November 2011), PubMed (1940–November 2011), CINAHL (1981–November 2011), AMED (1995–2011) and Web of Science.

Searches were carried out using the following key search terms and key words: experiences OR perceptions OR views OR perspectives OR attitudes AND qualitative methodology OR research OR qualitative studies AND art OR arts and health OR Performing arts OR Music OR Art therapy OR Visual art AND patient(s) OR Hospital OR Inpatient OR Clinical setting OR Clinical environment.

Due to the scarcity of relevant papers recovered, a decision was made to consider arts therapies research as well as arts and health literature as there appeared to be commonalities in terms of methodologies used to assess the role of arts in healthcare settings.

## Inclusion/exclusion search criteria

The aim of the search was to identify studies that used qualitative methodology in arts and health studies, and to explore which qualitative methodology was used. The only criterion used to select papers was that they explored qualitative methodology used in arts and health studies. Papers were excluded if they were not relevant to arts and healthcare, were not studies using qualitative methodology or were not in English. Papers relating to other arts based topics in healthcare were not included. The authors agreed the search terms and words and all papers that met the criteria above were included.

In addition to these searches, papers were included that were discovered by other forms of search, specifically reference lists from the papers selected, recommendations from colleagues, previous literature reviews of government documents from UK and Ireland and references from the library of the Society for the Arts in Healthcare, (USA).

In order to extract relevant data from each of the selected articles the papers were analysed by extracting a database with the following key pieces of information from each paper:

- ▶ Methodology used—Grounded Theory, Phenomenology, Ethnography and Other (with detailed description here of methodology used)
- ▶ Whether study was mixed methodology or single
- ▶ Brief description of study (clinical group, health setting, art form)
- ▶ Sample size—number of patients involved in study
- ▶ Data collection method—Interviews (Semi-structured or open), Focus group, Observation, Documentary Analysis, Other
- ▶ Brief description of key findings

The researchers then reviewed each paper to determine whether adequate details of methodology were given. This was determined by whether the study gave enough information on methodology to be considered replicable and if the above list of information was available. If there was incomplete methodology or unclear definitions or descriptions of methodology then the paper was considered to lack rigour. For example, in some studies no recognised qualitative methodology was described, or inadequate details were given regarding methods of analysis and processes to ensure authenticity and credibility.

The studies represented a wide variety of patient groups, clinical settings, diagnoses and art forms. This study did not aim

to distinguish between any differences in age, gender, clinical issues or art forms but rather to study which qualitative methodologies were chosen for any study of any of the arts in any healthcare setting. The small number of studies found made limiting these criteria unnecessary.

## RESULTS

The search resulted in  $n=680$  citations including journal articles, government documents and published books. The number of citations for specific arts and health studies using qualitative methodology was modest ( $n=54$ ). Thirty-one of these ( $n=31$ ) citations were arts and health studies,  $n=13$  were arts therapies research ( $n=7$  music therapy,  $n=5$  art therapy,  $n=1$  combination of arts therapies),  $n=6$  were theatre or arts based projects and  $n=3$  were concerned with patients' perception of the aesthetic environment. One ( $n=1$ ) combined music therapy and digital art. By art form, the most popular art form reported was visual art (including art classes and art therapy) ( $n=22$ ), music ( $n=9$ ), combination of art forms ( $n=11$ ), drama ( $n=5$ ) and environmental aesthetics ( $n=3$ ). There was only one study found each for creative writing ( $n=1$ ) and sculpture ( $n=1$ ) and two using digital art ( $n=2$ ). Most of the literature in this area was exploratory or descriptive based on art therapies or arts in health work in various contexts ( $n=165$ ) or other arts related research, for example, the role of medicine and rehabilitation for performing musicians ( $n=53$ ). The 54 papers selected were those that specifically explored patients' perceptions of arts in healthcare settings through qualitative research.

A variety of methodological approaches were used to shed light on the experiences of patients of the arts. The most common were phenomenology ( $n=9$ ) and grounded theory ( $n=11$ ). Twenty studies ( $n=21$ ) described the qualitative methodology as 'thematic analysis' or 'content analysis' and  $n=4$  studies gave no details about the methodology. Five studies ( $n=5$ ) employed 'arts based action research methods' in their study, again there was less detail given here of replicable methodology. There were  $n=3$  ethnographic studies and  $n=1$  narrative. Nine ( $n=9$ ) of the qualitative studies were part of larger mixed methods research projects.

The most common qualitative approach to collecting data was semi structured, in-depth interviews ( $n=39$ ), with 29 ( $n=29$ ) using purely interviews as data collection method and 10 ( $n=10$ ) combining this with another qualitative data collection approach. These included focus groups, data from group therapy sessions, observations, questionnaires and data from art processes. Of the remaining 15 studies, data collection methods included observation techniques ( $n=5$ ), theatre and other arts based research approaches ( $n=6$ ), focus groups ( $n=1$ ), written responses to open ended questions and qualitative questionnaires ( $n=4$ ) and analysis of song lyrics ( $n=1$ ).

Of note, the emphasis of all of the studies was on active or participative arts engagement (such as making art, writing poetry, creating drama productions or playing instruments) (54), with no focus on receptive engagement with the arts and aesthetics (such as reading or listening to music) (0).

The number of patients consulted for the studies ranged from 264 to 1 with a median of 18. Seven studies referred to children's arts and health services, the remaining 47 were adults in a range of health services, including cancer care, mental health, older age and physical disability. In total 2036 patient perspectives were recorded when all the studies are put together (table 1 and online table 2).



to inform debate on the optimum methodologies for research in this area.

## METHODOLOGY

A computer search was conducted using the following databases: PsycINFO (1872–November 2011), PubMed (1940–November 2011), CINAHL (1981–November 2011), AMED (1995–2011) and Web of Science.

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- ▶ Brief description of key findings

The researchers then reviewed each paper to determine whether adequate details of methodology were given. This was determined by whether the study gave enough information on methodology to be considered replicable and if the above list of information was available. If there was incomplete methodology or unclear definitions or descriptions of methodology then the paper was considered to lack rigour. For example, in some studies no recognised qualitative methodology was described, or inadequate details were given regarding methods of analysis and processes to ensure authenticity and credibility.

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A variety of methodological approaches were used to shed light on the experiences of patients of the arts. The most common were phenomenology ( $n=9$ ) and grounded theory ( $n=11$ ). Twenty studies ( $n=21$ ) described the qualitative methodology as 'thematic analysis' or 'content analysis' and  $n=4$  studies gave no details about the methodology. Five studies ( $n=5$ ) employed 'arts based action research methods' in their study, again there was less detail given here of replicable methodology. There were  $n=3$  ethnographic studies and  $n=1$  narrative. Nine ( $n=9$ ) of the qualitative studies were part of larger mixed methods research projects.

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Of note, the emphasis of all of the studies was on active or participative arts engagement (such as making art, writing poetry, creating drama productions or playing instruments) (54), with no focus on receptive engagement with the arts and aesthetics (such as reading or listening to music) (0).

The number of patients consulted for the studies ranged from 264 to 1 with a median of 18. Seven studies referred to children's arts and health services, the remaining 47 were adults in a range of health services, including cancer care, mental health, older age and physical disability. In total 2036 patient perspectives were recorded when all the studies are put together (table 1 and online table 2).

## Original article

**Table 1** Details of 54 arts and health studies using qualitative methodology

	Number of studies
<b>Art form</b>	
Visual Art	22
Music	9
Combination of art forms	11
Drama	5
Environmental aesthetics	3
Creative writing	1
Sculpture	1
Digital art	2
<b>Total</b>	<b>54</b>
<b>Type of study</b>	
Arts and health studies	31
Arts therapies	13
Theatre based	6
Environmental aesthetics	3
Combined arts and health and arts therapies	1
<b>Total</b>	<b>54</b>
<b>Methodology</b>	
Grounded Theory	11
Phenomenology	9
Thematic analysis or content analysis (various approaches)	21
No details of methodology	4
Arts based action research	5
Ethnography	3
Narrative	1
<b>Total</b>	<b>54</b>

**DISCUSSION**

Grounded theory and phenomenology are the most popular qualitative methods used in arts and health studies. Semi structured interviews are the most popular method of data collection. Following the analysis of the studies presented here, three key points stand out regarding choice of qualitative methodology for arts and health research. First, while the majority of the 54 papers chosen were rigorous and detailed studies, five papers in this sector appear to lack detail about methodology, 20 allude to 'content analysis' or 'thematic analysis' and most of the studies conclude that their sample provides only preliminary evidence and recommend further research in this area.<sup>2 19 25-26</sup> While the smaller studies give reliable evidence in themselves, there is a scarcity of larger sample groups in arts and health research and much of the research tends to be qualitative. It may be useful to carry out some larger studies, perhaps mixed methodology, to gather both intense individual accounts and research with a larger sample group.

Second, the most frequent approach to collecting data was the semi-structured interview. An individual approach (as opposed to focus groups or observation, for example) has been found by the majority of researchers as appropriate in this context, perhaps because this allows the personal nature of hospital experience and creative activity to be explored in a confidential setting and to explore in-depth an unfamiliar phenomenon. However, each context would need to be considered separately when conducting further qualitative studies.

Third, arts and health research into patient perception is a broad topic and relatively unexplored. It is impossible to recommend one qualitative approach over another as context will determine choice but the need for rigour and attention to methodological detail is important. It is interesting to note, however, that a large number of the thematic analysis methods used gave a rigorous account of how they carried out the

analysis and raises the question as to the added benefit of following a method such as phenomenology or grounded theory which might be more cumbersome and time consuming.

A further interesting insight is the almost complete neglect of receptive engagement with the arts. This is puzzling given clear evidence of not only the universality of this aspect of the arts, but also its importance in terms of quantitative and qualitative measures such as government and consumer spending, as well as surveys of the general public.<sup>23 24 26</sup> Further urgency to pursue this aspect of research has been fuelled by a recent large study in Norway which showed a positive association between well-being and receptive engagement with the arts.<sup>25</sup>

Our study confirms the finding by Daykin *et al*<sup>2</sup> that there is a need for further research that addresses the methodological challenges of evaluating complex interventions and a need for more qualitative research in this field that pays attention to procedures and reporting of data collection and analysis. Arts and health studies have a variety of aims and goals and whichever methodology is used, there is a need for rigour within the arts and health research sector. It also finds evidence to support the view that qualitative studies are needed to more accurately focus the target for possible further experimental studies.<sup>27</sup>

There was a diversity of approach to methodology and client groups in the 54 studies found; hence it is difficult to draw strong findings from the data. The individual lived experience is at the heart of qualitative research and replicability of these studies is not of paramount concern. No single methodology was seen in these studies to offer adequate solutions to the question of providing evidence of benefit of arts in health setting.<sup>24 25 28-30</sup> It may be important for some studies to focus on larger sample sizes and to combine quantitative and qualitative methodologies.

It is interesting to note that while many of the studies were small, the studies together gave rich data from 2086 patients who gave their perspective on arts and health interventions. A common theme throughout all the studies was the perceived benefit for participants of arts and health, particularly in areas such as boosting self esteem, self confidence, sense of achievement, positivity at a difficult time of life and promoting a sense of hope.<sup>23 31-36</sup>

A number of studies found in the literature review used arts based research to more accurately reflect the story and experience of participants in health and social services. For example, theatre and drawing were used as research tools. Lind *et al* report that arts-based research and participatory action research offer new ways of accessing marginalised populations' strengths and challenging harmful societal assumptions. Broadbent *et al* used visual art to assess how 65 students who experienced persistent headaches were affected.<sup>35-39</sup> Rapport *et al* report on specific issues in qualitative methodology in healthcare research and argue for new methods (such as those described above) which might broaden out the scope of qualitative inquiry in health and social care. These are argued to address the crossing of boundaries from one discipline to another and to aid collaboration between distinct disciplines such as arts and medicine. Arts based methodologies' might offer a new way to research arts and health projects but to date the new methods are experimental and the studies using these methods do not offer detailed replicable methodology.<sup>40</sup>

We also concur with Daykin that there is unlikely to be a single qualitative methodology that serves as the 'gold standard' in qualitative research.<sup>19</sup> However, qualitative research needs to produce solid and rigorous evaluations and too many studies have either limited information or a lack of depth to the



data analysis. There is a need identified in the current literature for larger samples, rigorous methodology and further research in this area and it is important that this is considered whichever methodology is chosen for an exploratory study of patients' perception of arts in healthcare settings. In addition, a focus on receptive engagement with the arts needs to be developed.

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**Provenance and peer review** Not commissioned; externally peer reviewed.

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## **Appendix 9 List of 'ARTS' for qualitative interview (Arts Council Survey 2006)**

### **Theatre**

Plays  
Opera  
Musicals  
Variety show/pantomime  
Stand-up Comedy  
Circus  
Open air street theatre/spectacle

### **Film**

Mainstream Film  
Art-house Film

### **Dance**

Contemporary Dance  
Ballet  
Traditional/Folk Dance  
Other dance

### **Music**

Classical music  
Jazz/Blues music  
Rock or popular music  
Traditional Irish or Folk music  
Country & Western music  
World music  
Other music  
Buying CDs, cassettes, downloads etc. – for listening

### **Books/Literature**

Reading  
Work of fiction, novel, story or play  
Poetry  
Biography or autobiography

Non-fiction/factual relating to the arts (e.g. book about theatre, architecture, music etc.)

Newspapers or magazines

### **Visual art**

Art Exhibitions (e.g. paintings, sculpture, photographs, multi-media)

### **Architecture/Design**

#### **Some Arts Activities .....**

Dancing (Clubbing/disco dancing, Set dancing, other dancing)

Singing (in a choir or other)

Playing a musical instrument

Writing (e.g. writing music, poetry, novels, plays)

Performing or rehearse in play/drama/opera/show

Helping with running arts event or organisation

Painting / drawing / sculpture

Photography

Making films or videos

Making artworks or animation on a computer

Attending arts groups in community

Attending performances (e.g. theatre, concert hall, traditional session)

## Appendix 10 Published paper of phenomenological study (Moss and O'Neill, 2014)

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### ORIGINAL RESEARCH

## The aesthetic and cultural interests of patients attending an acute hospital – a phenomenological study

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Accepted for publication 27 April 2013

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### Abstract

**Aim.** To describe the aesthetic and cultural pursuits of older patients in hospital. **Background.** Although there is much discussion of the importance of arts – used in this paper to refer to all art forms, as currently listed by the Arts Council of Ireland [www.artscouncil.ie](http://www.artscouncil.ie) – in health, little is known about the salience of aesthetic and cultural pursuits of hospital patients.

**Design.** A qualitative, hermeneutic phenomenological study examined artistic and cultural interests and experiences of older hospital patients and their perceptions of aesthetics of hospital.

**Methods.** A phenomenological study was carried out in 2011, using purposeful sampling with 20 inpatients aged over 65. Patients were selected from the geriatric medicine day hospital of a university teaching hospital, 10 had experience of the hospital arts programme.

**Results.** Seven themes identified: loss and the impact of illness on leisure activities; patients' interests and passions; a lack of expectation of arts in hospital; the positive impact of arts in hospital for those who had experienced them; varying preference between receptive and participative arts activity according to phase of illness; aesthetic aspects of the hospital experience; recommendations for changes to improve arts in hospital.

**Conclusions.** Aesthetic and cultural interests are important in the lives of older patients admitted to hospital. Illness can create barriers to artistic engagement. Participation in arts activities may be more important during recovery and rehabilitation, with receptive arts being more popular during the acute phase of illness in hospital. Further research recommended on the role of the aesthetic environment for patients' health and well-being as well as receptive arts in hospital.

**Keywords:** aesthetics, culture, gerontology, nursing, patients' perspective, phenomenology, qualitative methodology

**Why is this research important?**

- One of the first studies to explore the aesthetic and cultural preferences of older patients in hospital.
- One of the first studies to compare the experiences of older patients who have experienced hospital arts programmes with those who have not.
- Research in a new, emerging field with many studies in this field lacking methodological rigour.

**Three key findings**

- The findings from this study support findings in previous literature regarding the positive benefits of arts and aesthetic enrichment for hospital patients.
- Further research is recommended on the role of the aesthetic environment for patients' health and well-being.
- Facilitation of receptive artistic activities, such as reading and music is recommended.

**How should the findings be used to influence policy/research/education?**

- This research may facilitate a more patient-centred approach to the development of arts and health programmes in hospitals.
- The research indicates that arts and cultural interests are important to patients and should be given attention in hospital settings.
- Nurse managers and specialists are recommended as the experts to provide leadership regarding the importance of aesthetic and cultural interests of patients.

## Introduction

Although it is often stated that aesthetics, the arts, culture and leisure are important for well-being (Bygren *et al.* 2009, Cuypers *et al.* 2012, Hyypä *et al.* 2005) there is little experimental research into arts in health care and few international studies (Daykin *et al.* 2006, 2008). Nonetheless, there is growing international acceptance of the notion that participation in the creative arts can be beneficial for well-being and health (Clift 2012). The impact of participation in cultural activities is increasingly recognized as relevant to a healthy older age (Cuypers *et al.* 2012, Cohen 2009, Hyypä *et al.* 2005, Konlaan *et al.* 2000).

## Background

The arts and health field can be broadly divided into three fields – the medical humanities, the arts as therapeutic

intervention and arts in the hospital environment (Cohen 2009, Lawson & Phiri 2003, Moss & O'Neill 2012, Ulrich 1992, 2009). In this field, there are numerous interventions and approaches, including outreach programmes from major cultural institutions, arts therapy interventions and health-promotion activities (Society for the Arts in Healthcare 2012).

A recent review of qualitative studies specifically examining patients' perceptions of the role of arts in health and well-being yielded only 54 relevant studies, four of which focused specifically on the salience of aesthetic and cultural issues in their lives (Caspari *et al.* 2011, Moss *et al.* 2012, O'Sullivan & Chard 2010, Reynolds & Prior 2011, Wikstrom 2004). Without the perspective of the patients, arts and health programmes may be unduly shaped by the arts and health practitioners and fail to meet the wishes and needs of the patients. For a truly patient-centred arts and health programme, more understanding is needed of the salience of arts, culture and leisure activities of patients and the impact of illness on this aspect of their lives.

This study focused on older people because they are proportionately the largest demographic group using health services and a better understanding of the interaction between aesthetics and health in this group can inform investigative strategies for the whole population.

## The study

This qualitative study aimed to describe the aesthetic and cultural pursuits of older patients in hospital. Specifically, it aimed to provide a mapping of patient preferences, needs and perceived benefits regarding the arts and to explore the role of the arts in their lives and through the journey of care in a general hospital. It also explored their perceptions of the aesthetic environment of the hospital and captured the experience of those who had participated in an arts and health programme. This was considered to be important as it is difficult for patients to give their reflections on arts and health programmes unless they have experienced one.

## Aim

The primary aim of the study was to describe the aesthetic and cultural pursuits of older patients in hospital. The secondary aim was to study how much access patients currently have to arts and culture while in hospital, to develop theory in this area, in particular whether patients experience aesthetic deprivation while in hospital.



### Design

In-depth qualitative interviews were carried out with 20 older patients during 2011 who were inpatients in an acute hospital and continued to attend ambulatory care services. Ten patients who had experienced the hospital arts programme and 10 who had no experience of arts in hospital were selected. The study was designed following a hermeneutic phenomenological approach (Van Manen 1990).

### Sample

Patients included were adult, aged 65 or over, with an inpatient stay of more than 1 week in the hospital in the last 6 years. This time period related to the inception of the hospital arts programme from which some patients were recruited. Patients were excluded if they had cognitive or language difficulties sufficient to hinder engagement with the interview or were patients whose stay in the hospital was <1 week or more than 6 years ago.

Purposeful sampling was used to select the patients who were recruited by two methods. Those who had participated in the hospital arts programme were sent a letter outlining the research and inviting them to participate. These patients were participants of visual art, music or creative writing programmes while in hospital or as part of their rehabilitation and/or outpatient programmes (Moss 2010). All art sessions attended were up to 2 hours long and participants attended a maximum of 12 weekly sessions. People invited had ceased to attend any hospital arts programmes 6 months prior to the research, but had attended a programme in the last 2 years. Those who had not engaged in the art programme were invited after consultation with the Clinical Nurse Managers in the relevant areas, using verbal and written approaches.

Patients were taken from two groups, 10 who had previously participated in the hospital arts programme and 10 who had not. It was considered important to interview both patients who have engaged in the hospital arts programme (to explore how they use the arts in hospital and when recovering from illness) as well as those without experience or expectation of arts in hospital.

### Data collection

Both groups were asked the same questions and similar broad issues were explored in the interviews. The interviews used open interview techniques as described by Patton (Bowling 2009). Interview questions were devised following

literature review, review of Patton's guidelines for qualitative interview questions and two pilot interviews where a range of questions were tested.

After carrying out 10 interviews, an initial analysis was undertaken and then the following 10 were completed. The first 10 interviews were all conducted with people who had attended the arts programme. It was believed, on reviewing this material, that it was important to also interview those who had not engaged in the arts programme. Both groups would bring important experiences and expectations to understanding the phenomenon and it was important to explore differences and similarities in the experiences of the two groups.

After 20 interviews it was considered that saturation had been achieved and relatively little new material was being recovered. Although saturation is most often applied to grounded theory research, it is relevant in all qualitative research as researchers cannot make a judgement about sample size until they are involved in the data collection: saturation normally occurs between 10–30 interviews (Thomson 2004).

Interviews were recorded and transcribed verbatim. The researcher also recorded handwritten notes in a journal throughout the process, reflecting on interview process, ideas and assumptions. The process of collection of data and data analysis can be seen in Figure 1.

### Ethical considerations

Research Ethics Committee approval was granted for this study by the hospital ethics committee.

### Data analysis

A phenomenological approach was selected for this study, using Van Manen's hermeneutic phenomenological approach (Van Manen 1990). This qualitative method is commonly used in health and social science research: its emphasis is on bringing the essence of a phenomenon alive through written descriptions, with the aim being to describe and interpret the experience and to describe what makes the experience unique (Van Manen 1990).

The first stages of data analysis involved coding the interview text, line by line, into initial codes and then organizing these codes into clusters. Units of relevant meaning were then grouped together and seven emerging themes were identified. These emerging themes were presented as written descriptions, which were then tested for credibility and trustworthiness. Nvivo software was used to support the process of analysing the text.



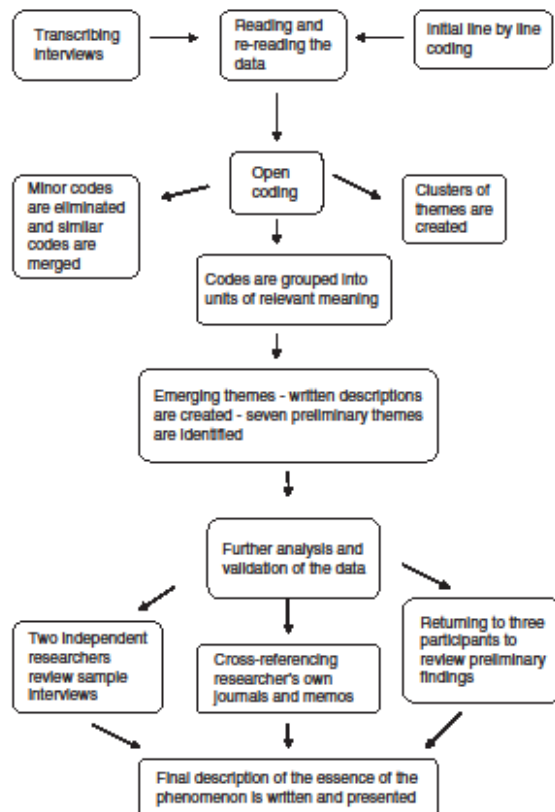


Figure 1 Diagram Data analysis process.

### Rigour

To increase credibility and trustworthiness, two independent researchers reviewed a sample of two interviews each. Rigour was established by methods of peer review, supervision and debriefing with two co-researchers/supervisors and returning to a sample of three patients who had been interviewed. In addition, the researcher recorded reflective field notes about the content and process of the interviews throughout the process, as well as any extra information or non-verbal observations that occurred (O'Sullivan & Chard 2010).

Following these validation exercises, the final themes were presented. The final step was to write a description of the phenomenon, taking into account all that was known through the process described above.

### Results

Ten men and 10 women were interviewed, with equal distribution of men and women in both the arts and non-arts groups. The ages of interviewees ranged from 65–94 years, with a mean age of 79.

Seven themes were identified:

#### Theme 1: Loss and the impact of my illness on leisure activities

Many patients described loss of confidence in their bodies, resulting from stroke or major cardiac event, loss of interests and hobbies, the loss of not being able to work, missing friends, loss of social life, activities and interests,

such as sports or gardening and not being able to be physically active with grandchildren. Other losses include the physical limitations of ill health, such as having poor memory, not being able to see very well, not being able to walk and get out to the theatre or films. Physical barriers to accessing places, such as poor mobility, mean a loss of social life and activity. These impact on social life, ability to work and to access arts venues.

A common theme was the emotional impact of their loss, experienced when in hospital or very ill at home, as well as the frustration, irritability, anger and/or anxiety associated with a loss of control over one's own life and abilities. This loss, and the associated emotions surrounding a stay in hospital and a major illness, affected engagement in arts. Either people put their arts interests on hold while in hospital, or lost the ability to pursue them, or took up new arts activities posthospital as their ability to engage with arts they enjoyed, such as dancing (cited in 8 interviews), was too physical and they needed a more sedentary activity or as a way to meet people.

Eighteen of the 20 interviewees made reference to loss and 58 references were coded to this overarching theme. This theme centred around the social and emotional aspects of illness as opposed to physical health issues:

It was a horrible experience when I discovered that I had this (rheumatoid arthritis). I was always a jolly guy and I was going to the pub four times a week and (going) for golf, I can't do those now. My social life is very limited ... Every day is a nightmare when I wake up because the first two or three hours are horrendous, the pain. Against that I have to fight it and I have to live with it. Doing the art courses, doing the watercolour courses and the painting (helped). From the writing one I think I am going to get a little small book published

#### Theme 2: Interests and passions

Each interviewee had key interests and hobbies and a major passion or interest. All interviewees cited an interest in at least one art form and all could name one or two key interests, whether arts or other leisure activities. The most popular interests were music, dancing and theatre. All 20 participants were interested in at least one art form and arts (music, dancing and theatre) were rated as the most popular interests by participants, as opposed to other popular activities, such as golf and walking. A notable aspect of this part of the interviews was the energy and passion with which the interviewee described their favourite activities and leisure pursuits, whether arts or otherwise:

I am a very creative person and I knit quite a bit. I am always anxious to get back to my knitting. I would be interested in what new yarns are coming on the market. I can't wait to go and get my few balls of the latest. I have an accumulation of scarves and things. I do find that it goes everywhere with me. I always have knitting with me. I would be sitting beside a lady on the bus and I would end up selling her a copy of the patterns and exchanging

#### Theme 3: A lack of expectation of arts in hospital

None of the patients expected to have access to arts of any kind in hospital. Many of the patients who took part in arts had never done so until they came to hospital. Engaging in arts in hospital was almost universally a surprise and unexpected and all participants comment about how beneficial the arts were when they did access them in hospital:

When you were in hospital did you expect to have any art or music or any...? I didn't expect to have any art. No? No. I mean I had never heard of it until I got the letter to see would I come up here and do it

#### Theme 4: The positive impact of arts in health care for those who had experienced them

Those who did experience arts as part of their inpatient or outpatient experience had many positive experiences of arts, most particularly in feeling cared for, the increased socialization that came from this activity and the discovery of new interests and achievements at a time of great loss. There were a wide range and large number of positive experiences associated with engagement in arts, either in hospital or during recovery from a major trauma. Eleven participants gave positive comments regarding arts in hospital and there were 60 references overall recorded to this theme. Those who had accessed hospital arts programmes tended to have many recommendations about future art courses, such as longer art programmes available for patients, linking this to clinical care and enhancing the environment:

I thought it was a fantastic thing for (the) hospital to put on these courses for people. I had done creative writing in the past. You just become engrossed in it and sharing ideas I thought and meeting people which is really nice

#### Theme 5: Preference between receptive and participative arts activities varied according to phase of illness

Ten of the 20 patients interviewed felt that arts would not be very important during the acute phase of hospital. Even

though there was no expectation of arts, many who had experienced arts in hospital felt that they would not have wanted arts at the most acute phase of illness as they were too busy coping with tests and expected to put aside 'normal life' while in hospital. Many of those who experienced arts as patients described the emotional support they experienced through engagement in arts and identified arts as more relevant during longer illnesses or recovery phases. The arts associated most with acute phase were reading and listening to music. The relevance of arts activities was related to length of stay and type of illness.

Eight of the 10 participants who engaged in hospital arts programmes stated that they would not have wanted arts at the acute stage:

In the hospital... I'm not so sure you are able or interested in (arts) because I'd be lying in the bed for a couple of days and then some bug developed. In the mornings, do you know when you're in a bed you twist and you turn, you're making yourself comfortable and then after a while that comfortable position no longer is comfortable. ... So you don't think music or anything would be really very useful to you in that situation? No, I think at that stage you're kind of feeling a bit sorry for yourself

#### Theme 6: The aesthetic aspects of the hospital experience

Overall this was not an area that attracted many comments, patients were more engaged in talking about the arts that they were interested in outside of hospital. The aesthetic environment of hospital was only commented on when prompted and was not a priority when discussing arts and hospital.

In terms of negative aesthetic experiences, the most common unprompted comments related to noise. Ten patients noted noise as a problem in hospital. Patients were more likely to comment on the nursing and medical care than the physical building, with a high number of positive comments about the care they received. Fifteen of the patients noted pleasant aspects of the environment when prompted, but many did not remember the art or colour of the room they stayed in and were more focused on the social life of the ward and visitors.

The significance of music and reading was apparent. Noise and sharing rooms were the most significant negative aesthetic issues, with the predominance of television in the wards being both loved and loathed.

The most commonly cited activities while in hospital were receptive rather than participative aesthetic activities: watching television, listening to the radio, listening to music

and reading. As patients recovered or began the longer process of adapting to ill health, those with experience of the arts and health programme were more likely to cite benefits from engaging in creative participative activities, such as creative writing groups or art classes:

This is my third trip to this day hospital and on one of the other trips I know there was a lot of music and young harpists came in and they were greatly appreciated because it's a terribly boring place up there, it's very boring indeed...one of the best memories I have is the day they put on some Bach music in their little .... music group, I can't remember who they were

#### Theme 7: Recommendations for changes to improve experience of arts in hospital

Patients who had experienced arts in hospital asked for more and felt it was very important. Those who had not experienced arts also had some ideas about improving the environment. More live music, a quiet room to use for reading or meeting visitors and a relaxing space on the ward were cited as important improvements that many would have liked in hospital as well as less sharing with disturbing patients. Nearly all who attended theatre or concert venues stated that post hospital stay, it was more difficult to continue this interest due to physical barriers or feeling they were a nuisance to others. Others stated how important it was to have a social life and some meaningful activity and where their health restricted their activities, some had taken up art groups to meet these needs:

When we did the art appreciation I thought that was very, very good .... It was a real eye opener because I had always been interested in art. I thought it was a great, great course. All in all I was so impressed. I felt that (the) hospital cared about the patients. (Art) courses like this ... make people feel that they are important. Their aftercare is so important as well

#### Summary – the essence of the phenomenon

In the Van Manen approach to phenomenological analysis a part of the process is for the primary researcher to report on the perceived essence of the experience. The aim of this study was to gain understanding and knowledge about what experience patients have of the arts in hospital and their normal experience of the arts, as well as gaining insight into how arts might be best applied in aiding recovery and coping with major illness and hospital stay. The following description is a summary of this analysis and of the patients' own description of their experience of arts in hospital:

The arts – notably in this study what music we listen to, what we read and dancing – are significant throughout our lives. They are integral to our leisure time, our enjoyment and are part of what makes us who we are. They are significant in terms of our social life, our sense of self and our recovery from ill health. In hospital, however, we suspend that interest in arts and other leisure pursuits

We expect to have to put these parts of us on hold, or we are deprived of them and we have no expectation that they will be possible or available in hospital. We are busy grappling with more urgent needs, such as pain, our physical being, even basic life or death survival. The arts play a part in our sense of health and well-being and there are many positives associated with arts. These include a sense of stimulation, enjoying a new activity, distraction from worries, providing a means for social connection and a sense of meaningful purpose in life. Having access to arts when recovering in hospital helped some of us feel cared for and supported

We have ideas about improving the hospital using arts, for example, linking arts programmes more closely with clinical treatment and enhancing the environment for patients and we are glad to have been consulted about this issue. However, we are not sure, as yet, whether the aesthetics of hospital are important but we do know that noise and other disturbed or distressed patients are a problem to us

## Discussion

The themes that arose in this study add to the findings of the modest existing experimental literature on arts and health. For example, although positive benefits of arts for patients in hospital, particularly in terms of positive stimulation, quality of life and individuality, are suggested in previous studies (Ansdeell & Meehan 2010, Howells & Zelnik 2009, Kennett 2000, Lane 2005, Lloyd *et al.* 2007, O'Callaghan 2001, van Lith *et al.* 2011, Wikstrom 2004), the interest in receptive arts when acutely ill receives little attention in the current literature on arts and health. One study, which is supportive of the receptive approach, showed improved recovery from stroke when patients were given access to their favourite music by facilitating listening to their compact discs in hospital (Sarkamo *et al.* 2008).

The findings suggest a need for carefully nuanced art programming in hospitals and consultation with patients regarding aesthetic and cultural interests. Arts programmes need to be carefully selected for different stages of illness and recovery: for example, specific therapeutic arts programmes were recommended by some patients at critical points in their care, while for others arts were important as part of rebuilding social life and for intellectual stimulation post hospital stay. Nurse managers may be able to lead this

emerging area of work and indeed may need to enhance awareness of the aesthetic and cultural interests of their patients. Nurse educators, clinical nurse specialists and advanced nurse practitioners may also play an important role in supporting and advocating for the aesthetic, cultural and leisure interests of their patients. Future areas of study recommended include the aesthetic and cultural interests of nurses and awareness of the aesthetic needs of patients. The emotional needs of patients was a theme apparent in all the interviews and arts in health may be a means to a helpful expression of, and accommodation to, such losses (Moss 1987). The lack of expectation of arts provision during the acute phases of the illness does not mean that aesthetics and the arts are unimportant. Rather, a sensitive curatorial role is needed for arts and health programmes at this stage of the illness, in conjunction with patients, nursing professionals and those who design and shape the healthcare environment (Kirklin & Richardson 2003).

This study produced qualitative findings from a sample of a specific group of patients in an Irish acute hospital and although it may be difficult to generalize in other health systems and cultures from these findings, many of the findings are likely to be found in these settings.

## Limitations of the study

A limitation of this study is the small number of patients involved, and the population interviewed were all Irish and from one acute hospital. Further studies are recommended with specific populations (e.g. mental health services, nursing home residents, international studies) to further understand the aesthetic, cultural and leisure interests of patients in a variety of health contexts. A further limitation is that patients were not categorized by type of illness or specific length of stay. The importance of aesthetic, cultural and leisure interests may be affected by type of illness and exact length of stay. For example, a short stay of 3 days following a surgical procedure might be a very different aesthetic experience to a longer stay of several months. Our own experience suggests that studies with longer term patients would be of interest as the aesthetics of hospital may be most relevant to these groups.

## Conclusion

An in-depth consultation with patients is important as a starting point for more extensive research on how best to measure aesthetic deprivation and injury (such as noise) in healthcare settings and how best to meet these deficits. Phenomenology was found to offer a useful method to describe



the experience of patients and to develop an in-depth understanding about a new area of research. Further research is needed in this area, particularly on the area of the role of receptive arts in hospital and how best to develop a more patient-centred model for arts and health programmes. The everyday aesthetics of health care continues to be a relatively neglected aspect of patient care and more attention could be given to the aesthetic environment for patients, in particular in our study the area of noise pollution. These findings support those of previous studies regarding the aesthetics of hospitals, which indicate aesthetics to be a neglected field in health care (Caspari *et al.* 2006, 2007, 2011). The cultural, aesthetic and leisure pursuits of patients were found to be important and warrant further attention.

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### Conflict of interest

No conflict of interest has been declared by the authors.

### Patient consent/Study approval

Research Ethics Committee approval was granted for this study by the hospital ethics committee.

### Author contributions

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE: [http://www.icmje.org/ethical\\_1author.html](http://www.icmje.org/ethical_1author.html)):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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## Appendix 11 Original draft survey

### CONFIDENTIAL SURVEY

Aesthetic Measure in Healthcare

Survey No:

Participant number □□□

Date

#### Section 1 Arts interests

In this section you are asked a number of questions about your most important arts, culture and leisure interests.

Q 1.1 Please tick which of the events you have attended in the last 12 months (in Ireland or elsewhere).

If you have attended the event, please tick the box and tick how often you have attended this event.

Arts events attended in the last year	Attended 1 - 6 times in the last 12 months	Attended 6 or more times in the last 12 months
Mainstream film		
Play		
Rock or Popular Music		
Traditional Irish or Folk Music		
Stand-up Comedy		
Musical		
Variety show/Pantomime		
Art exhibition (for example, paintings,		

sculpture, photographs)		
Circus		
Country and Western music		
Traditional/Folk Dance		
Jazz/Blues Concert		
Classical Music Concert or Recital		
World Music		
Readings (e.g. literature or poetry		
Art house film		
Opera		
Modern dance		
Ballet		
Other Live music event – please name		
Other dance event – please name		
Other – please name		

Q1.2 Have you taken part in any of these activities in the last 12 months?  
Please tick yes or no.

Arts activity participation	Yes	No
Play a musical instrument for your own pleasure, rehearse or for an audience		
Helping with running arts event or group		
Painting/drawing/sculpture		
Sing in a choir		
Set dancing		
Perform or rehearse in play/drama		
Other dancing (not fitness class)		
Other Irish traditional/folk dancing		
Photography as an artistic activity		
Writing (e.g. poems, stories or plays)		



Writing any music		
Making artworks or animations on a computer		
Perform or rehearse in light opera/musical		
Making films as an artistic activity (not family or holidays)		
Perform or rehearse in opera		
Other singing to an audience or rehearsing (not karaoke)		
Other – please name		
I have stopped to look at any art (i.e., a sculpture) in a public place (e.g. in a park, on a street etc.) within the last 12 months		

Q 1.3 Which of the following do you normally use at home?

Please tick yes or no.

Media normally used at home	Yes	No
Television		
Radio		
DVD player		
CD player		
Video recorder		
Digital music player (e.g. MP3 or iPod)		
Computer (laptop, tablet etc.)		
Internet		
Cassette player		
Mobile phone or other mobile communication device		
Games console		
Mini disc player		
Record player		
E-reader (e.g. Kindle)		
Books		
Newspapers or magazines		
Other – please name		

Q1.4 Do you currently have any difficulties in taking part in those arts or leisure activities which interest you?

Yes ☐

No ☐ If you answered no, please move on to Section 2

Q1.5 If yes, please tick which difficulties you currently have:

Difficulties access arts and leisure interests	Tick if you have difficulty with this
Health Issues	
1.5.2 Access to venue	
1.5.3 Can't afford – cost	
1.5.4 Family commitments	
1.5.5 Other commitments	
1.5.6 Transport difficulties	
1.5.7 Fear of going out in the evening	
1.5.8 Too far away/ inconvenient	
1.5.9 Nobody to go with	
1.5.10 Inadequate information on event	
1.5.11 Not very interested in these kind of things	
1.5.12 I might feel uncomfortable or out of place	
1.5.13 Difficult to find time	
1.5.14 Loss of confidence	
1.5.15 Too much pain/physical difficulties	
1.5.16 Low mood	
1.5.17 Lack of motivation	
1.5.18 Other (specify)	

## Section 2 Arts in hospital

Q 2 This section asks questions about your hospital stay.

Please answer the following statements with Strongly agree (SA), Agree (A), Neither agree nor disagree (NAD), Disagree (D) or Strongly disagree (SD).

Q 2.1 Interest in receptive arts

	SA	A	N	D	SD
2.1.1 In hospital I was able to watch TV/DVD of my choice					
2.1.2 I was able to use a computer in hospital					
2.1.3 In hospital I was able to listen to radio programmes of my choice					
2.1.4 In hospital I had access to films of my choice					
2.1.5 In hospital I was able to listen to music					
2.1.6 In hospital I was able to read for pleasure					
2.1.7 In hospital I was able to use e-reading devices					

Q 2.2 Noise

	SA	A	N	D	SD
2.2.1 I had control over whether the TV was on or off while in hospital					
2.2.2 Sounds from TV or radio disturbed me when I was in hospital					
2.2.3 I had control over whether the radio					

was on or off while in hospital					
2.2.4 Music being played on the ward disturbed me when I was in hospital					
2.2.5 Sounds from other patients disturbed me when I was in hospital					
2.2.6 Sounds from machines or equipment disturbed me when I was in hospital					
2.2.7 Sounds from staff disturbed me when I was in hospital					
2.2.8 I was able to choose whether to share a room with other patients while in hospital					
2.2.9 I had access to a quiet place when I needed it in hospital					
2.2.10 I had access to company and conversation when I needed it in hospital					

### Q 2.3 Most popular art forms - music, dance, art, writing, film

	SA	A	N	D	SD
2.3.1 I had control over the music I listened to while in hospital					
2.3.2 I was able to listen to live music when I was in hospital					
2.3.3 I was able to play a musical instrument in hospital					
2.3.4 I was able to dance in hospital					
2.3.5 I was able to write in hospital					
2.3.6 I was able to paint or draw in hospital					

### Q 2.4 Noticing the visual art on the walls

	SA	A	N	D	SD
2.4.1 I noticed the visual art, pictures or photographs on the wall in my room or ward					
2.4.2 I wanted to put art, pictures or photographs on the wall in my room or ward					
2.4.3 I was satisfied with the visual art on display in the hospital					

#### Q 2.5 Access to arts activities in hospital

	SA	A	N	D	SD
2.5.1 If I wanted to, I was able to continue the arts or leisure activities I enjoy while in hospital					
2.5.2 My arts and leisure interests were not important to me when I was in hospital					
2.5.3 I expected to have arts in hospital					
2.5.4 Arts and culture programmes are important in hospital					

### Section 3

This question asks you some background information. This will be anonymous and confidential.

Q3.1 Are you:

- Male
- Female

Q3.2 Your date of birth \_\_\_\_\_

Q3.3 Your marital status

- Single
- Married
- Divorced/Separated
- Widowed

Q3.4 Your occupation or former occupation

---

Q3.5 Your current working status

- Retired
- Working Full-time
- Working Part-time
- Self employed
- Unemployed (seeking employment)
- Fulltime Homemaker
- Student
- Full-time farmer
- Part-time farmer
- Other (please state)

Q3.6 What education did you complete?

- No formal education
- Primary Level
- Attended 2<sup>nd</sup> Level
- 3<sup>rd</sup> Level Undergraduate
- 3<sup>rd</sup> Level Postgraduate
- Still at 3<sup>rd</sup> Level

Q3.7 Do you have children living with you under the age of 18?

- Yes
- No

Q3.8 Please indicate your household income category per year:

- Below €15000
- Between €15000 and €29999
- Between €30000 and €44999
- Between €45000 and €59999
- Between €60000 and €74999
- €75000 and over

Q3.9 What is your ethnic or cultural background?

- White Irish
- White Irish Traveller
- Any other white background
- Black Irish
- Any other black background
- Chinese
- Any other Asian background
- Other, including mixed background, please write in description

Q3.10 During your hospital stay were you:

- In a private room
- In a shared ward
- Both

Q 3.11 During your hospital stay were you:

- A private patient
- A public patient

#### Section 4

There are 2 more brief tests we need you to answer for us. Please circle the correct answer in each section

*Insert Barthel and GDS tests here.*

Thank you for completing this survey.

## Appendix 12 Final survey following all testing

### CONFIDENTIAL SURVEY

#### Aesthetic Measure in Healthcare

##### Section 1 Arts interests

This section asks about your most important arts interests.

Q 1.1 Have you attended these events in the last 12 months (in Ireland or elsewhere)?  
And in the last 10 years? Please tick if you have attended these events.

Arts events attended in the last year	In the last 12 months	In the last 10 years
1.1.1 Mainstream film (e.g. cinema)		
1.1.2 Play		
1.1.3 Rock or Popular Music event		
1.1.4 Traditional Irish or Folk Music event		
1.1.5 Stand-up Comedy		
1.1.6 Musical		
1.1.7 Variety show/Pantomime		
1.1.8 Art exhibition (for example, paintings, sculpture, photographs)		
1.1.9 Circus		
1.1.10 Country and Western music event		
1.1.11 Traditional/Folk Dance event		
1.1.12 Jazz/Blues Concert		
1.1.13 Classical Music Concert or Recital		
1.1.14 Readings (e.g. literature or poetry)		
1.1.15 Art house film		
1.1.16 Opera		
1.1.17 Modern dance event		
1.1.18 Ballet		
1.1.19 Other – please name		

Q1.2 Have you taken part in any of these activities in the last 12 months (in Ireland or elsewhere)? And in the last 10 years? Please tick yes if you have participated in these activities.

Arts activity participation	In the last 12 months	In the last 10 years
1.2.1 Play a musical instrument for your		



own pleasure, rehearse or for an audience		
1.2.2 Painting/drawing/sculpture		
1.2.3 Sing in a choir		
1.2.4 Set dancing		
1.2.5 Perform or rehearse in play/drama		
1.2.6 Other dancing (not fitness class)		
1.2.7 Other Irish traditional/folk dancing		
1.2.8 Photography		
1.2.9 Writing (e.g. poems, stories or plays)		
1.2.10 Writing any music		
1.2.11 Making artworks or animations on a Computer		
1.2.12 Perform or rehearse in light opera/musical		
1.2.13 Making films as an artistic activity		
1.2.14 Perform or rehearse in opera		
1.2.15 Other singing to an audience or rehearsing (not karaoke)		
1.2.16 Other – please name		
1.2.17 I have stopped to look at any art (i.e., a sculpture) in a public place (e.g. in a park, on a street) within the last 12 months/10 years		

Q1.3 Do you currently find it difficult to take part in the arts activities which interest you?  
Please tick yes or no.

- Yes
- No                      If you answered no, please move on to Section 2

Q1.4 If yes, please tick which difficulties you currently have:

<del>Difficulties access arts and leisure interests</del>	Yes	No
Physical health issues (for example, too much pain, physical difficulties)		
1.4.2 Access to venue		
1.4.3 Cost		
1.4.4 Family commitments		

1.4.5	Transport difficulties		
1.4.6	Fear of going out		
1.4.7	Too far away		
1.4.8	Nobody to go with		
1.4.9	Inadequate information on event		
1.4.10	I might feel uncomfortable or out of place		
1.4.11	Difficult to find time		
1.4.12	Loss of confidence		
1.4.13	Low mood		
1.4.14	Lack of motivation		
1.4.15	Other (please specify)		

## Section 2 Arts in hospital

Q 2 This section asks questions about your hospital stay.

### Q 2.1 Receptive arts in hospital

Please answer the following statements with Agree or Disagree or mark if 'Don't know' or 'not sure'.

	Agree	Disagree
2.1.1 In hospital I watched TV/DVD of my choice		
2.1.2 In hospital I used a computer		
2.1.3 In hospital I listened to radio programmes of my choice		
2.1.4 In hospital I watched films of my choice		
2.1.5 In hospital I listened to music of my choice		
2.1.6 In hospital I read for pleasure		
2.1.7 In hospital I used e-reading devices		

### Q 2.2 Noise

Please answer the following statements with Agree or Disagree

	Agree	Disagree
2.2.1 I had control over whether the TV was on or off while in hospital		
2.2.2 Sounds from TV or radio disturbed me when I was in hospital		
2.2.3 I had control over whether the radio was on or off while in hospital		
2.2.4 Music being played on the ward disturbed me when I was in hospital		
2.2.5 Sounds from other patients disturbed me when I was in hospital		
2.2.6 Sounds from machines or equipment disturbed me when I was in hospital		
2.2.7 Sounds from staff disturbed me when I was in hospital		
2.2.8 I was able to choose whether to share a room with other patients while in hospital		
2.2.9 I had access to a quiet place when I needed it in hospital		
2.2.10 I had access to company and conversation when I needed it in hospital		

### Q 2.3 Most popular art forms - music, dance, art, writing, film

Please answer the following statements with Agree or Disagree

	Agree	Disagree
2.3.1 I listened to music while in hospital		
2.3.2 I listened to live music when I was in hospital		
2.3.3 I played a musical instrument in hospital		
2.3.4 I wrote in hospital		
2.3.5 I painted or drew in hospital		
2.3.6 I watched films in hospital		

#### Q 2.4 Visual art in hospital

Please answer the following statements with Agree or Disagree

	Agree	Disagree
2.4.1 I noticed the visual art, pictures or photographs on the wall in my room or ward		
2.4.2 I put my own art, pictures or photographs on the wall in my room or ward		
2.4.3 I was satisfied with the visual art on display in the hospital		
2.4.4 The visual art in hospital was interesting and varied.		

#### Q 2.5 Access to arts activities in hospital

Please answer the following statements with Agree or Disagree

	Agree	Disagree
2.5.1 continued the arts activities I enjoy while in hospital		
2.5.2 My arts interests were important to me when I was in hospital		
2.5.3 Arts programmes are important in hospital		
2.5.4 I did not access arts in hospital because I was too ill		

### Section 3

This question asks you some background information. This will be anonymous and confidential.

Q3.1 Are you:

- Male
- Female

Q3.2 Your date of birth \_\_\_\_\_

Q3.3 Your marital status

- Single
- Married
- Divorced/Separated
- Widowed

Q3.4 Your \_\_\_\_\_ occupation \_\_\_\_\_ or \_\_\_\_\_ former \_\_\_\_\_ occupation

Q3.5 Your current working status

- Retired
- Working Full-time
- Working Part-time
- Self employed
- Unemployed (seeking employment)
- Fulltime Homemaker
- Student
- Full-time farmer
- Part-time farmer
- Other (please state)

Q3.6 What education did you complete?

- No formal education
- Primary Level
- Attended 2<sup>nd</sup> Level
- 3<sup>rd</sup> Level Undergraduate
- 3<sup>rd</sup> Level Postgraduate
- Still at 3<sup>rd</sup> Level

Q3.7 Do you have children living with you under the age of 18?

- Yes
- No

Q3.8 What is your ethnic or cultural background?

- White Irish
- White Irish Traveller
- Any other white background
- Black Irish
- Any other black background
- Chinese
- Any other Asian background
- Other, including mixed background, please write in description

Q3.9 During your hospital stay were you:

- In a private room
- In a shared ward
- Both

Q 3.10 During your hospital stay were you:

- A private patient
- A public patient

## Section 4

There are 2 more brief tests we need you to answer for us. Please circle the correct answer in each section

BARTHEL ADL INDEX		PATIENT'S NAME:						
		HOSPITAL NUMBER:						
DATE								
BOWELS	0 = Incontinent 1 = Occasional accident ( 1 per week) 2 = Continent							
BLADDER	0 = Incontinent or catheterised & unable to manage 1 = Occasional accident (max 1 x per 24 hours) 2 = Continent for over 7 days							
GROOMING	0 = Needs help 1 = Independent, face, hair, teeth, shaving.							
TOILET USE	0 = Dependent 1 = Needs some help but can do something. 2 = Independent (on and off, dressing, wiping).							
FEEDING	0 = Unable 1 = Needs help cutting, spreading butter etc. 2 = Independent.							
TRANSFER	0 = Unable 1 = Major help (1-2 people, physical). 2 = Minor help (verbal or physical). 3 = Independent							
MOBILITY	0 = Immobile 1 = Wheelchair independent including corners etc. 2 = Walks with help of 1 person (verbal or physical). 3 = Independent (but may use any aid, eg. stick).							
DRESSING	0 = Dependent 1 = Needs help but can do half unaided. 2 = Independent							
STAIRS	0 = Unable 1 = Needs help (verbal, physical, carrying aid). 2 = Independent up and down.							
BATHING	0 = Dependent 1 = Independent							
TOTAL								

## Geriatric Depression Scale (short form)

**Instructions:** Circle the answer that best describes how you felt over the past week.

- |   |     |    |
|---|-----|----|
| 1. Are you basically satisfied with your life?                            | yes | no |
| 2. Have you dropped many of your activities and interests?                | yes | no |
| 3. Do you feel that your life is empty?                                   | yes | no |
| 4. Do you often get bored?  | yes | no |
| 5. Are you in good spirits most of the time?                              | yes | no |
| 6. Are you afraid that something bad is going to happen to you?           | yes | no |
| 7. Do you feel happy most of the time?                                    | yes | no |
| 8. Do you often feel helpless?  | yes | no |
| 9. Do you prefer to stay at home, rather than going out and doing things? | yes | no |
| 10. Do you feel that you have more problems with memory than most?        | yes | no |
| 11. Do you think it is wonderful to be alive now?                         | yes | no |
| 12. Do you feel worthless the way you are now?                            | yes | no |
| 13. Do you feel full of energy?   | yes | no |
| 14. Do you feel that your situation is hopeless?                          | yes | no |
| 15. Do you think that most people are better off than you are?            | yes | no |

**Total Score** \_\_\_\_\_

Thank you for completing this survey.



## Appendix 13 Published paper on aesthetic interests of patients with stroke

### The Aesthetic and Cultural Pursuits of Patients with Stroke

Clare O'Connell,\* Aoife Cassidy,†

Desmond O'Neill, MA, MD, FRCPI, AGSF, FRCP (Glasg),\* and Hilary Moss, MBA, DipMTh‡

**Background:** There has been an increasing interest in the arts in health care, with a suggestion that the arts and aesthetics can augment patient outcomes in stroke and other illnesses. Designing such programmes requires better knowledge of the artistic, aesthetic, and cultural pursuits of people affected by stroke. The aim of this study was to obtain the insights of this group about the profile of art and aesthetic activities in their lives and the influence of stroke on these aspects. **Methods:** Patients attending a stroke service were administered questions adapted from the Irish Arts Council's 2006 questionnaire on participation in aesthetics and cultural pursuits. Information was also collected on stroke type and present functional and cognitive status. Thirty-eight patients were interviewed. Of these, 20 were inpatients in hospital at the time of the interview and 18 were interviewed in an outpatient setting. **Results:** Popular activities included mainstream cinema, listening to music, dancing, attending plays or musicals, and being outdoors. Many patients ceased these activities after their stroke, mostly because of health issues and inaccessibility. Most of the patients valued the importance of the arts in the health-care setting. **Conclusions:** This study gives a perspective for the first time on the aesthetic and cultural pursuits of stroke patients before their stroke. It portrays a wide variety of cultural and leisure activities and the cessation of these poststroke. It revealed the restrictions patients felt on gaining access to leisure pursuits both while in hospital and following discharge. **Key Words:** Stroke—culture—leisure—aesthetics—arts.  
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#### Introduction

There is an emerging interest in the role of arts and aesthetics in the augmentation of the experience of health care. Särkämö et al<sup>1,2</sup> demonstrated that patients who listened to their own music or audiobooks for an hour a day (minimum) during their recovery from stroke

showed improvements in sensory processing and verbal memory, compared with a control group. This study illustrates that the mere act of listening to music or audiobooks may help induce long-term plastic changes facilitating improvements in higher cognitive functions and auditory sensory memory or possibly that aesthetic deprivation hinders recovery.<sup>3,4</sup> Building further on this research, the design of aesthetic interventions ideally requires better knowledge of the artistic, aesthetic, and cultural pursuits of people affected by stroke and any such programme would be better informed by obtaining the opinions of this group about the role of the arts and aesthetics in the health-care environment. We could find no research assessing the nature of cultural and aesthetic pursuits among patients with stroke and thus designed this study.

There is a paucity of literature on the possible benefits of the arts (as opposed to formal art or music therapy) in stroke rehabilitation and the possible hindrance to recovery caused by aesthetic deprivation. Some of the literature quoted as discussing leisure and recreation does not

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Patient consent/ethical approval: Ethical approval was granted for this study.

Disclosure: None.

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actually examine these aspects,<sup>5</sup> and others dismiss time spent at leisure and recreation as “nontherapeutic.”<sup>6,7</sup> Even in a review of social activities after stroke, some of the articles included in terms of examining leisure and recreation contained no mention of this aspect of recovery.<sup>8</sup> One insightful article reported a significant curtailment of recreational activities after stroke, 38% compared with 8% in age-matched controls.<sup>9</sup>

The existing literature also has a focus on clinical benefits of art therapies and arts and health programmes (particularly music therapy) in areas such as depression, improving communication for patients with aphasia, and as a rehabilitation tool.<sup>10,11-16</sup> Although there have been many articles written on the benefits of arts in hospital environments<sup>1,17-19</sup> and particularly arts for older people in various settings,<sup>20,21-23</sup> only 2 articles focus specifically on the experience of stroke patients in arts poststroke,<sup>11,24</sup> but none examine stroke patients’ interests in arts and culture prestroke and during hospital stay. Three articles were found regarding leisure activities and stroke but not art or cultural interests.<sup>25-27</sup> If arts and aesthetics play a potentially important role in stroke rehabilitation, more knowledge is needed on the role played by arts, culture, and aesthetics in patients’ lives. The study, therefore, also explored the perception of the participants about art activities in hospital and their relevance.

### Materials and Methods

Thirty-eight patients completed a questionnaire administered using questions from a major population study of cultural and aesthetic pursuits in the Irish population. The questionnaire was developed from a previously validated survey by the Arts Council of Ireland, which is used to determine public perception and involvement in the arts.<sup>28</sup> Relevant questions were taken from the Arts Council questionnaire that related directly to attendance at art events, participation in the arts, and receptive engagement in arts as these were relevant to the aesthetic and cultural pursuits of hospital patients with stroke. Questions relating to purchasing art materials and whether people attended rural or urban art centers were not included as these were deemed less relevant to our study. The questionnaire was then adapted to include questions regarding the patients’ aesthetic experience of hospital and the experience of patients’ pre- and poststroke. The Arts Council questionnaire included demographic questions including income, level of education, occupation, and marital status. Wherever possible, questions were taken directly from the Arts Council questionnaire as this was a previously validated questionnaire concerned with the aesthetic and cultural interests of the general public.

Most of the questions were closed, with yes/no or a grading of answers (eg, “did you attend art events

once in the last year, 1-6 times or more than 6 times?”). The patients were asked only one open-ended question about their preferred art and leisure past-times, both before and after their stroke. Please see Appendix 1 for full questionnaire.

A convenience sample was used of 21 consecutive admissions to the Stroke Service and 17 outpatients from 3 consecutive outpatient clinics at a university teaching hospital. Inclusion criteria included patients who have had a stroke as a primary cause of admission to the Stroke Service. Exclusion criteria were severe cognitive impairment, severe aphasia/language impairment sufficient to preclude participation, or patients who were too ill to take part in the study.

Although 38 patients in total were surveyed, 21 of these were inpatients and 17 outpatients at the time of survey. The full 38 were therefore asked about their art activities prestroke and only the 17 outpatients were asked about participation and attendance at activities poststroke, as clearly the inpatients could not comment on this aspect. However, the full 38 were asked about their engagement in receptive arts poststroke (questions 7 and 9 of the survey), specifically the questions relating to receptive participation in the arts, particularly which media patients used to listen or watch arts and questions relating to reading.

The assessment included demographic variables, the date and type of stroke (ischemic/hemorrhagic), Oxfordshire Community Stroke Project classification,<sup>29</sup> cognitive screening with the Ottawa 3DY 4-Question Screen for Cognitive Impairment (3DY),<sup>30</sup> and current functional status via the modified Rankin Scale.<sup>31</sup> The 3DY cognitive test has 4 questions, giving a maximum score of 4, a simple way to quickly assess cognitive ability. The modified Rankin Scale is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who had a stroke or other causes of neurological disability, score runs from 0 to 6 with 0 being no symptoms and 6 being “dead.”

### Statistical Analysis

Chi-square tests were undertaken on 7 of the most popular art activities and events. Chi-square tests are used to see if there is a relationship between 2 categorical variables, in this case the group of patients pre- and poststroke. For these statistics, the full 38 patients were counted for reading and listening to music, whereas the 17 poststroke outpatients were used for the other 7 activities.

### Results

#### Before Stroke

Twenty-one men and 17 women participated; mean age was 67 years, and their functional and cognitive status is summarized in Table 1. Where possible participants

Table 1. Patient population

	N	Age	Men	3DY	Rankin
Inpatients surveyed	21	69 ( $\pm 29$ )	11 (52.4%)	2.5 ( $\pm 1.5$ )*	2.5 ( $\pm 2.5$ )
Outpatients	17	64 ( $\pm 24$ )	10 (58.8%)	3.7 ( $\pm 1.7$ )	1.2 ( $\pm 1.8$ )
Total	38	67 ( $\pm 27$ )	21 (55.3%)	3.1 ( $\pm 2.1$ )*	2 ( $\pm 3$ )

Abbreviation: 3DY, Ottawa 3DY 4-Question Screen for Cognitive Impairment.

\*Two participants excluded from 3DY cognitive test

completed the questionnaire independently, but where assistance was needed (eg, where participants had difficulty writing or reading the questions), the researchers assisted patients by reading out questions or filling in the answers, as directed by the participant.

The participants described a wide range of arts and cultural activity. The most popular activity was dancing, with 19 (50%) of patients having participated at some point before their stroke. Some enjoyed this activity right up to the time of their stroke; others danced earlier in life but remembered enjoying it. Popular types of dance were traditional Irish, ballroom, and "60's" dancing.

Other very popular activities were singsongs in pubs, gardening, and "being outdoors." Eight (21.1%) patients played a musical instrument. Other activities mentioned by patients were "doing impersonations," painting, swimming, going to the gym, and choir singing.

Of the subjects who listened to music regularly, the media used to do so was radio or CDs in most of the cases, with some participants using a digital music player. The popular genres of music within this patient population were classical, country and western, and Irish ballad singers; however, rock, house, and pop music also featured. The preferred genres of music concerts attended were classical, rock, pop, and traditional music.

Popular choices of reading material were true crime, biographies, and the newspaper. Popular television and DVD viewing was sport, murder mysteries, and "old-fashioned" films.

Twenty-seven patients (71.1%) said they had stopped to look at artwork in a public place; if the patients who said they had noticed such artwork are included, this figure rises to 34 (89.5%).

#### After Stroke

For participants who had returned to the community poststroke ( $n = 17$ , 44.7%), there was generally a decline in attendance at art events after stroke. Most stated that the decline in attendance was not because of reasons related to their stroke but because of a variety of other factors including other health issues, "having no one to go with" and inaccessibility of certain art events (local cinema closing down was one example). However, 4 ( $n = 4$ , 24%) patients stated they had simply "lost interest" in attending these events.

The most popular art events prestroke were attending films ( $n = 21$ , 55%), concerts or other musical events ( $n = 20$ , 53%), and plays or shows ( $n = 18$ , 47%).

Tables 2-5 give further information regarding patients' attendance at art and cultural events pre- and poststroke, their participation in art activities pre- and poststroke, their key leisure/cultural activities, and their opinions about the arts.

The reasons given for not continuing participation in activities after their stroke were health issues because of their stroke ( $n = 4$ ), health issues unrelated to their stroke ( $n = 5$ ), and transport difficulties ( $n = 3$ ). One patient ( $n = 1$ ) had been attending a ballroom dancing evening weekly up until the age of 70 years, when she began to feel "out of place" as she was the oldest person in attendance at the event.

It is interesting to note that there was a decline in participation in all leisure and art pursuits listed after stroke, from reading to attending art exhibitions.

For the whole sample, receptive arts were popular, with listening to music ( $n = 35$ , 92%), watching arts on television ( $n = 19$ , 50%), and reading ( $n = 25$ , 66%) being popular activities prestroke. Interestingly, these were also some of the most popular art activities poststroke (listening to music,  $n = 24$ , 63%, watching arts on television,  $n = 13$ , 34%, and reading,  $n = 14$ , 37%). Reasons cited for the discontinuation of reading as an activity after stroke included headaches ( $n = 1$ ), poor eyesight ( $n = 5$ ), and lack of concentration ( $n = 6$ ).

Table 2. Participation in art activities prestroke

	Before stroke, $n = 38$
Dancing	19
Singing	9
Musical activities (eg, playing an instrument)	8
Drama activities (eg, performing in a play or musical society)	1
Events (eg, helping organise an art event)	0
Art (eg, painting, photography, making films)	3
Literature (eg, writing)	2

**Table 3.** Attendance at art and cultural events of participants prestroke

	Before stroke, n = 38
Cinema	21
Plays/shows	20
Comedy	5
Concerts/musical performances	18
Art exhibitions	11
Readings	0
Festivals	3
Dance events	2

Statistical results of chi-square tests are seen in Tables 4 and 5 for both receptive arts and participative arts activities and events pre- and poststroke. Results of pre- and poststroke levels of engagement in the two receptive arts (listening to music and reading) can be seen to be statistically significant. Results are mixed in the five most popular participative activities; the most probable reason for lack of statistical significance in some categories is the very small number in the study.

#### *While in Hospital*

Twenty patients (52.6%) had stopped to look at artwork in the hospital; if the patients who had noticed the artwork are included, this figure rises to 24 (63.2%). However, many of the acute patients had not left the stroke unit at the time of assessment and, therefore, may not have had the chance to notice the artwork distributed around the hospital.

Twenty-five inpatients (65.8%) said they had difficulty gaining access to either the television or the radio/CD player. Nineteen of these (50% of all patients) said that they missed the television or radio/CD player while being in hospital. Some patients mentioned that they felt it would disturb other patients to have the radio on or that it was impossible to concentrate because of "people coming in and out of the room all the time." The patients who did not have access to the television and/or music but did not miss it stated that this was because of health problems while in hospital such as headaches or that they had lost interest or the power of concentration.

Most patients spoke positively about the artwork on display in the hospital, and there was a general consensus among most of the patients that artwork improves the

hospital environment and provides a positive distraction, whereas some patients even mentioned that a habit of talking walks along the corridors to look at the paintings on the walls.

When asked where patients would allocate spending on the arts in hospital, 13 (34.2%) said they would spend it on art classes for patients, 12 (31.6%) would spend it on concerts for patients, and 12 (31.6%) would allocate it to exhibiting more artwork throughout the hospital. Other suggestions included cooking workshops, computer skills workshops (to get people "back to work" after stroke), singsongs, and dancing evenings (eg, ballroom, set, and 60s dancing).

#### *Attitudes to Arts and Arts Spending*

Thirty-five (92.1%) participants thought that the arts have become more available in the past 10 years. Thirty respondents (78.9%) believed that as much importance should be given to providing art amenities as providing sports amenities. Thirty-one (81.6%) participants agreed that today's arts and artists are as important to our society as the legacy of the arts and artists of the past. Twenty-four (63.2%) participants stated that they were interested in the arts. Thirty-eight participants (89.5%) thought that the arts play a valuable and important role in a modern society such as Ireland. Thirty (78.9%) participants thought that the arts from different cultures give us an insight into the lives of people from different cultures. Thirty-one respondents (81.6%) believed that the current level of spending on the arts should be maintained even in times of economic recession; however, only 21 (55.3%) thought that spending by the Arts Council in hospitals should be increased, if it meant a cut or smaller increase elsewhere in arts spending.

#### **Discussion**

This study gives a new perspective on the aesthetic and cultural pursuits of stroke patients before their stroke. It portrays a wide variety of cultural and leisure activities. Most patients had several past-times, which they enjoyed before their stroke, many involving the arts. The most popular activities were dancing, mainstream cinema, listening to music and radio, being outdoors, and gardening.

Most of these activities could not be accessed while in hospital, with the exception of patients who enjoyed listening to music/radio and had a radio or electronic

**Table 4.** Receptive arts pre- and poststroke (*chi-squared test*), total sample

	Before stroke, n = 38	After stroke, n = 38	Pearson chi-square result, asymp. sig
Listening to music (CD/DVD/radio)	35	24	.018
Reading for pleasure (fiction, poetry, biographies, newspapers, and magazines)	25	14	.001

**Table 5.** *Participative arts pre- and poststroke (chi-squared test), outpatient sample*

	No participating prestroke, n = 17	No participating poststroke, n = 17	Pearson chi-square result, asymp. sig
Dancing	11	1	.446
Singing	5	1	.110
Attending cinema	10	8	.001
Attending concerts/musical performances	9	5	.012
Attending art exhibitions	4	6	.002

music device at their bedside (eg, radio or digital music/cassette player).

These findings create an impetus to ensure that needs of patients in hospital are met and that those who design hospital units for people with stroke, and those who provide the clinical services, plan accordingly. Provision to the patient's own choice of music in a manner sensitive to noise for other patients and staff would seem to be a priority, a finding given extra weight by Särkämö's study showing better cognitive and affective outcome for patients with access to their own choice of music after stroke.

For inpatient services, for example, planning outdoor garden spaces may in part meet some of those needs.<sup>32</sup> In addition, new technological methods may provide "windows" to the outside world for those who are confined by the physical and cognitive changes of stroke.<sup>33</sup> Attention to access to radio and television, in a manner sensitive to privacy and noise pollution, is important.

Many patients suggested that having a dancing evening or class for inpatients would be enjoyable and sociable. With some imagination, this sort of program might be implemented and be effective at several levels; a program has been described for dance for patients with chronic heart failure.<sup>34</sup>

This study also raises the issue of the change in people's activities after stroke, a topic that is under-researched.<sup>27</sup> Many of the outpatients interviewed had given up or lost interest in former activities. The reasons for this varied hugely including lack of local facilities, visual problems after stroke, loss of confidence after stroke, and general health problems. Many of the inpatients stated that they were looking forward to getting back their normal daily activities and hoped they would be able to participate in their former past-times.

There was also a lack of patient awareness of the arts programme at the hospital. Despite this, the vast majority of patients expressed interest in it and would have liked to know more about it (including patients who expressed little/no interest in the arts in general). An even greater majority thought that having an arts program in a hospital was important, with many stating that it would give people something to look forward to and would serve as a positive distraction from immediate health problems.

It is clear that one of the obstacles faced in augmenting an arts programme is improving patient awareness of art activities in the hospital.

Patient views on the arts, and arts in health care, showed considerable diversity and should help to inform the design and implementation of art programmes. Although a number of patients were interested in the arts, a similar number showed little or no interest. Notwithstanding, the vast majority believed the arts play a valuable and important role in society, and most did not think arts spending should be cut during the recession. Most also thought that providing art amenities was as important as the provision of sports amenities. These findings mirror the findings of Staricoff et al.<sup>35</sup>

Although increasing academic focus is directed on the contribution of architecture, design of health-care spaces, and visual and performing arts in the hospital environment to patient well-being,<sup>36</sup> the end user has rarely been adequately consulted or participated directly in this research. A recent study of qualitative research that engaged patient perceptions of arts in health recovered only 54 relevant studies and a number of these recommended further research, a more rigorous approach to consulting patients and larger sample sizes.<sup>37</sup> If arts and aesthetics are to provide tools for assisting patients through the journey of illness, and a means of providing intellectual and social stimulation to patients while in hospital, more insight into the relevance and nature of aesthetic and cultural pursuits is needed.

This study advances our knowledge by providing a foundation for what has been identified by several articles as a key issue and how to tailor the environment, aesthetic supports, and art programmes for patients with stroke. In addition, it can also help us to learn what to avoid in such programmes, an ethical imperative in any health-care environment. One commentator has noted that "ethics becomes an imperative consideration when art is displayed to a captive population of vulnerable patients who are stressed, fearful, in pain, and may be unable to choose the art "... "inappropriate art styles and subject matter may sometimes worsen outcome."<sup>38</sup> Studies such as this one begin an inquiry as to the basis on which selection of art for patients might be made.

### Limitations

There are a few limitations to the research in this study. First, this study focuses on a patient population, not only small in number but also (because of the geographical location of the hospital) featured a specific section of society. Ten participants (26%) had not continued education after primary education and 8 (21.1%) had not completed their second-level education. Only 10 participants (26%) had attended third-level education. A large majority of the patients were from a lower socioeconomic bracket.

Another limitation of this study was that over half of the participants were still inpatients of the hospital, and therefore, the findings of events and activities enjoyed by stroke patients after their stroke are limited to those who were outpatients as the patients still on the wards had not yet had the opportunity or were still too unwell to participate in many leisure activities. This decreased the "after-stroke" results to a patient population of just 17.

Although the study indicates that patients did value visual art in the hospital and had preferences regarding aesthetic input in hospital (eg, providing more concerts, exhibitions, and art classes in hospital), the study did not compare inpatient and outpatient responses to these issues. This would be a useful direction for future research and further exploration of the role of arts in rehabilitation during different stages of recovery. It is not possible to make concrete recommendations as to which arts should be provided in different stages of rehabilitation, but this research points to the importance of consulting patients about their aesthetic, cultural, and leisure interests to programme art interventions appropriately at all stages of health care.

### Conclusion

This study provided an insight into the cultural, leisure, and art pursuits of stroke patients. It demonstrated the wide variety of activities preferred by this particular patient population and highlighted many areas and activities that could be potentially incorporated into the art programmes of stroke units. Furthermore, this study has drawn attention to patients' lack of access to resources such as television, radio, and music players and to the restrictions felt by the patient after stroke in relation to involvement in activities and attendance at art events. This study also suggests that stroke patients would benefit from further awareness of the art programme in hospital and that despite the climate of economic cutbacks, patients value the arts highly in both the community and hospital settings.

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## Appendix 14 Survey document with all statements aligned to qualitative themes (given in red) next to the statements

DRAFT

CONFIDENTIAL SURVEY

Aesthetic and Cultural Measure in Healthcare (ACMHC)

Questionnaire No:

This research aims to find out more about the arts and leisure interests of patients in this hospital. We hope this survey will help us to improve the range of arts and leisure facilities available for patients in hospitals and would be grateful if you could spend about 15 minutes completing this survey. Please tick the box that most closely matches your answer. Thank you.

Participant number □□□

Date

### Section 1 Arts interests

In this section you are asked a number of questions about your most important arts, cultural and leisure interests. *Arts Council survey Q1*

Q 1.1 Please tick which of the following activities you have attended in the last 12 months (in Ireland or elsewhere).

If you have attended the activity, please tick the box and tick how often you have attended this activity.

*Arts Council survey Q1, qualitative theme 'interests and passions'*

<i>Arts activities attended in the last year</i>	<i>Attended 1 - 6 times in the last 12 months</i>	<b>Attended 6 or more times in the last 12 months</b>
Mainstream film		



Play		
Rock or Popular Music		
Traditional Irish or Folk Music		
Stand-up Comedy		
Musical		
Variety show/Pantomime		
Art exhibition (for example, paintings, sculpture, photographs)		
Circus		
Country and Western music		
Traditional/Folk Dance		
Jazz/Blues Concert		
Classical Music Concert or Recital		
World Music		
Readings (e.g. literature or poetry)		
Art house film		
Opera		
Contemporary dance		
Ballet		
Other Live music performance – please name		
Other dance performance – please name		
<b>Other – please name</b>		

Q1.2 Have you taken part in any of the following activities in the last 12 months?

If you have taken part in the activity, please tick the box.

*Arts Council survey Q8, qualitative theme 'interests and passions'*

Arts activity	Taken part in this activity in last 12 months
Play a musical instrument for your own pleasure, rehearsing or for an audience	
Helping with running arts event or organisation	
Painting/drawing/sculpture	
Sing in a choir	

Set dancing	
Performing or rehearsing in play/drama	
Other dancing (not fitness class)	
Other Irish traditional/folk dancing	
Photography as an artistic activity	
Writing (e.g. poetry, stories or plays)	
Writing any music	
Making artworks or animations on a computer	
Performing or rehearsing in light opera/musical	
Making films as an artistic activity (not family or holidays)	
Performing or rehearsing in opera	
Other singing to an audience or rehearsing (not karaoke)	
Other – please name	
I have stopped to look at any art (i.e., a sculpture) in a public place (e.g. in a park, on a street etc.) within the last 12 months	

Q 1.3 Which of the following do you use at home?

If you normally use this at home, please tick the box.

*Arts Council survey Q13a, qualitative theme 'role of receptive arts'*

Media	Normally use this at home
Television	
Radio	
DVD player	
CD player	
Video recorder	
Digital music player (e.g. MP3 or iPod)	
Computer (laptop, tablet etc.)	
Internet	
Cassette player	
Mobile phone or other mobile communication device	
Games console	
Mini disc player	
Record player	
E-reader (e.g. Kindle)	
Books	

Newspapers or magazines	
Other – please name	

Q1.4 Do you currently have any difficulties in attending or taking part in those arts or leisure activities which interest you?

*Arts Council survey Q14 a and b, qualitative theme 'loss and the effect of illness on attendance at aesthetic and cultural interests'*

Yes ☐

No ☐ If you answered no, please move on to Section 2

Q1.5 If yes, please tick which difficulties you currently have:

Difficulties access arts and leisure interests	Tick if you have difficulty with this
Health Issues	
1.5.2 Access to venue	
1.5.3 Can't afford – cost	
1.5.4 Family commitments	
1.5.5 Other commitments	
1.5.6 Transport difficulties	
1.5.7 Fear of going out in the evening	
1.5.8 Too far away/ inconvenient	
1.5.9 Nobody to go with	
1.5.10 Inadequate information on event	
1.5.11 Not very interested in these kind of things	
1.5.12 I might feel uncomfortable or out of place	
1.5.13 Difficult to find time	
1.5.14 Loss of confidence	
1.5.15 Too much pain/physical difficulties	
1.5.16 Low mood	
1.5.17 Lack of motivation	
1.5.18 Other (specify)	

## Section 2 Arts in hospital

Q 2 This section focuses on questions about your hospital stay.

Please answer the following statements with Strongly agree (SA), Agree (A), Neither agree nor disagree (NAD), Disagree (D) or Strongly disagree (SD).

Themes from the qualitative findings are indicated beside statements:

Interest in receptive arts

Noise disturbance (sharing rooms, noise from staff, patients and machines)

The most popular art forms - music, dance and reading and their availability in hospital

Noticing the visual art on the walls

Access to arts activities while in hospital - expectations

### Q 2.1 Interest in receptive arts

	SA	A	N	D	SD
2.1.1 In hospital I was able to watch TV/DVD of my choice <i>Receptive arts, choice</i>					
2.1.2 I was able to use a computer if I wanted to in hospital <i>Receptive arts</i>					
2.1.3 In hospital I was able to listen to radio programmes of my choice <i>Receptive arts, choice</i>					
2.1.4 In hospital I had access to films of my choice <i>Receptive arts, choice</i>					
2.1.5 In hospital I was able to listen to music of my own choice <i>Receptive arts, choice, popular art form</i>					
2.1.6 In hospital I was able to read for pleasure <i>Receptive arts, choice</i>					
2.1.7 In hospital I was able to use e-reading devices <i>Receptive arts, choice</i>					

### Q 2.2 Noise

	SA	A	N	D	SD
2.2.1 I had control over whether the TV was on or off while in hospital <i>Noise, control, pollution, receptive arts</i>					
2.2.2 Sounds from TV or radio were disturbing to me when I was in hospital <i>Noise pollution</i>					

2.2.3 I had control over whether the radio was on or off while in hospital <i>Noise, control, receptive arts, choice</i>					
2.2.4 Music being played on the ward was disturbing to me when I was in hospital <i>Noise pollution, popular art form</i>					
2.2.5 Sounds from other patients were disturbing to me when I was in hospital <i>Noise pollution</i>					
2.2.6 Sounds from machines or equipment were disturbing to me when I was in hospital <i>Noise pollution</i>					
2.2.7 Sounds from staff were disturbing to me when I was in hospital <i>Noise pollution, control</i>					
2.2.8 I was able to choose whether to share a room with other patients while in hospital <i>Noise, control, choice</i>					
2.2.9 I had access to a quiet place when I needed it in hospital <i>Control, choice, noise</i>					
2.2.10 I had access to company and conversation when I needed it in hospital <i>Control, choice, noise</i>					

Q 2.3 Most popular art forms - music, dance, art, writing, film

	SA	A	N	D	SD
2.3.1 In hospital I was able to listen to music of my own choice <i>Receptive arts, choice, popular art form</i>					
2.3.2 I had control over the music I listened to while in hospital <i>Choice, receptive arts, popular art form</i>					
2.3.3 I was able to listen to live music when I was in hospital <i>Arts interest (most popular art form)</i>					
2.3.4 I was able to play a musical instrument if I wanted to in hospital <i>Choice, Arts interest (most popular art form)</i>					
2.3.5 In hospital I had access to films of my choice <i>Receptive arts, choice</i>					
2.3.6 I was able to dance while I was in hospital <i>Arts interest (second most popular art form)</i>					

2.3.7 I was able to write if I wanted to in hospital					
2.3.8 I was able to paint or draw in hospital <i>Visual art, aesthetic environment, choice</i>					

Q 2.4 Noticing the visual art on the walls

	SA	A	N	D	SD
2.4.1 I noticed the visual art, pictures or photographs on the wall in my room or ward <i>Visual art, aesthetic environment, choice</i>					
2.4.2 I wanted to put art, pictures or photographs on the wall in my room or ward <i>Visual art, aesthetic environment, choice</i>					
2.4.3 I was satisfied with the visual art on display in the hospital <i>Visual art, aesthetic environment, choice</i>					

Q 2.5 Access to arts activities in hospital

	SA	A	N	D	SD
2.5.1 If I wanted to, I was able to continue the arts or leisure activities I enjoy while in hospital <i>General question regarding whether arts were important for patient in hospital – qualitative findings indicated some patients did not expect or want arts while in hospital</i>					
2.5.2 My arts and leisure interests were not important to me when I was in hospital <i>General question regarding whether arts were important in hospital – qualitative findings indicated some patients did not expect or want arts while in hospital</i>					
2.5.3 I expected to have arts in hospital <i>General question regarding whether arts were important in hospital – qualitative findings indicated some patients did not expect or want arts while in hospital</i>					
2.5.4 Arts and cultural programmes are important in hospital General question regarding whether arts were important in hospital – qualitative findings indicated some patients did not expect or want arts while in hospital					

Thank you for completing this survey.

## Appendix 15 Ethnicity question in survey ([www.census.ie](http://www.census.ie))

[illegible]

## **Appendix 16 Content validity: letter to reviewers and survey**

12<sup>th</sup> November 2012

Dear \_\_\_\_\_,

Thank you for agreeing to review my survey. The aim of this review is to determine whether the survey measures what it is intended to measure, before it goes out to 150 people. To do this, I need ten people to review the survey and indicate how relevant each question is to the aim of the survey. This is known as *Content Validity*.

You will find attached the questions as they appear in the survey, but instead of boxes for answers, I have put in four new boxes beside each question. You are asked to indicate whether each question in the survey is relevant to the aims of the study by ticking the relevant box beside the questions:

- Relevant to the aim of the study
- Needs minor revisions to be relevant to the aim of the study
- Needs major revisions to be relevant to the aim of the study
- Not relevant at all to the aim of the study

There are no right or wrong answers, please just give your opinion.

To do this you will need to read this brief outline of the aims of the survey:

The overall research aim of the study is *What is the role of aesthetics for patients in hospital?* (The term 'aesthetics' means the role of the arts in our lives and why they matter).

The aim of Section 1 of this survey is to record patient preferences regarding the arts and to explore the role of the arts in patients' lives.



The aim of Section 2 of this survey is to study how much access patients currently have to arts while in hospital.

In both sections, the role of receptive arts is particularly important and this is a key aim of the study. (The term 'receptive arts' means arts that you listen to or watch rather than actively participate in, for example listening to music, reading, watching films).

The survey was designed by interviewing patients in detail and reviewing relevant literature.

Thank you for helping to design this survey. Your contribution is gratefully received. Please do not hesitate to contact me if you have any questions.

Yours sincerely,

Hilary Moss  
Researcher

## Content validity: Survey to be answered

### Section Arts interests

Q 1.1 Please tick which of the following activities you have attended in the last 12 months (in Ireland or elsewhere)

Arts activities attended in the last year	Relevant	Needs minor revisions	Needs major revisions	Not relevant
Mainstream film				
Play				
Rock or Popular Music				
Traditional Irish or Folk Music				
Stand-up Comedy				
Musical				
Variety show/Pantomime				
Art exhibition (for example, paintings, sculpture, photographs)				
Circus				
Country and Western music				
Traditional/Folk Dance				
Jazz/Blues Concert				
Classical Music Concert or Recital				
World Music				
Readings (e.g. literature or poetry)				
Art house film				
Opera				
Contemporary dance				

Ballet				
Other Live music performance – please name				
Other dance performance – please name				
Other – please name				

Q1.2 Have you taken part in any of the following activities in the last 12 months?

Arts activity participation	Relevant	Needs minor revisions	Needs major revision	Not relevant
Play a musical instrument for your own pleasure, rehearsing or for an audience				
Helping with running arts event or organisation				
Painting/drawing/sculpture				
Sing in a choir				
Set dancing				
Performing or rehearsing in play/drama				
Other dancing (not fitness class)				
Other Irish traditional/folk dancing				
Photography as an artistic activity				
Writing (e.g. poetry, stories or plays)				
Writing any music				
Making artworks or animations on a computer				
Performing or rehearsing in light opera/musical				

Making films as an artistic activity (not family or holidays)				
Performing or rehearsing in opera				
Other singing to an audience or rehearsing (not karaoke)				
Other – please name				
I have stopped to look at any art (i.e., a sculpture) in a public place (e.g. in a park, on a street etc.) within the last 12 months				

Q 1.3 Which of the following do you normally use at home?

Media normally used at home	Relevant	Needs minor revisions	Needs major revisions	Not relevant
Television				
Radio				
DVD player				
CD player				
Video recorder				
Digital music player (e.g. MP3 or iPod)				
Computer (laptop, tablet etc.)				
Internet				
Cassette player				
Mobile phone or other mobile communication device				
Games console				
Mini disc player				
Record player				
E-reader (e.g. Kindle)				

Books				
Newspapers or magazines				
Other – please name				

Q1.4 Do you currently have any difficulties in attending or taking part in those arts or leisure activities which interest you?

*(Participants tick yes or no. If they tick yes they are asked to answer Q1.5)*

Relevant	Needs minor revisions	Needs major revisions	Not relevant

Q1.5 If yes, please tick which difficulties you currently have:

*(Participants tick yes or no)*

Difficulties access arts and leisure interests	Relevant	Needs minor revisions	Needs major revisions	Not relevant
1.5.1 Health Issues				
1.5.2 Access to venue				
1.5.3 Can't afford – cost				
1.5.4 Family commitments				
1.5.5 Other commitments				
1.5.6 Transport difficulties				
1.5.7 Fear of going out in the evening				
1.5.8 Too far away/ inconvenient				
1.5.9 Nobody to go with				
1.5.10 Inadequate information on event				
1.5.11 Not very				

interested in these kind of things				
1.5.12 I might feel uncomfortable or out of place				
1.5.13 Difficult to find time				
1.5.14 Loss of confidence				
1.5.15 Too much pain/physical difficulties				
1.5.16 Low mood				
1.5.17 Lack of motivation				
1.5.18 Other (specify)				

## Section 2 Arts in hospital

(For each question and statement in this section participants choose one of five options: 'Strongly agree', 'agree', 'disagree', 'strongly disagree' or 'neither agree nor disagree')

### Q 2.1 Interest in receptive arts

	Relevant	Needs minor revisions	Needs major revisions	Not relevant
2.1.1 In hospital I was able to watch TV/DVD of my choice				
2.1.2 I was able to use a computer if I wanted to in hospital				
2.1.3 In hospital I was able to listen to radio programmes of my choice				
2.1.4 In hospital I had access to films of my choice				
2.1.5 In hospital I was able to listen to music of my own choice				
2.1.6 In hospital I was able to read for pleasure				
2.1.7 In hospital I was able to use e-reading devices				

### Q 2.2 Noise

	Relevant	Needs minor revisions	Needs major revisions	Not relevant

2.2.1 I had control over whether the TV was on or off while in hospital				
2.2.2 Sounds from TV or radio were disturbing to me when I was in hospital				
2.2.3 I had control over whether the radio was on or off while in hospital				
2.2.4 Music being played on the ward was disturbing to me when I was in hospital				
2.2.5 Sounds from other patients were disturbing to me when I was in hospital				
2.2.6 Sounds from machines or equipment were disturbing to me when I was in hospital				
2.2.7 Sounds from staff were disturbing to me when I was in hospital				
2.2.8 I was able to choose whether to share a room with other patients while in hospital				
2.2.9 I had access to a quiet place when I needed it in hospital				
2.2.10 I had access to company and conversation when I needed it in hospital				

Q 2.3 Most popular art forms - music, dance, art, writing, film

	Relevant	Needs minor revisions	Needs major revisions	Not relevant
2.3.1 I had control over the music I listened to while in hospital				
2.3.2 I was able to listen to live music when I was in hospital				



2.3.3 I was able to play a musical instrument if I wanted to in hospital				
2.3.4 I was able to dance while I was in hospital				
2.3.5 I was able to write if I wanted to in hospital				
2.3.6 I was able to paint or draw in hospital				

#### Q 2.4 Noticing the visual art on the walls

	Relevant	Needs minor revisions	Needs major revisions	Not relevant
2.4.1 I noticed the visual art, pictures or photographs on the wall in my room or ward				
2.4.2 I wanted to put art, pictures or photographs on the wall in my room or ward				
2.4.3 I was satisfied with the visual art on display in the hospital				

#### Q 2.5 Access to arts activities in hospital

	SA	A	N	D
2.5.1 If I wanted to, I was able to continue the arts or leisure activities I enjoy while in hospital				
2.5.2 My arts and leisure interests were not important to me when I was in hospital				
2.5.3 I expected to have arts in hospital				

2.5.4 Arts and cultural programmes are important in hospital				
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Two additional questions for reviewers (please continue overleaf if you need more space):

1. Do you think there are any questions missing from this survey which should be included?

2. Do you have any further comments about any aspect of the survey?

*Thank you for completing this review! Please return it to Hilary Moss, Director of Arts and Health, Tallaght Hospital or email [hilarymoss36@ymail.com](mailto:hilarymoss36@ymail.com)*

## **Appendix 17 Qualitative comments from Content Validity Tests**

### Section 1.1

*Some a little confusing- perhaps using the word 'event' after some of the categories would be helpful in framing the question further.*

*I do not like this question. I think 12 months is too long a period. I could not answer it. I do not like the numbering – very distracting*

*No idea what world music is*

*Put 'e.g. cinema' after mainstream film to make it easier.*

*I was unsure about circus and how people may view this?*

### Section 1.2

*1.2.2 Helping with running arts event or organisation – is this an arts activity? Not really?! NB 2 reviewers mentioned this*

*1.2.9 Photography - is it necessary to say 'as an artistic activity'*

*1.2.18 I have stopped to look at any art (i.e., a sculpture) in a public place (e.g. in a park, on a street etc.) within the last 12 months - do not think this question belongs here*

### Section 1.3

*Question 1.3 - one reviewer reported that the listed media could also be used for listening to the news, working, social networking, learning etc., functions that do not necessarily correspond with engagement in aesthetics. So even if participants use all of these it does not mean that they have a higher level of engagement in aesthetics than someone who uses very little of these.*

*Which of the following do you normally 'I hate that word' use at home? What do you mean by normally? I could also be travelling when using these media. I listen to music on bus a lot. I think this question needs to be revised. More*

*detail is required to what they listen to or look at especially if people engage most while either listening to Radio or looking at TV's. They may not attend of the above but may listen to Radio 3 or look at other shows on TV*

#### *1.3.17 Add Blu-ray player? Specify iPad?*

*In section 1.3 you asked about mostly audio equipment (7 items) which would be linked to listening to music and/or radio. Listening to a play on the radio would fit into Arts, but I don't see how listening to Joe Duffy would. This would be considered as leisure.*

*The games console as well is in the leisure category. I suppose I was just wondering is this section's focus on the technology or what is done with it?*

*Some of the survey does seem to be about leisure activities and not just arts-based activities, so I suppose I wondered about craft (knitting, crochet) and other leisure activities such as cards (bridge) or sport or gardening.*

*I guess it is important to define, why some leisure activities are included and others are not.*

#### *Section 1.4*

*This question needs revising. What do you mean by leisure activities? They are very different and what happens if I want to say yes to 1 and no to the other. I am not sure I like the word difficulties. How about if people are just not interested. I do not think you are going to pick that up. Also you mention why they matter in your introduction. I do not think you have addressed this at all.*

#### *Section 1.5*

*1.5.3 Just put cost (delete 'can't afford') - participants might be reluctant to say that they can't afford something? Perhaps rephrase?*

*1.5.5 1 reviewer: needs minor revisions*

*1.5.7 Fear of going out (delete 'in the evening - one could also be fearful of going out during the day!)*

*1.5.8 Too far away (delete inconvenient)*

*1.5.10, 1.5.11 Not sure this is a difficulty?*

*1.5.15 Is this not the same as health issues?*

## **Section 2.1**

*I think you will need to know whether they are in a ward or private room etc.*

*Q 2.1 Interest in receptive arts I do not think this is measuring interest more what you can do. In all the items below you should allow the situation that they are too sick to participate.*

*2.1.2 Change wording to 'in hospital I was able to use a computer if I wanted to'*

*Section 2.2 For the above 10 items I do not think the scale is right strongly agree etc.*

*Section 2.3 - does not mention film explicitly – should there be a 2.3.8 in respect of film?*

*Personal TV vs earphones?*

*2.3.1 Choosing to listen to music in hospital ('control over' too much?)*

*2.3.4 Dancing in hospital? Strange one!*

## **Section 2.4**

*2.4 - having had 3 babies in the Rotunda I always wondered why they didn't rotate the visual art; by baby no. 3 I knew every painting on the pre-labour pacing route!! This could be of particular value for long stay patients.*

*'The visual art display was interesting, varied and changed on a regular basis' or some such.*

#### *2.4.2 Confusing question?*

#### *Section 2.5*

*2.5 – I would be interested to know what barriers patient may have experienced in accessing art in hospital – I wonder if it is easy to integrate arts activities into the daily hospital routine, is it possible during the week or easier at weekends? I would also be interested to know if issues such as security of personal electronic equipment or instruments affected patients' enjoyment of arts activities.*

*I would be very interested to know what arts activity patients found most therapeutic and beneficial in their recovery or what is the patients' perception of the role of aesthetics in hospital.*

*The question: If I wanted to, I was able to continue the arts or leisure activities I enjoy while in hospital has two concepts, need to clarify  
'My arts and leisure interests were not important to me when I was in hospital' - need to remove the negative statement and make it more positive  
'I expected to have arts in hospital' - wording does not make sense  
'Arts and cultural programmes are important in hospital' – review this, there are 2 concepts here*

#### *11.4.5 General comments*

*I'm not sure if much space/opportunity for 'doing' art/s in hospital – is that a possible question?*

*Need larger print and more spaced out – hard to read.*

*I would encourage you to ask yourself what you will be able to say when you get these data. You will be able to say whether people attended or played instruments. What about how Art matters to them?*

*I will be able to say, when I get this data –*

- Which arts interests patients actively engage when prior to and when not in hospital i.e. normal arts interests and engagements of our patient group.*
- To compare this to the general population (Arts Council survey results 2006)*
- What difficulties patients have accessing arts post hospital*
- What media patients use at home to access arts*
- Basic information about their perception of arts in hospital*

*Section 2 may be difficult for those with literacy problems etc. to read and understand*

*Most of the content is very relevant, however I wondered if the survey is concentration on Arts specifically or including leisure activities.*

*I think one question missing might be somebody's faith – for a lot of people leisure activities may include going to mass/service, prayer groups or hymn singing. This is especially relevant for older adults*

*I think the survey looks great! It is covering a lot and will produce very interesting data.*

*I think the issue I have raised regarding leisure activities (crafts, sport, gardening etc.) and spirituality are important. If the survey is to concentrate on Arts only then I do think some of the options are unsuitable (Game consoles) and the content listened to on the radio is of importance as to whether it fits into the correct category.*

## Appendix 18 Readability testing: details of text sampled and calculations for each section

### Section 1 Original text reviewed for readability:

CONFIDENTIAL SURVEY

Aesthetic and Cultural Measure in Healthcare (ACMHC)

Questionnaire No:

Participant number □□□

Date

#### Section 1 Arts interests

In this section you are asked a number of questions about your most important arts, cultural and leisure interests.

Q 1.1 Please tick which of the following activities you have attended in the last 12 months (in Ireland or elsewhere).

If you have attended the activity, please tick the box and tick how often you have attended this activity.

Arts activities attended in the last year	Attended 1 - 6 times in the last 12 months	Attended 6 or more times in the last 12 months
Mainstream film		
Play		
Rock or Popular Music		
Traditional Irish or Folk Music		
Stand-up Comedy		
Musical		



Variety show/Pantomime		
Art exhibition (for example, paintings, sculpture, photographs)		
Circus		
Country and Western music		
Traditional/Folk Dance		
Jazz/Blues Concert		
Classical Music Concert or Recital		
World Music		
Readings (e.g. literature or poetry)		
Art house film		
Opera		

**Calculation for section above:**

160 words, 27 sentences, 31 complex words (3+ syllables).

$0.4((160/27) + 100 (31/160)) = \text{Readability of } 10.122$

**Section 1: New text with revised readability:**

CONFIDENTIAL SURVEY

Aesthetic Measure in Healthcare

Survey No:

Participant number □□□

Date

Section 1 Arts interests

In this section you are asked a number of questions about your most important arts, culture and leisure interests.

Q 1.1 Please tick which of the events you have attended in the last 12 months (in Ireland or elsewhere).

If you have attended the event, please tick the box and tick how often you have attended this event.

Arts events attended in the last year	Attended 1 - 6 times in the last 12 months	Attended 6 or more times in the last 12 months
Mainstream film		
Play		
Rock or Popular Music		
Traditional Irish or Folk Music		
Stand-up Comedy		
Musical		
Variety show/Pantomime		
Art exhibition (for example, paintings, sculpture, photographs)		
Circus		
Country and Western music		
Traditional/Folk Dance		
Jazz/Blues Concert		
Classical Music Concert or Recital		
World Music		
Readings (e.g. literature or poetry)		
Art house film		
Opera		

**Readability for section above:**

160 words, 27 sentences, 24 complex words

$0.4 ((160/27) + 100 (24/160)) = 8.37$

*Thus, this section has a readability score of 8.37 with revised text, falling from 10.122*

**Section 2 original text tested for readability:**

Contemporary dance		
Ballet		
Other Live music performance – please name		
Other dance performance – please name		
Other – please name		

Q1.2 Have you taken part in any of the following activities in the last 12 months?

Please tick yes or no.

Arts activity participation	Yes	No
Play a musical instrument for your own pleasure, rehearsing or for an audience		
Helping with running arts event or organisation		
Painting/drawing/sculpture		
Sing in a choir		
Set dancing		
Performing or rehearsing in play/drama		
Other dancing (not fitness class)		
Other Irish traditional/folk dancing		
Photography as an artistic activity		
Writing (e.g. poetry, stories or plays)		
Writing any music		
Making artworks or animations on a computer		
Performing or rehearsing in light opera/musical		
Making films as an artistic activity (not family or holidays)		
Performing or rehearsing in opera		
Other singing to an audience or rehearsing (not karaoke)		
Other – please name		

I have stopped to look at any art (i.e., a sculpture) in a public place (e.g. in a park, on a street etc) within the last 12 months		
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**Calculation for section 2 text above:**

First time 166 words, 26 sentences, 34 complex words

$$0.4 ((166/26) + 100 (34/166)) = 10.7$$

**Section 2 revised text tested for readability:**

Modern dance		
Ballet		
Other Live music event – please name		
Other dance event – please name		
Other – please name		

Q1.2 Have you taken part in any of the following activities in the last 12 months?

Please tick yes or no.

Arts activity participation	Yes	No
Play a musical instrument for your own pleasure, rehearse or for an audience		
Helping with running arts event or group		
Painting/drawing/sculpture		
Sing in a choir		
Set dancing		
Perform or rehearse in play/drama		
Other dancing (not fitness class)		
Other Irish traditional/folk dancing		
Photography as an artistic activity		
Writing (e.g. poems, stories or plays)		
Writing any music		

Making artworks or animations on a computer		
Perform or rehearse in light opera/musical		
Making films as an artistic activity (not family or holidays)		
Perform or rehearse in opera		
Other singing to an audience or rehearsing (not karaoke)		
Other – please name		
I have stopped to look at any art (i.e., a sculpture) in a public place (e.g. in a park, on a street etc.) within the last 12 months		

**Calculation for revised text above:**

166 words, 26 sentences, 23 complex words

$$0.4 ((166/26) + 100 (23/166)) = 8.15$$

*New text was thus changed, as there was a reduction from 10.7 to 8.15 making this section more easily readable.*

### Section 3 text tested for readability:

#### Section 2 Arts in hospital

Q 2 This section focuses on questions about your hospital stay.

Please answer the following statements with Strongly agree (SA), Agree (A), Neither agree nor disagree (NAD), Disagree (D) or Strongly disagree (SD).

##### Q 2.1 Interest in receptive arts

	SA	A	N	D	SD
In hospital I was able to watch TV/DVD of my choice					
I was able to use a computer if I wanted to in hospital					
In hospital I was able to listen to radio programmes of my choice					
In hospital I had access to films of my choice					
In hospital I was able to listen to music of my own choice					
In hospital I was able to read for pleasure					
In hospital I was able to use e-reading devices					

##### Q 2.2 Noise

	SA	A	N	D	SD
I had control over whether the TV was on or off while in hospital					
Sounds from TV or radio were disturbing to					

me when I was in hospital					
I had control over whether the radio was on or off while in hospital					
Music being played on the ward was disturbing to me when I was in hospital					
Sounds from other patients were disturbing to me when I was in hospital					
Sounds from machines or equipment were disturbing to me when I was in hospital					

**Calculation section 3 text above:**

Words 207, sentences 18, complex words 30.

$$0.4 ((207/18) + 100 (30/207)) = 10.3$$

**Revised section 3 text, tested for readability:**

Section 2 Arts in hospital

Q 2 This section asks questions about your hospital stay.

Please answer the statements with Strongly agree (SA), Agree (A), Neither agree nor disagree (NAD), Disagree (D) or Strongly disagree (SD).

Q 2.1 Interest in receptive arts

	SA	A	N	D	SD
In hospital I was able to watch TV/DVD of my choice					
I was able to use a computer in hospital					
In hospital I was able to listen to radio programmes of my choice					
In hospital I had access to films of my choice					
In hospital I was able to listen to music					

In hospital I was able to read for pleasure					
In hospital I was able to use e-reading devices					

## Q 2.2 Noise

	SA	A	N	D	SD
I had control over whether the TV was on or off while in hospital					
Sounds from TV or radio disturbed me when I was in hospital					
I had control over whether the radio was on or off while in hospital					
Music being played on the ward disturbed me when I was in hospital					
Sounds from other patients disturbed me when I was in hospital					
Sounds from machines or equipment disturbed me when I was in hospital					

### Revised text calculation:

Words 180, sentences 18, complex words 23

$$0.4 ((180/18) + 100(23/180)) = 9.1$$

*Although this result was still a little high for readability, the text uses the word 'hospital' frequently, which is classed as a complex word as it has 3 syllables. It was impossible to remove all these references; hence the score is slightly higher than ideal.*



## **Appendix 19 Study Protocol – Quantitative Study**

THE ARTS INTERESTS OF OLDER PATIENTS IN HOSPITAL AND THEIR  
EXPERIENCE OF AESTHETIC DEPRIVATION IN HOSPITAL

### **PROTOCOL**

#### **PURPOSE**

To research the arts interests of older patients in hospital and their experience of hospital aesthetics

#### **MATERIALS**

Patient population will consist of:

150 patients aged over 65 attending the Age Related Day Hospital

Patients will have had a hospital stay of at least one week in the last five years.

A significant period of development was undertaken to produce the survey which has two sections - (1) the arts interests of patients (questions taken from a previously validated survey by the Arts Council 2006) and (2) their aesthetic experiences in hospital and possible aesthetic deprivation (as no relevant survey is in existence, this survey was created by the research team, with full validity and reliability undertaken).

#### **METHODS**

Demographic information was collected on patients.

Each patient was then tested using the 3DY cognitive test (Molner et al). This is a cognitive test that takes a much shorter time than the Mini Mental State Exam. In the 3DY test, the patient is asked the Day, the Date, spell "world" backwards (DLROW) and the Year.

Patient's level of disability was assessed using the Barthel assessment.

The Geriatric Depression Scale was used to test patients' mental health.

The patient was then asked a series of questions (32 items) about their preferred activities in the arts before hospital stay and their experience in the hospital.

**INCLUSION CRITERIA**

Patients who are over 65, had a hospital stay of one week in last five years

**EXCLUSION CRITERIA**

Patients who have a severe cognitive impairment.

Patients with severe aphasia/language impairment.

Patients who are too ill to take part in the study.

Patients with hospital stay less than one week.

**SAMPLING**

All patients attending the Day Hospital will be deemed eligible for the study.

**ANALYSIS**

Descriptive and inferential statistics will be used, using SPSS software.

## Appendix 20 Data dictionary

ABBREVIATION	VARIABLE LABEL	DESCRIPTION/DEFINITION OF VARIABLE	SOURCE(S)	INDEPENDENT/DEPENDENT VARIABLE	CODING OPTION
Survey_number	Survey number	Number assigned chronologically	Assigned	NA	Enter number
Participant number	Participant number	Number assigned chronologically	Assigned	NA	Enter number
Date	Date survey completed	Self-explanatory	Assigned	NA	dd.mm.yy 09.09.1989 = missing
Q1.1.1a	Mainstream film (e.g. cinema)	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.1b	Mainstream film (e.g. cinema)	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.2	Play	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.2b	Play	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.3a	Rock or popular music event	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.3b	Rock or popular music event	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.4a	Traditional Irish or folk music	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.4b	Traditional Irish or folk music	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.5a	Stand-up comedy	In the last 12months have you	Survey	Dependent	0=no, 1=yes, 9=unknown

		attended this arts event?			
Q1.1.5b	Stand-up comedy	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.6a	Musical	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.6b	Musical	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.7a	Variety show_pantomime	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.7b	Variety show_pantomime	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.8a	Art exhibition (for example, paintings, sculpture, photographs)	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.8b	Art exhibition (for example, paintings, sculpture, photographs)	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.9a	Circus	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.9b	Circus	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.10a	Country and western music	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.10b	Country and western music	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.11a	Traditional_folk dance	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown

Q1.1.11b	Traditional_folk dance	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.12a	Jazz_blues concert	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.12b	Jazz_blues concert	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.13a	Classical music concert or recital	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.13b	Classical music concert or recital	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.14a	Readings (e.g. literature or poetry)	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.14b	Readings (e.g. literature or poetry)	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.15a	Art house film	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.15b	Art house film	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.16a	Opera	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.16b	Opera	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.17a	modern dance event	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.17b	modern dance event	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.18a	Ballet	In the last 12months have you	Survey	Dependent	0=no, 1=yes, 9=unknown

		attended this arts event?			
Q1.1.18b	Ballet	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.19a	Other - please name	In the last 12months have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.1.19b	Other - please name	In the last 10 years have you attended this arts event?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.1a	Play a musical instrument for your own pleasure, rehearsing or for an audience	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.1b	Play a musical instrument for your own pleasure, rehearsing or for an audience	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.2a	Painting/drawing/sculpture	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.2b	Painting/drawing/sculpture	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.3a	Sing in a choir	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.3b	Sing in a choir	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown

Q1.2.4a	Set dancing	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.4b	Set dancing	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.5a	Perform or rehearse in play/drama	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.5b	Perform or rehearse in play/drama	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.6a	Other dancing (not fitness class)	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.6b	Other dancing (not fitness class)	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.7a	Other Irish traditional/folk dancing	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.7b	Other Irish traditional/folk dancing	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.8a	Photography	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown

Q1.2.8b	Photography	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.9a	Writing (e.g. poems, stories, plays)	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.9b	Writing (e.g. poems, stories, plays)	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.10a	Writing any music	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.10b	Writing any music	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.11a	Making artworks or animations on a computer	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.11b	Making artworks or animations on a computer	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.12a	Perform or rehearse in a light opera/musical	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.12b	Perform or rehearse in a light opera/musical	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown



Q1.2.13a	Making films as an artistic activity	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.13b	Making films as an artistic activity	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.14a	Perform or rehearse in an opera	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.14b	Perform or rehearse in an opera	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.15a	Other singing to an audience or rehearsing (not karaoke)	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.15b	Other singing to an audience or rehearsing (not karaoke)	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.16a	Other - please name	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.16b	Other - please name	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.2.17a	I have stopped to look at any art (i.e. a sculpture) in a public place (e.g. in a	In the last 12months have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown

	park, on a street etc.) within the last twelve months				
Q1.2.17b	I have stopped to look at any art (i.e. a sculpture) in a public place (e.g. in a park, on a street etc.) within the last 10 years	In the last 10 years have you participated in this arts activity?	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.3	Do you currently have any difficulties in attending or taking part in those arts or leisure activities which interest you?	Self-explanatory	Survey	Dependent	0=no, 1=yes, 9=unknown
Q1.4.1	Physical health issues (for example, too much pain, physical difficulties)	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.2	Access to venue	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.3	Cost	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.4	Family commitments	If yes to question 1.3 then is this why you do not currently	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer

		attend or take part in arts activities?			
Q1.4.5	Transport difficulties	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.6	Fear of going out	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.7	Too far away	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.8	Nobody to go with	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.9	Inadequate information on event	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.10	I might feel uncomfortable or out of place	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.11	Difficult to find time	If yes to question 1.3 then is	Survey	Dependent	0=no, 1=yes, 9=unknown.

		this why you do not currently attend or take part in arts activities?			888=reasonable no answer
Q1.4.12	Loss of confidence	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.13	Low mood	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.14	Lack of motivation	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q1.4.15	Other (please specify)	If yes to question 1.3 then is this why you do not currently attend or take part in arts activities?	Survey	Dependent	0=no, 1=yes, 9=unknown. 888=reasonable no answer
Q2.1.1	I watched TV/DVD of my choice	In hospital I... (see Variable label)	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.1.2	I used a computer in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.1.3	I listened to radio programmes of my choice	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.1.4	I watched films of my choice	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown

Q2.1.5	I listened to music	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.1.6	I read for pleasure	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.1.7	I used e-reading devices	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.1	control over whether TV was on or off	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.2	sounds from TV/radio were disturbed me	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.3	control over whether radio was on or off	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.4	music being played on ward disturbed me	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.5	sounds from other patients disturbed me	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.6	sounds from machines or equipment were disturbing to me	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.7	sounds from staff were disturbing to me	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.8	able to choose whether to share a room with other patients	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.9	access to a quiet place when I needed it	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.2.10	access to company and	In hospital I...	Survey	Dependent	0=disagree, 1=agree,

	conversation when I needed it				9=unknown
Q2.3.1	listened to music while in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.3.2	listened to live music in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.3.3	played a musical instrument while in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.3.4	wrote while I was in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.3.5	painted or drew in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.3.6	watched films in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.4.1	noticed the visual art, pictures or photographs in my room or ward	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.4.2	put art, pictures or photographs on the wall in my room or ward	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.4.3	satisfied with the visual art on display	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.4.4	visual art in hospital was interesting and varied	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.5.1	continued the arts activities I enjoy while in	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown

	hospital				
Q2.5.2	my arts interests were not important to me when I was in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.5.3	Arts programmes are important in hospital	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q2.5.4	I did not access arts interests in hospital because I was too ill	In hospital I...	Survey	Dependent	0=disagree, 1=agree, 9=unknown
Q3.1	Gender	Self-explanatory	Survey	Independent - categorical	0=male, 1=female
Q3.2	DOB/Age	Self-explanatory	PIMS and survey	Independent - continuous	dd.mm.yy 09.09.1989 = missing
Q3.3	Marital status	Self-explanatory	PIMS and survey	Independent - categorical	0=single, 1=married, 2=separated or divorced, 3=widowed, 9=unknown
Q3.4	Occupation/former occupation	Self-explanatory	Survey	Independent - continuous	Input as new category emerges, assign number each time new occupation is listed
Q3.5	Working status	Self-explanatory	Survey	Independent - categorical	0=retired, 1=working full-time, 2=working part-time, 3=self-employed, 4=unemployed, 5=full-time homemaker, 6=student, 7=full-time farmer, 8=part-time farmer, 9=unknown
Q3.6	Educational level	Self-explanatory	Survey	Independent - categorical	0=no formal education,

					1=primary, 2=attended 2nd level, 3=3rd level undergraduate, 4=3rd level postgraduate, 5=still in 3rd level, 9 - unknown
Q3.7	Children still living with you under age 18?	Self-explanatory	Survey	Independent - categorical	0=no, 1=yes, 9=unknown
Q3.8	Ethnic background	Self-explanatory	Survey	Independent - categorical	0=Irish, 1=White traveller, 2=White other, 3=Black African, 4=Any other black, 5=Chinese, 6=Any other Asian, 7=Other, 8=Unknown
Q3.9	Type of accommodation	Self-explanatory	PIMS and survey	Independent - categorical	0=private, 1=shared ward, 2=both, 9=unknown
Q3.10	Private/public patient	Self-explanatory	PIMS and survey	Independent - categorical	0=private, 1=public, 2=both, 9=unknown
Q3.11	Barthel index max score of 20. higher the score the more independent the person	Self-explanatory	Survey and nurse report	Independent - continuous	Mark out of 20
Q3.12	Geriatric depression scale score 5+ indicates depression	Self-explanatory	Survey	Independent - continuous	Geriatric depression scale score 5+ no indicates depression number entered is number of no
Q3.13	Consent given	Self-explanatory	Survey	N/A	0=no, 1=yes
Q3.14	3DY cognitive test	Self-explanatory	Survey	N/A	Mark out of 4



	maximum score 4				
Q3.15	length of longest stay in last 5 years	Self-explanatory	PIMS	N/A	Number of days of longest stay recorded in last 5 years

