Music Therapy for Treating Spiritual Health Needs of People with Substance Use Disorders: A Survey Study

by

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MUSIC THERAPY FOR TREATING SPIRITUAL HEALTH NEEDS OF PEOPLE WITH SUBSTANCE USE DISORDERS: A SURVEY STUDY

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# Table of Contents

Abstract

Chapter 1

Introduction

Spirituality as a Crucial Element of Recovery from Substance Use Disorders

Defining Music Therapy

Music: A Bridge to Connection

Chapter 2

Literature Review

Music Therapy in Addictions Treatment: Recent Systematic Reviews

Music Therapy and Spirituality

Music Therapists’ Perceptions of Spirituality in their Practice

Music Therapy and Spirituality in End-of-Life Care

Spiritual Themes in the Literature for Music Therapy in the Treatment of Substance Use Disorders

The Bonny Method of Guided Imagery in Music (BMGIM) in the Treatment of Substance Use Disorders

Gaps in the Literature for Music Therapy in Meeting Spiritual Health Needs of People with Substance Use Disorders
Chapter 3 30

Method 30

Materials 30

Survey Participants 30

Procedure 30

Ethics 31

Data Analysis 31

Chapter 4 32

Results 32

Music Therapist Demographics 32

Clinical Practice with Individuals with Substance Use Disorders 36

Number of Years Practicing Music Therapy 36

Work Setting 36

Session Format 36

Music Therapy Methods 38

Receptive Methods 38

Recreational Methods 39

Compositional Methods 40

Improvisational Methods 40

Music Therapy and Spiritual Health Goals 41
Music Therapy Methods Utilized to Meet Spiritual Health Goals

Popular Music Therapy Methods to Meet Other Listed Spiritual Health Goals: Connection with a Higher Power

Connection with Others

Cultivating Sense of Meaning

Achieving Catharsis

Enhancing Sense of Wellbeing

Exploring Spiritual Principles as Found in the 12-Steps

Exploring the Theme of “Letting Go” and/or “Surrender”

Exploring Meditation

Exploring Prayer

Exploring Relationship with Self

Perceived Efficacy

Assessing Spiritual Growth

Chapter 5

Discussion

Music Therapy Clinical Practice

Theoretical Orientations

Music Therapy Treatment

Treatment Setting
Abstract

Individuals with Substance Use Disorders (SUDs) require multiple levels of care and support for recovery. Aside from the myriad physical and psychological realms of recovery, people with SUDs are in need of adopting a novel lifestyle to sustain sobriety and prevent relapse. Twelve step programs provide people in recovery with the means of cultivating spiritual practices which when integrated, can provide foundations and support for living sober. Research suggests that spiritual practices and principles can foster a variety of beneficial outcomes for recovering individuals. Music therapy might be a helpful form of treatment for people with SUDs, though more research is needed to determine the efficacy of the modality for this population. Furthermore, there is a scarcity of research which examines music therapy’s potential to treat the spiritual needs of individuals with SUDs. A survey was conducted to learn more about how, and if music therapists in the United States are treating the spiritual health needs for people with SUDs. Music therapists reported that connection with others and exploring relationship with self were the most common spiritual health goals addressed in music therapy. Song discussion and lyric analysis were the most commonly used methods to address spiritual goals. Participant text responses indicated a variety of perspectives on what music therapists considered to be “spiritual goals,” as well as several views on scope of practice to address such needs. The present study can help to broaden the knowledge base of current trends in music therapy practice in meeting the spiritual health needs for persons with SUDs, as well as provide recommendations for future research.

Keywords: music therapy, substance use disorders, spiritual health.
Chapter 1

Introduction

Addiction is a multi-faceted illness. The National Institute on Drug Abuse (NIDA, 2014) considers it to be “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences” (p. 5). In 2021, an estimated 46.3 million individuals (around 16.5 percent of the international population) were reported to have a substance abuse disorder (SUD) within that past year (Substance Abuse and Mental Health Services [SAMHSA], 2021) with 29.5 million of those specifically affected by alcoholism. The Center for Disease Control (CDC, 2023) has reported over 100,000 deaths a month from an opioid overdose. Internationally, many have experienced at least one instance of an adverse consequence due to someone else’s problem drinking (13-78%) or drug use (13-28%) (Merkouris et al., 2022).

There are several risk-factors that might influence the development of a substance use disorder. Some of these include genetic predispositions, social/cultural influences, prolonged stress, traumatic experiences, and psychopathology (Hägele et al., 2014; Kamens et al., 2023). The COVID-19 Pandemic, a worldwide traumatic event resulting in a rise in some of the above risk-factors, might be linked to an international increase in patterns of drug abuse and subsequent addiction diagnoses (Kamens et al., 2023; La Rosa et al., 2022; United Nations Office on Drugs and Crime [UNODC], 2022).

Substance use disorders are also associated with an increased risk of contracting diseases such as HIV/AIDS (Crane et al., 2017; Duko et al., 2019), and Hepatitis B/C (Moradi et al., 2019). Additionally, those with SUDs have higher rates of incarceration (Van de Baan et al.,
2021), decreased ability to maintain regular employment, homelessness, strained relationships, depression, anxiety, and psychosis (UNODC, 2014).

Despite the extensive body of research into the etiology of substance use disorders, there is not a single explanation as to why certain people become addicted to drugs or alcohol and others do not (SAMSHA, 2010). There is also no uniform treatment approach that meets the needs for all persons diagnosed with SUD as addiction presents differently in each individual (NIDA, 2018). Treatments should address multiple issues within a person’s life (i.e., psychological, medical, and social needs), not just the person’s substance abuse (NIDA, 2018).

Many individuals who have an SUD also suffer from at least one co-occurring mental disorder. Previous research suggests that the presence of a co-occurring mental, cognitive, or affective disorder might increase the development of a substance use disorder (Chambers, 2013; Hägele et al., 2014; Sciacka & Thompson, 1996). Multiple types of treatment modalities are often needed to meet the diverse needs of individuals who have a co-occurring mental disorder.

Though there is not a unified consensus on a clinical level as to what “recovery” from a substance use disorder looks like, there is growing evidence that speaks to the idea that addiction is often considered to be a lifelong illness (Dupont & Skipper, 2012; Gubi & Hughes, 2013; Hamilton & Nestler, 2019). Proponents of “long-term recovery” feel that even if an addicted individual manages to achieve a certain amount of abstinence, long-term sobriety requires an ongoing effort on the part of the individual to continuously treat and manage their disease.

One of the most widely utilized approaches to recovery, since the founding of Alcoholics Anonymous (AA) in 1935, is the 12-step program (SAMSHA, 2010). 12-step recovery programs function as a prescriptive outline of “steps” that those who seek recovery can take with more experienced members. The 12-steps are outlined as a program of recovery (See Appendix A),
that the recovering individual adopts as a set of spiritual principles for daily living that support long term sobriety by addressing the underlining issues of the disease.

There is an ongoing need for qualitative and quantitative research that demonstrates the effectiveness of 12-step programs given the millions of individuals who participate in AA/NA. The literature varies in the constructs examined within a 12-step context. Recent research found positive effects for 12-step program’s efficacy on levels of abstinence (Kelly et al., 2011; Galanter et al., 2013a, 2013b; Tonigan et al., 2013), quality of life (Mokhatari et al., 2019) the positive aspects of having a sober community (Kelly, 2022; SAMSHA, 2010; Zemore et al., 2018), as well as spiritual benefits (Chukwunta, 2018; Dermatis & Galanter, 2016; Galanter et al., 2012, 2013a, 2014a, 2014b; Tonigan et al., 2017; Young 2012, 2013).

**Spirituality as a Crucial Element of Recovery from Substance Use Disorders**

Defining spirituality is not an easy task as there is no widely agreed upon definition for the term. It has been described as a construct that exists in the self, relations to others, the world around them, and that it “can never be paired or contained, captured, or caught by any pair of terms” (Cobussen, 2008, p. 26). It has also been described as a worldview that helps to derive meaning and purpose in one`s life (Puchalski, 2003).

Whitfield (1984) divides spirituality into “one`s relationship in three areas: (1) with the universe, (2) with other people, and (3) with one`s self” (p. 14). Spirituality can encompass the way people conduct themselves, their perspectives, thought processes, and how they relate to their emotions. Spiritual principles can be incorporated in how we relate to and interact with every aspect of our lives (Nagai-Jacobson & Burkhardt, 1989). There are many factors that can obstruct the channel to improving spiritual health for individuals with addictions as well as people in general. For instance, “egocentricity, grandiosity, low frustration tolerance, the
inability to listen to others, rigidity, problems with interpersonal skills, low self-esteem, denial, demand for control and general resistance may block the path to spiritual growth” (Walker, 1995, p. 150).

The nature of what is associated with “spiritual experiences” is quite broad. Maslow (1964) introduced and explored the concept of “peak experiences,” in which a person, often suddenly, is transcended into a state of euphoric fulfillment and awe. These occurrences can be understood through the lens of a spiritual experience, in which a person comes to embody a sense of unity, where “the whole universe is perceived as an integrated and unified whole” (Maslow, 1964, p. 59). Often, when people report these “peak” or spiritual experiences, one’s sensorial perceptions can become heightened and more attuned to (Maslow, 1964). On such occasions, the person can completely attend to the present moment, with appreciation, awareness, and gratitude for what is happening in the “here-and-now.”

In the second printing of Alcoholics Anonymous’ first publication, an appendix entitled “Spiritual Experience” was added, in which the authors provide further explanation on the term. The content of this addition was influenced by the work of James (1902), The Variety of Religious Experiences: A Study in Human Nature. The writers illustrate how many members who take the 12 Steps go through a gradual spiritual experience known as the “educational variety, because they develop slowly over a period of time” (Alcoholics Anonymous World Services, 2001, p. 567). As an individual grows spiritually, they might notice positive alterations in their personality, feelings, and overall perspective towards life. In other words, though spiritual experiences can be seen as sudden, or isolated incidents, they can also occur over a longer period as one grows, heals, and expands their sense of meaning.
Though spirituality can be associated with religion, spiritual practices and beliefs can extend beyond affiliation with religious institutions (Puchalski & Ferrell, 2010). Where many definitions converge is through the altruistic principles of giving freely to others, love, compassion, community, forgiveness, acceptance, humility, courage, and a relationship with a “Higher Power,” or God. 12-step groups might refer to these as “spiritual principles” (Alcoholics Anonymous World Services, 1981, 2001; Narcotics Anonymous World Services, 2008). Though addiction is a disease which can be generally defined, spirituality is a subjective concept.

Though there is no agreed upon approach on what is deemed the most effective recovery model, or the way to address spiritual needs, this thesis is concerned with how music therapists meet the spiritual needs of individuals in recovery from substance use disorders. Not all recovery models involve spiritual practices, while some are completely secular (LifeRing, 2023; SMART Recovery, 2022). However, most of the literature in the intersection between spirituality and recovery from addictions is situated in and around 12-step recovery programs.

Numerous studies suggest that spirituality plays a significant role in the lives of individuals in recovery and is associated with a variety of positive outcomes (e.g., Chukwunta, 2018; Dermatis & Galanter, 2016). Between 2012 and 2014, Galanter et al. (2012, 2013a, 2013b, 2014b) conducted 4 survey studies. Survey participants included 527 NA members (Galanter et al., 2013a), physicians in recovery from alcoholism who attend AA meetings (Galanter et al., 2013b), United States veterans participating in NA (Galanter et al., 2014b), and young AA members (under age 25) (Galanter et al., 2012). The results across these studies suggest that 12-step members in recovery reported spiritual awakenings associated with positive outcomes, such as enhanced spirituality, longer durations of abstinence, and less cravings. The two studies involving NA members found associations between spiritual awakenings and decreased
depression (Galanter et al., 2013a, 2014b). The results of these studies suggest that the spiritual benefits that come from completing the 12 steps might lead to further positive effects for individuals in recovery.

There may be a link between spirituality, meeting attendance, and sobriety. As an example, Kelly et al., (2011) found that “a consistent effect of AA attendance on subsequent drinking outcomes was observed, which was partially explained by AA’s effect on increasing spirituality/religiousness” (p. 458). Tonigan et al. (2013) reported similar findings suggesting spiritual change was predictive of decreases in drinking intensity and increased abstinence rates. More research should be done to examine the interplay of meeting attendance, spirituality, and duration of abstinence.

The spiritual principle of Step 12 is service, hence “carrying the message” to others seeking sobriety (Alcoholics Anonymous World Services, 1987). Galanter et al.’s study (2012) reported those who had a spiritual awakening were also more likely to have sponsored, or “carried the message” to more than 5 fellow members. The results support the idea that spirituality might be a supportive element for individuals in recovery from both alcoholism and prolonged drug abuse. In addition, the effects of having a sponsor were associated with positive spiritual outcomes such as a higher perception of experiences which were attributed to a relationship with a Higher Power (Zemore & Kaskutas, 2004). Lastly, belief in a God of one’s own understanding is associated with higher frequency of spiritual practices such as prayer and/or meditation (Young, 2012, 2013).

One of the key texts in 12-step literature, colloquially referred to as “The Big Book,” articulates illustrates the strength of community that exists within such mutual help organizations. AA co-founder Bill W. writes:
“…there exists among us a fellowship, a friendliness, and an understanding which is indescribably wonderful… The feeling of having shared in a common peril is one element in the powerful cement which binds us” (Alcoholics Anonymous World Services, 2001, p. 17).

The above sentiment has been substantiated by existing clinical literature. Researchers have found that many individuals in recovery associate their spirituality with a sense of community and social support found within their 12-step groups, which may also be related to improved outcomes (Galanter et al., 2012; Kelly, 2022; Lookatch et al., 2019; Zemore et al., 2018). The many different expressions of spirituality highlight the diversity of the construct. Thus, researchers should continue to examine the different ways that spirituality is presented within the ongoing sobriety of patients in recovery from substance use disorders.

Multiple treatment modalities might be needed to accommodate the needs of those in recovery as the disease is multifaceted (NIDA, 2018). Music therapy has gained traction over the past several years as a possible treatment model for meeting the clinical, therapeutic needs of individuals in recovery from substance abuse disorders.

Defining Music Therapy

Defining music therapy is challenging, as there is not a unified definition within the field. What constitutes music therapy practice may differ from one clinician to another depending on the therapist's theoretical orientation. Bruscia (2014) defines music therapy as “a reflexive process wherein the therapist helps the client to optimize the client’s health, using various facets of music experience and the relationships formed through them as the impetus for change,” (p. 36). The music therapist harnesses the properties and elements of music to assist in meeting their clients’ therapeutic needs. In the United States, music therapists receive a degree in music
therapy from an accredited university. After graduation, individuals must pass the board certification exam offered by the Certification Board for Music Therapy to receive the title of a board-certified music therapist (MT-BC) (CBMT, 2024). Once certified, music therapists can work with a broad range of clinical populations, though working with individuals with substance abuse disorders requires at least a master’s degree in music therapy.

Music: A Bridge to Connection

It has been said that “the opposite of addiction is connection” (Hari, 2015). The experience surrounding the destructive force of being entangled in the vicious cycle of substance abuse can be understood as total disconnection and isolation. Detachment not only from the world and others, but also from the self. Crucial to recovery from SUDs is to help the individual cultivate a novel sense of connection in all aspects of their lives.

E. Thayer Gaston, the person often regarded as “the father of music therapy” (Johnson, 1981, p. 279), eloquently states: “music involves the individual so totally and in such unique fashion that closeness is felt, and painful aloneness may be alleviated” (Gaston, 1968, p. 25). Music’s ability to reconnect is just one of its many healing properties that might help to “alleviate the painful aloneness” that is characteristic of active addiction. Though music therapy practice in the treatment of SUDs has expanded over recent years, there remains the need for significant research to solidify its stance as an effective form of therapy for this clinical population.
Chapter 2:

Literature Review

Music Therapy in Addictions Treatment: Recent Systematic Reviews

The literature related to music therapy practice in addictions over the past decade is scant. Four major systematic reviews have been conducted since 2017. Most recently, the Cochrane Review completed by Ghetti et al. (2022) examined the efficacy of music therapy in addition to standard care versus standard care independently for individuals with substance use disorders. The review included 21 trials involving 1,984 participants. Various facets of therapeutic music experiences were represented in the review. The results of this review suggest that music therapy as an additional treatment to standard care in detoxification and short-term rehabilitation units might lead to moderate reductions in craving symptoms. Further, music therapy was noted to be more effective when participants received more than a single session. (Ghetti et al., 2022). Music therapy retained a moderate effect on motivation for treatment/change “when comparing MT plus standard care to another active intervention plus standard care, though certainty in the results was lower” (Ghetti et al., 2022, p. 23).

The review found no beneficial effect on depression or anxiety when music therapy plus standard care was compared to standard treatment on its own. This contrasts to Carter and Panisch’s (2021) findings, which suggest that “music therapy is an expressive intervention that can reduce depressive symptoms” (p. 1551), though it is agreed that the limited body of quantitative research makes it difficult to make decisive conclusions. Ghetti et al. (2022) also found that there were no beneficial effects when comparing music therapy to other active interventions on their own, though they were uncertain about such results. Lastly, the authors acknowledge limitations to their work, stating “the results of this review may have limited
generalizability, as 15/21 included studies were conducted in short-term detoxification settings with length of stay shorter than five days” (Ghetti et al., 2022, p. 23). However, it is noteworthy that similar issues concerning study length are noted across all 4 systematic reviews (Carter & Panisch, 2021; Ghetti et al., 2022; Hohmann et al., 2017; Murphy, 2017).

Murphy (2017) reviewed 12 studies that met the criteria for randomized control trials. The studies examined were of average quality, with a moderate risk of bias. The researcher found that there was a lack of variety in music therapy methods (Murphy, 2017), which contrasts to the findings of Ghetti et al. (2022), as the latter identified a wider variety of methods. Murphy’s (2017) review found that lyric analysis was the most frequent independent variable. Both studies also suggested that music therapy in addictions would benefit from a broader inclusion of treatment settings, as much of the research took place in inpatient rehabilitation/detoxification units (Ghetti et al., 2022; Murphy, 2017). Murphy (2017) suggested that future researchers should examine the efficacy of both group and individual sessions. This recommendation is consistent across all 4 systematic reviews (Carter & Panisch, 2021; Ghetti et al., 2022; Hohmann et al., 2017). Lastly, the reviewed studies showed a “moderate to high risk of bias” (Murphy, 2017, p. 21). The author made suggestions to mitigate these risks, such as adhering to intention-to-treat guidelines and having someone other than the interventionist perform outcome measures and analysis (Murphy, 2017).

Carter and Panisch’s (2021) review focused on music therapy’s effect on psychosocial outcomes for persons with substance use disorders. Fourteen of the 195 potential studies were included in the review (Carter & Panisch, 2021). To meet inclusion criteria, the studies needed to be randomized control trials or quasi-experimental studies on music therapy and substance use disorders. Studies were considered to meet such criteria if they tested a music therapy
intervention using pre- and post-test with or without equivalent groups, or interrupted time-series designs (Carter & Panisch, 2021). Findings from this review suggest that music therapy is sometimes as effective in the treatment of depression symptoms when compared to traditional treatments (Carter & Panisch, 2021). The findings also suggest that music therapy might help to meet psychosocial outcomes, treatment motivation, and foster readiness to make changes to addictive behavior (Carter & Panisch, 2021). Specifically, the results suggest that improvisational therapeutic music experiences might have the potential to decrease clinical depression symptoms for individuals in addictions treatment (Carter & Panisch, 2021).

The authors recognize high rates of co-occurring disorders for individuals with substance abuse disorders, such as depression. Carter and Panisch (2021) surmise that treating adjacent mental health symptoms in patients with co-occurring mental and SUDs might also help to achieve positive outcomes for symptoms directly related to their addiction. This necessitates future research to evaluate music therapy’s efficacy to address the many needs of patients with co-occurring mental and substance use disorders.

A major limitation of the studies as identified by Carter and Panisch (2021) was a substantial degree of homogeneity among participants, with most studies taking place at a single detoxification unit in the Midwestern region of the United States. Such recognized limitations are similar to the findings of Ghetti et al. (2022). This raises a further issue for generalizing results. More longitudinal studies with greater sample heterogeneity, and different treatment settings were suggested for future research. Finally, the findings concur with the results of other systematic reviews, in that a deficit of significant results makes generalizability difficult.

Hohmann et al.’s (2017) review differs from the previously mentioned systematic reviews, in that it also includes research articles that tested both music-based and music therapy
interventions. The authors identified a clear increase in quantitative research over the years leading up to 2017, though they still indicated the lack of statistically significant results. Up to eight outcomes measured through random control trials were identified in which music therapy had some positive effects. Outcomes of motivation, enjoyment and locus of control contained beneficial effects, though there was a lack of consistency in results across all studies (Hohmann et al., 2017). Notably, the authors found no significant effects on withdrawal/craving outcomes, which differs from the findings of Ghetti et al.’s (2022).

The reported results of each systematic review suggest that there is still not enough evidence to support music therapy’s efficacy for the treatment of substance use disorders. All 4 systematic reviews identified an overall lack of results with statistical significance (Carter & Panisch, 2021; Ghetti et al., 2022; Hohmann et al., 2017; Murphy, 2017). The only consistent construct that was considered to have potential benefits across the 4 reviews was treatment readiness/motivation to change, while there were differences in findings for depressive symptoms, perceived helpfulness of music therapy, state anxiety, participation level, sense of coherence, and emotional benefits. Future research should work to mitigate bias based on the suggestions from Murphy (2017), such as diversifying treatment settings, greater trial lengths, longitudinal studies, and striving to increase participant heterogeneity. Murphy (2017) aptly states, “a formal recommendation for or against the inclusion of music therapy as a primary treatment modality in addictions treatment would be premature” (p. 22).

More research is needed to determine if music therapy is effective on its own when treating clients with SUDs. Murphy (2017) also noted that the inclusion of qualitative studies might be beneficial to advance the field, as systematic reviews have traditionally only examined
randomized control trials, as per the “Cochrane Handbook for Systematic Reviews of Interventions” (Higgins & Green, 2011).

**Music Therapy and Spirituality**

Borling (2011) organizes the phases of recovery from addiction as the bio-physical, psycho-emotional, and psycho-spiritual. The bio-physical deals with the initial physical symptoms of early recovery (i.e., withdrawal and cravings), while the psycho-emotional and psycho-spiritual domains refer to the underpinning issues that drive addictive use, as well as the psychic, spiritual aspects of long-term recovery. Music therapists may be uniquely equipped to address the many needs of clients who are in recovery, specifically in the psycho-spiritual health domain. Over the past several years, music therapy researchers have conducted studies spanning a wide variety of clinical populations to examine the treatment modality’s effects on spiritual health needs. Clinical populations that were suggested to have received spiritual benefits from music therapy include persons with severe mental illnesses (Grocke et al., 2014), receiving cancer care (McClean et al., 2012), who have acquired neurodisabilities (Baker et al., 2017), and receiving end-of-life care (Burns et al., 2015; Warth et al., 2021; Walden et al., 2021).

**Music Therapists Perceptions of Spirituality in their Practice**

Tsiris (2017) explored music therapist’s perception of spirituality in relation to their work with clients. Sixty-four percent of survey respondents reported that spirituality informs their practice, and more than half reported having experienced transcendent, spiritual experiences in their work with clients (Tsiris, 2017). The results of this study imply that spirituality may also be important to music therapists and the people they serve. Research findings support the need for more research on spirituality and its perceived relevance in music therapy practice (Tsiris, 2017) and music therapist’s perceptions of the construct and how (or if) it arises in their work.
Music Therapy and Spirituality in End-of-Life Care

Since 2012, there have been 4 major research studies which examined music therapy’s effect on spiritual outcomes for individuals in end-of-life care. The findings of such studies were consistent in that they each suggested ways in which music therapy yielded positive outcomes for spiritual wellbeing.

McClean et al. (2012) reported findings related to music therapy’s effect on perceptions of spiritual meaning for individuals with cancer. The study’s music therapist utilized a music-centered approach to group therapy in which improvisational and receptive music methods were used to facilitate therapeutic discussions related to participants’ shared experience of living with cancer (McClean et al., 2012). Sessions took place at a 5-day retreat program for persons with cancer in the United Kingdom. The group organically developed a rapport that was conducive to the sharing of personal struggles related to their shared illness. Group and personal themes such as “chaos to cohesion, despair to hope, anger to joy” (McClean et al., 2012, p. 404) were integrated within improvisational music experiences and processed verbally with the aid of the therapist. The session closures provided participants with the opportunity to decompress by listening to therapist selected classical music after a verbal check in (McClean et al., 2012).

Two researchers other than the interventionist conducted in-depth interviews with 23 cancer patients who took part in the music therapy sessions. Interviews were coded, analyzed, and grouped into “spiritual themes” (McClean et al., 2012, p. 404). Results from the data analysis suggest that music therapy was associated with spiritual outcomes such as meaning-making, transcendence, connectedness, hope and faith (McClean et al., 2012). The improvisational methods used in the intervention inspired discussions surrounding the search for meaning and other spiritual themes.
A study that also indicated music therapy’s potential to result in spiritual outcomes was conducted by Burns et al. (2015). In this study, the researchers analyzed electronic medical records from 10,534 cancer patients who received hospice care over 4 years to determine the effects of music therapy. The results indicated that music therapy was associated with a “higher likelihood of discussions surrounding spiritual beliefs” (p. 229) with family members and lower dyspnea scores.

A biographical music therapy intervention, “Song of Life,” was tested against a control group with 104 participants in palliative care in a randomized control trial (Warth et al., 2021). The music therapists worked with participants to identify biographically meaningful songs. The selected songs were then played for the patient in a lullaby style during the follow-up session. The lullaby arrangement was recorded during the follow-up session. This recording was then used as the basis for therapeutic reflection on the client’s feelings and memories during the final session. Participants in the experimental group reported significantly higher spiritual well-being than the control group (Warth et al., 2021). One of the noted spiritual outcomes was an increase in patient perceived life meaning post-intervention, which are similar to the findings of McClean et al.’s (2012) study.

A phenomenological study by Walden and colleagues (2021) also suggest spiritual benefits among participants. Eleven parents of children in palliative care for progressive neurodegenerative illnesses received music therapy via an intervention entitled the “Heartbeat Recordings.” The intervention involved synchronizing the rhythm of their child’s heartbeat to a song that was meaningful to the parents. Three months later, the parents were interviewed to discuss the therapeutic benefits of receiving their heartbeat recordings, and how it assisted in their pre-loss grieving processes (Walden et al., 2021). Participants reported feelings of spiritual
support and enhanced meaning-making as revealed through themes from interviews (Walden et al., 2021). Specifically, “coping through spirituality” (Walden et al., 2021, p. 1026) was identified as a theme, in which the intervention brought upon the concept of prayer and faith in a chosen Higher Power for coping with one’s anticipatory grief.

Though the research is scant, music therapists in addictions treatment might consider reviewing both recent and older music therapy in end-of-life care literature to determine if methods of addressing spiritual issues in hospice/palliative care would be relevant for work in substance use disorders.

**Spiritual Themes in the Literature for Music Therapy in the Treatment of Substance Use Disorders**

Two studies from the past decade which focus on women in recovery report findings that are reflective of spiritual themes and principles (Gardstrom et al., 2017; Miller, 2017). That said, only 1 aimed to understand the effect of music therapy methods on spiritual outcomes. Miller (2017) found that clinical song discussion in a female recovery community was a helpful method for participants to internalize and better understand the spiritual principles of Steps 1 through 3 via AA/NA slogans. Moreover, song discussion, and “Mindfulness & Music” prompted participant comments about sensations of enlightenment, connection to a higher power, and enhanced feelings of connection and community support (Miller, 2017).

Gardstrom et al., (2017) examined group music therapy’s perceived effectiveness for women in recovery. The researchers identified seven emergent themes in their qualitative data, which have similarities to participant comments from Miller’s (2017) study: “universality, altruism, instillation of hope, group cohesiveness, existential factors, catharsis, and self-
understanding” (Gardstrom, et al., 2017, p. 347). Lastly, catharsis, group cohesion, and connectedness were reflected in both studies.

Although Gardstrom et al. (2017) did not aim to specifically examine music therapy’s effect on spiritual health needs, the resulting therapeutic themes align with the spiritual principles of altruism, hope, service, unity, and self-awareness as discussed in The Twelve Steps and Twelve Traditions, a seminal piece of recovery literature (Alcoholics Anonymous World Services, 1981). More research is needed to specifically examine perceptions of music therapy on the spiritual aspects of recovery from substance use disorders. Additionally, there is a paucity of research that seeks to determine how (or if) group music therapy can be helpful to treat the spiritual needs of individuals within this population. Finally, more research is needed comparing the effect of group and individual music therapy to meet spiritual goals for people with addictive disorders.

**The Bonny Method of Guided Imagery in Music (BMGIM) in the Treatment of Substance Use Disorders**

The Bonny Method of Guided Imagery in Music (BMGIM) is a model of music therapy that requires post-masters, advanced training. BMGIM involves listening to music with a BMGIM practitioner, who helps move the client into a relaxed state so that they can be “guided” through the therapeutic process which involves the eliciting of imagery as stimulated by music (Bonny, 2002). The music therapist acts as a “guide,” while the client “travels” through the layers of their psyche. Examining the emotions, memories, thoughts, and perspectives elicited by the music can help one to foster self-understanding and acceptance (Van Doort, 2015).

Though the literature examining BMGIM in addictions treatment is limited, three studies were completed in the last decade. Heiderscheit (2017) investigated the effect of individual
BMGIM sessions on “interpersonal problems, coping measures and immune function in 19 adults in chemical dependency treatment” (p. 15). The results suggested that the intervention led to significant improvements in areas related to domineering, non-assertive and emotionally distant personality traits (Heiderscheit, 2017, p. 21). Salivary immunoglobin A (IgA) of participants was collected pre- and post-treatment to measure the intervention’s effect on immune function. There was a lack of significance for motivation, depression, sense of coherence and salivary IgA level scores (Heiderscheit, 2017). Furthermore, this study took place at a rehabilitation unit which incorporated 12-step philosophies. The researcher notes that their study did not consider the impact that such principles might have had on the study (Heiderscheit, 2017). Creating a measure for the influence of spiritual principles of 12-Step programs as presented in many rehabilitation programs would be a valuable addition to future BMGIM and addictions research.

Moe (2012) conducted a study which examined group BMGIM’s effects on sense of coherence. Eighteen individuals in a cognitive therapy program were given pre- and post-tests to measure their sense of coherence after 10 group BMGIM sessions. Findings revealed statistically significant results, in which 17 out of 18 participants showed an increase in sense of coherence (Moe, 2012). Additionally, through post-intervention interviews, participants expressed that BMGIM was effective for their psychological well-being overall, and that the symbols which were evoked throughout the therapeutic process were of positive value to them.

Results from a feasibility study conducted by Murphy and Ziedonis (2016) found that participants and inpatient staff viewed group BMGIM as being a potential asset to complement traditional addictions rehabilitation treatment at an inpatient facility. In addition to evaluating the feasibility of incorporating group BMGIM into the treatment regimen of a residential
rehabilitation program, the intervention’s effects on motivation, mood symptoms and self-efficacy outcomes were measured (Murphy & Ziedonis, 2016). Like Moe (2012) and Heiderscheit (2017), the intervention’s effect on sense of coherence was also measured. Although outcomes showed many improvements among participants receiving group BMGIM, there were no statistically significant between-group-differences.

However, the researchers noted that when measuring outcomes for motivation, both the control and experimental groups' motivation to change remained high from the beginning of the study through its conclusion. A noteworthy finding was that significantly higher retention rates for the experimental group might suggest that group GIM somehow positively influenced the participants’ motivation to stay in treatment (Murphy & Ziedonis, 2016). This is substantiated further by the fact that 7 out of the 10 who withdrew from the treatment facility before the study’s end were in the control group (Murphy & Ziedonis, 2016). The authors draw a parallel for retention in Moe’s (2012) study, in which there was a 92% treatment attendance rate. One participant relapsed during the study, and only 4 of the 18 participants were readmitted to the facility 2.5 years after the study’s end (Moe, 2012). Considering the small sample sizes, similarities of these findings should be interpreted carefully, though they are worthy of further investigation (Murphy & Ziedonis, 2016).

There is a variance of results for BMGIM’s effect on sense of coherence outcomes among the three above studies. Moe (2012) was the only study to find statistically significant results when examining the interventions effects on the construct. That said, Heiderscheit (2017) explored individual BMGIM, while Moe (2012) and Murphy and Ziedonis’ (2016) study examined group BMGIM. The varying results across studies necessitate further research to understand if the intervention is effective in improving sense of coherence for persons with
substance use disorders who receive BMGIM. Furthermore, additional research is needed to investigate the efficacy of both group and individual BMGIM on sense of coherence for individuals with substance use disorders.

The significance of the results for both group and individual BMGIM in the treatment of substance use disorders are mixed. Future research should consider longitudinal studies, larger sample sizes, and follow-up studies. Moreover, all the above studies took place at inpatient treatment facilities. Including more diverse treatment settings (i.e., intensive outpatient programs, community recovery centers) should expand on the above BMGIM studies.

**Gaps in the Literature for Music Therapy in Meeting Spiritual Health Needs of People with Substance Use Disorders**

There is a paucity of research on music therapy’s effects on spiritual outcomes for individuals with substance use disorders. There are, however, examples in the literature which report outcomes that could be considered spiritual benefits, i.e., themes of hope, unity and altruism as reported in the findings of Gardstrom et al. (2017). However, there are not any studies to date specifically designed to study the effect or influence participation in music therapy may have on meeting spiritual needs of persons with substance use disorders. In fact, the only study from recent years that directly incorporates spiritual 12-step principles into its design is that of Miller (2017).

Since the spiritual principles of programs like AA and NA can be pertinent for recovering from substance use disorders, this area of research should be given much more attention by music therapists in addictions treatment. Therefore, the purpose of this survey study is to learn more about how or if music therapists working with individuals diagnosed with an SUD are addressing spiritual health needs. The specific research question is: How do music therapists in
the United States meet the spiritual health needs of individuals diagnosed with SUDs? The sub questions are:

1. What spiritual goals do music therapists identify in their work with individuals who have SUDs?

2. What music therapy methods are commonly used?

3. How do music therapists rate the perceived efficacy of music therapy’s ability to address the spiritual needs of individuals who have SUDs?

4. How do music therapists evaluate spiritual growth in their clients who have SUDs?
Chapter 3

Method

Materials

A 25-question survey was designed by the researcher and his thesis chair in order to learn more about how music therapists working in the United States are addressing the spiritual health needs of individuals with substance use disorders. The survey was divided into 5 sections: 1) demographics, 2) work history, 3) music therapy treatment settings and format, 4) music therapy goals related to spirituality in addictions, 5) music therapy methods used to address goals related to spirituality. Additionally, two experts in music therapy in addictions treatment were consulted with during the survey's construction. Revisions to the survey were made based on feedback received. A copy of the survey and informed consent statement can be found in Appendix B.

The spiritual goals included in the survey are reflective of the spiritual principles as reflected in 12-step recovery literature (Alcoholics Anonymous World Services, 1981, 2001; Narcotics Anonymous World Services, 2008) and existing articles related to music therapy and spiritual needs for those with substance use disorders (e.g., Borling, 2011; Walker, 1995.)

Survey Participants

Survey participants were board-certified music therapists in the United States who work or have previous experience working in the field of addictions treatment. Email addresses of board-certified music therapists who were working in the United States at the time of this survey was provided by the Certification Board for Music Therapists (CBMT).

Procedure

E-mail invitations with a link to an anonymized survey hosted by Qualtrics ® was sent to all MT-BCs who consented to allow the CBMT to share their e-mail addresses for research
purposes. Survey invitation email can be found in Appendix C. The first three questions asked participants to confirm eligibility and affirm consent. Participants who responded “yes” to all 3 screening questions were directed to the survey. Those who responded “no” were thanked for their time and directed to the end of the survey. Music therapists who met inclusion criteria were invited to complete the rest of the survey. Five days after the survey was sent, a thank you and reminder email were sent. A final reminder email was sent 10 days after the initial link was emailed. The survey was available for completion for a total of 20 days.

**Ethics**

This study was determined to be exempt by the Human Research and Ethics Board at State University of New York at New Paltz (see Appendix D). A modification was needed for the survey invitation email. The modification was accepted and can be found in Appendix E.

**Data Analysis**

Descriptive statistics were automatically generated by Qualtrics ® in the form of frequency counts, means, and percentages.
Chapter 4

Results

In total, 9,758 Board-Certified Music Therapists were invited to complete the survey. One hundred fifty-eight emails bounced; 2 emails failed to send, reducing the number of potential respondents to 9,598. 218 invitees responded to the survey for a 2% response rate. However, 53 respondents did not complete the survey past the demographic questions. Twenty-one respondents indicated that they did not meet inclusion criteria. The final number of completed surveys was 144.

Music Therapist Demographics

Participants were asked to indicate their gender identity, age range, and race/ethnicity. The majority of respondents identified as women (83%) and chose not of Hispanic/Latino or Spanish origin in response to the question about ethnicity. Most respondents were between the ages of 25-30 (25%). Complete demographic information may be found in Table 1. Respondents from all geographic regions were represented. All respondents were board-certified music therapists.

The majority of respondents had a master’s degree in music therapy, and 83 reported completing specialized music therapy trainings. The most selected theoretical orientation was Humanistic (n=101), followed by Cognitive Behavioral (n=77) and Music-Centered (n=54).
<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Music Therapist Demographics</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Gender Identity</strong></td>
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</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Transgender</td>
</tr>
<tr>
<td>Non-binary</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Prefer not to say</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<td>31-35</td>
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<td>51-55</td>
</tr>
<tr>
<td>56-60</td>
</tr>
<tr>
<td>61-65</td>
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<td>Over 70</td>
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<td>Asian</td>
</tr>
<tr>
<td>Black or African American</td>
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<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
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<td>White</td>
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<td><strong>Hispanic/Latino/ Spanish Origin</strong></td>
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<td><strong>AMTA Region</strong> (n=141)</td>
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<td>Mid-Atlantic</td>
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<td>Mid-Western</td>
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<td>Master’s degree</td>
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<td>Humanistic</td>
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<td></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Jungian</td>
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<tr>
<td>Music-Centered</td>
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<td>Neurologic</td>
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<tr>
<td>Psychodynamic</td>
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<tr>
<td>Resource-Oriented</td>
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<tr>
<td>Transpersonal</td>
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<td>Other</td>
</tr>
</tbody>
</table>

**Credentials, Licensures, Professional Designations.**

<table>
<thead>
<tr>
<th></th>
<th># of participants</th>
<th>% of participants</th>
</tr>
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<tbody>
<tr>
<td>MT-BC</td>
<td>143</td>
<td>100</td>
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<tr>
<td>Fellow of the Association of Music and Imagery</td>
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<td>Analytic Music Therapy</td>
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<td>.006</td>
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<tr>
<td>Nordoff Robbins Music Therapy</td>
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<td>0</td>
</tr>
<tr>
<td>Vocal Psychotherapy (Austin Model)</td>
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<td>.01</td>
</tr>
<tr>
<td>Hospice/Palliative Care Music Therapist</td>
<td>5</td>
<td>.03</td>
</tr>
<tr>
<td>Neurologic Music Therapist</td>
<td>23</td>
<td>.16</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>.02</td>
</tr>
</tbody>
</table>
Clinical Practice with Individuals with Substance Use Disorders

*Number of Years Practicing Music Therapy*

Most respondents reported practicing music therapy for 6 to 12 years (25%) followed by 1 to 5 years (23%) (see Table 2). Thirty-seven percent of respondents reported working with individuals with substance use disorders for 1 to 5 years, with 31% reporting 6 to 12 years.

*Work Setting*

Inpatient facilities were the most selected work setting (n=107) followed by Intensive Outpatient Programs (n=38). Thirty-six (n=36) respondents worked in both Outpatient Facilities and Private Practice. Detoxification units were the least selected choice (n=28). Sixty-one respondents working in inpatient facilities (n=115) indicated the number of music therapy sessions clients received before discharge was greater than 5 (n=61).

*Session Format*

Group music therapy was the most popular treatment format (n=113), followed by individual music therapy (n=79). Fifteen respondents (n=15) reported working with the individual and their family. Most respondents who indicated they work in group formats (n=135) reported the average size of music therapy groups was 5-7 participants (33%) followed by 8-10 participants as average group size (32%).

*Table 2*

<table>
<thead>
<tr>
<th>Clinical Practice</th>
<th># of participants</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years Experience as a Music Therapist</strong></td>
<td>(n=141)</td>
<td></td>
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<tr>
<td>1 month to 1 year</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Age Group</td>
<td># of participants</td>
<td>% of participants</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>6 to 12 years</td>
<td>36</td>
<td>25</td>
</tr>
<tr>
<td>13 to 20 years</td>
<td>27</td>
<td>19</td>
</tr>
<tr>
<td>21 to 24 years</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>25 years or more</td>
<td>26</td>
<td>18</td>
</tr>
</tbody>
</table>

**Years Working with People with SUDs**

<table>
<thead>
<tr>
<th>Years</th>
<th># of participants</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month to 1 year</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>53</td>
<td>37</td>
</tr>
<tr>
<td>6 to 12 years</td>
<td>44</td>
<td>31</td>
</tr>
<tr>
<td>13 to 20 years</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>21 to 24 years</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>25 years or more</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

**Work Setting**

- Inpatient facility: 107
- IOP: 38
- Detoxification unit: 28
- Outpatient facility: 36
- Private practice: 36
- Other: 22

**Session Format**

- Group: 131
- Individual: 79
- Individual and family: 15
Music Therapy Methods

The second section of the survey asked respondents to identify the music therapy method (receptive, re-creative and their variations used their work with individuals in substance use treatment. All four music therapy methods were reported to be used in music therapy treatment with Receptive methods chosen most frequently. Respondents indicated which method variations they used in their work.

Receptive Methods

The most selected receptive music therapy methods were lyric analysis (n=135) and song discussion (n= 133). Music relaxation (or “music assisted relaxation”) was the third most popular method (n=129). (See Table 3).
Table 3

_Receptive Music Therapy Methods to Meet Spiritual Goals for Individuals with SUDs._

<table>
<thead>
<tr>
<th>Music Therapy Method Variations:</th>
<th># of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Receptive</em></td>
<td></td>
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<tr>
<td>Song discussion</td>
<td>133</td>
</tr>
<tr>
<td>Lyric analysis</td>
<td>135</td>
</tr>
<tr>
<td>Bonny method of guided imagery and music (BMGIM)</td>
<td>14</td>
</tr>
<tr>
<td>Unguided imaginal listening</td>
<td>43</td>
</tr>
<tr>
<td>Directed imaginal listening</td>
<td>57</td>
</tr>
<tr>
<td>Projective drawing</td>
<td>69</td>
</tr>
<tr>
<td>Projective movement</td>
<td>34</td>
</tr>
<tr>
<td>Projective writing</td>
<td>56</td>
</tr>
<tr>
<td>Physiological entrainment</td>
<td>43</td>
</tr>
<tr>
<td>Music assisted relaxation</td>
<td>129</td>
</tr>
<tr>
<td>Listening to pre-recorded music</td>
<td>121</td>
</tr>
<tr>
<td>Listening to live music</td>
<td>114</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
</tr>
</tbody>
</table>

_Recreative Methods_

Vocal recreation (n=92) and instrumental recreation (n=81) were the most popular recreative music therapy methods. This was followed by performance of pre-composed music (n=53). (See Table 4).
Table 4

Recreative Music Therapy Methods to Meet Spiritual Goals for Individuals with SUDs

<table>
<thead>
<tr>
<th>Music Therapy Method Variations: Recreative</th>
<th># of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocal recreation</td>
<td>92</td>
</tr>
<tr>
<td>Instrumental recreation</td>
<td>81</td>
</tr>
<tr>
<td>Performance of pre-composed music</td>
<td>53</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
</tr>
</tbody>
</table>

Compositional Methods

Songwriting (n=121) and song transformation (lyric substitution) (n=113) were the most popular compositional music therapy methods. This was followed by instrumental composition (n=47). (See Table 5).

Table 5

Compositional Music Therapy Methods to Meet Spiritual Goals for Individuals with SUDs

<table>
<thead>
<tr>
<th>Music Therapy Method Variations: Compositional</th>
<th># of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Songwriting</td>
<td>121</td>
</tr>
<tr>
<td>Instrumental composition</td>
<td>47</td>
</tr>
<tr>
<td>Musical Collage</td>
<td>35</td>
</tr>
<tr>
<td>Song Transformation (Lyric Substitution)</td>
<td>113</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>

Improvisational Methods

Instrumental improvisation (n=119) and therapeutic drum circles (n=111) were the most popular improvisational music therapy methods. This was followed by vocal improvisation (n=57). (See Table 6)
Table 6

*Improvisational Music Therapy Methods to Meet Spiritual Goals for Individuals with SUDs*

<table>
<thead>
<tr>
<th>Music Therapy Method Variations: Improvisational</th>
<th># of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental improvisation</td>
<td>119</td>
</tr>
<tr>
<td>Vocal improvisation</td>
<td>57</td>
</tr>
<tr>
<td>Therapeutic drum circles</td>
<td>111</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
</tbody>
</table>

**Music Therapy and Spiritual Health Goals**

The third section of the survey asked respondents to consider which spiritual health goals they address, and the music therapy methods used. Respondents were asked to select what spiritual health goals they address during music therapy sessions when treating individuals with substance use disorders.

A total of 136 respondents (94%) answered “yes” when asked if they consider spiritual health goals as a part of their work with persons with substance use disorders. Eight respondents (6%) answered “no.” Respondents were given the option to select which if any of the following spiritual health goals they address during music therapy sessions: Connection with a Higher Power, Connection with others, Cultivating sense of meaning, Achieving catharsis, Enhancing sense of wellbeing, Exploring spiritual principles as found in the 12 steps, Exploring the theme of “Letting Go,” and/or “Surrender,” Exploring meditation, Exploring prayer, and Exploring relationship with self,. Respondents were also given the option to share other spiritual health goals they addressed if one was not listed.

Spiritual health goals addressed by respondents are indicated in Figure 1. The most common spiritual health goal for meeting the spiritual needs of individuals with SUDs was
connection with others (n=131) followed by exploring relationship with self (n=128) and enhancing sense of wellbeing (n=126). Exploring prayer was the least popular spiritual health goal (n=25). (See Figure 1).

**Figure 1**

*Spiritual Health Goals Addressed by Music Therapists working with Individuals with SUD*

<table>
<thead>
<tr>
<th>Spiritual Health Goal</th>
<th># of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecting with others</td>
<td>131</td>
</tr>
<tr>
<td>Cultivating sense of meaning</td>
<td>126</td>
</tr>
<tr>
<td>Enhancing sense of wellbeing</td>
<td>82</td>
</tr>
<tr>
<td>Exploring the theme of ‘Letting Go’ and/or ‘Surrender’</td>
<td>104</td>
</tr>
<tr>
<td>Exploring prayer</td>
<td>25</td>
</tr>
<tr>
<td>Connecting with self at explored stage</td>
<td>22</td>
</tr>
</tbody>
</table>

**Music Therapy Methods Utilized to Meet Spiritual Health Goals**

Respondents identified the music therapy methods they utilize to address each listed spiritual health goal. Figures 2-11 illustrate the distribution of the popularity of each method utilized. Song discussion was the most utilized method for connection with others (n=109), enhancing sense of wellbeing (n=79) and cultivating sense of meaning (n=110). The second most popular music therapy method for connection with others was lyric analysis (n=106), followed by therapeutic drum circles (n=88).

The second most popular music therapy method for enhancing sense of wellbeing was lyric analysis (n=77), followed by Music Assisted Relaxation (n=67). The second most popular
music therapy method for cultivating sense of meaning was lyric analysis (n=101), followed by songwriting (n=81).

**Popular Music Therapy Methods to Meet Other Listed Spiritual Health Goals: Connection with a Higher Power**

The most popular music therapy method for connection with a Higher Power was song discussion (n=55). This was followed by lyric analysis (n=51), and songwriting (n=42). (See Figure 2, 2a and 2b).

**Figure 2**

*Music Therapy Methods Commonly Used to Address Connection with a Higher Power*

![Figure 2](image)

**Figure 2a**

*Music Therapy Methods Commonly Used to Address Connection with a Higher Power*
Music Therapy Methods Commonly Used to Address Connection with a Higher Power

Connection with Others

The most popular music therapy method for addressing connection with others was song discussion (n=109). This was followed by lyric analysis (n=106), and therapeutic drum circles (n=88). (See Figures 3, 3a and 3b).

Figure 3

Music Therapy Methods Commonly Used to Address Connection with Others
Figure 3a

*Music Therapy Methods Commonly Used to Address Connection with Others*

![Bar graph showing music therapy methods commonly used to address connection with others.](image)

Figure 3b

*Music Therapy Methods Commonly Used to Address Connection with Others*

![Bar graph showing music therapy methods commonly used to address connection with others.](image)
**Cultivating Sense of Meaning**

The most popular music therapy method for cultivating sense of meaning was song discussion (n=110). This was followed by lyric analysis (n=101), and songwriting (n=81). (See Figures 4, 4a and 4b).

**Figure 4**

*Music Therapy Methods Commonly Used to Address Cultivating Sense of Meaning*

![Figure 4: Music Therapy Methods Commonly Used to Address Cultivating Sense of Meaning](image)

**Figure 4a**

*Music Therapy Methods Commonly Used to Address Cultivating Sense of Meaning*

![Figure 4a: Music Therapy Methods Commonly Used to Address Cultivating Sense of Meaning](image)
Music Therapy Methods Commonly Used to Address Cultivating Sense of Meaning

**Achieving Catharsis**

The most popular music therapy method for achieving catharsis was therapeutic drum circles (n=46). This was followed by songwriting (n=42) and song discussion (n=40). (See Figure 5, 5a and 5b).

**Figure 5**

Music Therapy Methods Commonly Used to Address Achieving Catharsis
Enhancing Sense of Wellbeing

The most common music therapy method used for enhancing sense of wellbeing was song discussion (n=79). This was followed by lyric analysis (n=77), and Music Assisted Relaxation (n=67). (See Figures 6, 6a and 6b).
Figure 6

*Music Therapy Methods Commonly Used for Enhancing Sense of Wellbeing.*

![Figure 6](image)

Figure 6a

*Music Therapy Methods Commonly Used for Enhancing Sense of Wellbeing.*

![Figure 6a](image)
Exploring Spiritual Principles as Found in the 12-Steps

The most popular music therapy method for exploring spiritual principles as found in the 12-steps was song discussion (n=28). This was followed by lyric analysis (n=27), and songwriting (n=23). (See Figures 7, 7a and 7b).
Music Therapy Methods Commonly Used to Address Exploring Spiritual Principles as Found in the 12-Steps

Figure 7a

Music Therapy Methods Commonly Used to Address Exploring Spiritual Principles as Found in the 12-Steps.
**Exploring the Theme of “Letting Go” and/or “Surrender”**

The most popular music therapy method for exploring the theme of “letting go” and/or “surrender” was lyric analysis (n=51). This was followed by song discussion (n=48), and songwriting (n=32). (See Figure 8, 8a and 8b).

**Figure 8**

*Music Therapy Methods Commonly Used to Address Exploring the Theme of “Letting Go” and/or “Surrender.”*
Figure 8a

*Music Therapy Methods Commonly Used to Address Exploring the Theme of “Letting Go” and/or “Surrender.”*

![Bar chart showing the number of responses for different music therapy methods.](image)

Figure 8b

*Music Therapy Methods Commonly Used to Address Exploring the Theme of “Letting Go” and/or “Surrender.”*

![Bar chart showing the number of responses for different music therapy methods.](image)
Exploring Meditation

The most popular music therapy method for exploring meditation was Music Assisted Relaxation (n=50). This was followed by Directed Imaginal Listening (n=27). Listening to pre-recorded music and listening to live music had the same number of selections (n=26). (See Figures 9, 9a and 9b).

Figure 9

Music Therapy Methods Commonly Used to Address Exploring Meditation

![Bar chart showing the number of responses for various music therapy methods.]

Figure 9a

Music Therapy Methods Commonly Used to Address Exploring Meditation.

![Bar chart showing specific music therapy methods and their number of responses.]
Music Therapy Methods Commonly Used to Address Exploring Meditation

**Figure 10**

*Music Therapy Methods Commonly Used for Exploring Prayer.*
Figure 10a

*Music Therapy Methods Commonly Used for Exploring Prayer.*

Figure 10b

*Music Therapy Methods Commonly Used for Exploring Prayer.*
**Exploring Relationship with Self**

The most popular music therapy method for exploring relationship with self was Song Discussion (n=81). This was followed by lyric analysis (n=81), and songwriting (n=67). (See Figures 11, 11a and 11b).

**Figure 11**

*Music Therapy Methods Commonly Used to Address Exploring Relationship with Self.*

![Graph showing the popularity of various music therapy methods for exploring relationship with self.](image1)

**Figure 11a**

*Music Therapy Methods Commonly Used to Address Exploring Relationship with Self.*

![Graph showing detailed methods for exploring relationship with self.](image2)
**Perceived Efficacy**

Respondents were asked to rate their perceived efficacy of music therapy to address spiritual health needs in individuals with substance use disorders on a scale of 1 (not effective) to 5 (very effective). The average perceived efficacy was 4.19 (SD=0.81).

**Assessing Spiritual Growth**

Respondents were asked to share how they assessed spiritual growth in the people they work with (see Figure 12). The most popular way of assessing spiritual growth was novel insight shared by client(s) (n=115). This was followed by self-report of spiritual change from client (n=111). The third most popular method of assessing spiritual growth was ability to reframe an experience (n=95).
**Figure 12**

*How Music Therapists Assess Spiritual Growth in their Clients*

![Bar Chart Image](image-url)
Chapter 5

Discussion

Music therapists who work with individuals with SUDs were surveyed to learn how spiritual health needs are addressed in current clinical practice. In general, research in music therapy addictions treatment is scant. Literature is even more limited regarding clinically relevant spiritual health goals for those within this population. However, there is a substantial body of research that indicates the spiritual domain of health is often paramount to many individuals' recovery from SUDs. Moreover, music therapy literature suggests that spiritual benefits may arise from the treatment modality, though research that specifically examines such outcomes is nearly non-existent. The descriptive data collected in the survey responses illustrate a range of clinical practices to meet spiritual needs of individuals with SUDs. Moreover, survey responses are suggestive of what music therapists consider relevant to the largely subjective construct of spiritual needs.

Music Therapy Clinical Practice

Theoretical Orientations

The Humanistic approach to music therapy acknowledges each person’s unique individuality within the treatment process. Humanistic clinicians work to help individuals harness resources across all aspects of their humanity, with an emphasis on selfhood, agency, personal strengths, values, and the “here-and-now” (Abrams, 2018). The approach recognizes that while each person contains universal qualities synonymous with humanness and personhood, expressions of humanity are distinctive to the individual. Humanistic music therapy is relevant to those with SUDs, as it recognizes that though individuals with addictions may share many common traits, symptoms, and experiences, the manifestation of the disease from person to
person is heavily nuanced. Working from a Humanistic approach requires an understanding from the music therapist that everyone's recovery process will be different. Humanism was the most popular theoretical orientation selected by music therapists working in the treatment of SUDs (n=101).

Silverman (2007) conducted a survey study to evaluate trends of music therapy practices in psychiatric health care. Music therapy in the treatment of SUDs was included under mental health populations. The researcher found that the Behavioral orientation was the most popular among survey respondents, which contrasts with the findings of this study. For the current study, the Behavioral orientation was the third least popular among survey respondents (n=25).

Behaviorism posits that maladaptive behaviors can be studied and replaced with new, healthier behaviors (Skinner, 1938). Music therapists working from a Behavioral orientation utilize music as a stimulus for modifying behaviors based on the ideas of reinforcement principles (Madsen et al., 1968). The Behaviorist approach for music therapy to treat SUDs might involve identifying behaviors associated with one’s addiction patterns, with music as the impetus to correct maladaptive habits.

Perhaps this potential shift from Behavioral to Humanistic orientations is indicative of how music therapists are currently viewing their role as professionals who work in the field of SUDs. To practice in an integral manner, the music therapist must assess what it is that their clients need from the treatment modality and its use of music in the therapeutic process to meet their unique needs. The holistic, person-centered approach of Humanism realizes that the diagnosis of pathologies such as SUDs do not tell the whole story of the person-in-therapy. Further, to assess music therapy’s efficacy solely based on supposed measured behavioral changes does not consider the multitude of other factors beneath the surface of addictions. It may
be that Humanistic practice can encourage clients to search inside themselves for what their recovery means to them, the changes they want to implore, the obstacles for actualizing such changes, and their individual strengths as resources for a renewed life in sobriety.

The differing results between these two studies, close to 20 years apart, may indicate a paradigm-shift in theoretical orientation among music therapists who work in mental health populations such as addictions. However, more research is needed to ascertain if the shift is replicable for music therapy in mental health care as a whole, as this study only sought to understand music therapy trends in addictions treatment.

**Music Therapy Treatment**

**Treatment Setting**

Inpatient facilities were the most common treatment setting. Detoxification units were the least commonly selected treatment setting. This contrasts with the findings of the most recent Cochrane Review by Ghetti et al. (2022) in which 15 out of 21 studies that met inclusion criteria took place in short-term detoxification units. Only 2 studies took place in inpatient facilities (Ghetti et al., 2022). Furthermore, the results of their systematic review were conducted mostly by one researcher at a single setting. This necessitates further research to examine music therapy practices and efficacy in inpatient facilities.

**Treatment Format**

Group music therapy was the most prominent treatment format (n=131). This might be due to the nature of institutions which treat persons with SUDs, as group therapy is one of the most common approaches for addiction treatment centers (SAMSHA, 2021). Several studies illustrate how group therapy might be indicated because of its advantages for individuals with
SUDs, such as providing social support, decreasing stigma, and practicing recovery-based coping strategies (Brown & Yalom, 1977; Wendt & Gone, 2017).

In terms of spiritual health needs, several spiritual principles are parallel to Yalom and Lescze’s (2008) therapeutic factors in group psychotherapy. Therapeutic group work can help to instill hope, explore themes of altruism, universality, and catharsis (Yalom & Lescze, 2008). Lastly, therapy groups can help to alleviate the sense of isolation that many individuals with SUDs experience in and out of active addiction (SAMSHA, 2021). That said, 79 participants indicated working in individual formats, with very few indicating that they work with clients and their families (n=15).

**Number of Sessions Before Discharge**

The findings of Ghetti et al. (2022) suggest that music therapy was most effective when individuals with SUDs received more than a single session. The majority of respondents indicated that patients in inpatient facilities received greater than 5 music therapy sessions before discharge (n=61). This suggests that SUD patients might currently receive the surmised benefits of music therapy, as only 21 respondents indicated that individuals received 1-3 sessions. Future studies might want to inquire to see how many patients with SUDs only obtain “one-and-done” music therapy sessions. Music therapists should continue to advocate for greater access to music therapy sessions wherever possible.

**Music Therapy Practice and Spiritual Health**

**Spiritual Health Goals**

Music therapists were asked to select what spiritual health goals they addressed in their practice. The writer worked with his thesis chair and two additional experts who practice music therapy with individuals with SUDs to refine and form goals considered relevant to spiritual
health for this population. The dataset was analyzed to learn more about the most popular spiritual health goals addressed by music therapists in addictions treatment based on the results of this survey study.

The most selected spiritual health goal of “connection with others” (n=131) speaks to what music therapists consider to be of most importance in terms of their work for addressing spiritual health needs in those with SUDs. This seems to relate to group music therapy being the most common session format. The spiritual principle of “connection with others” is often considered pertinent to recovery, which is a central factor to 12-step meetings, in which individuals with common addiction disorders congregate to share their experience in support of one another.

A study often considered quintessential to the understanding of addictions, colloquially referred to as “Rat Park,” was conducted by Alexander et al. (1978). To examine the relationship between isolation and morphine consumption, rats were placed in both isolated and integrated cages, in which conditions where both water and morphine were available. The researchers found that isolated rats consumed more morphine on both days where water and morphine were available. The researchers posed that the explanation for increased morphine consumption in the isolated rats was to provide relief from social isolation (Alexander et al., 1978). Subjects who were placed in community with fellow rats consumed significantly less morphine. In other words, “connection with others” helped to decrease drug consumption in the rats.

Though a study of this kind has not been replicated with human subjects, 12-step mutual help organizations provide individuals with SUDs outlets for connection with others via social networks. Programs like AA/NA’s provision of social networks are one of many empirically supported mechanisms which are suggestive of benefits to recovery from SUDs (Kelly, 2022).
Importantly, 2nd to “connection with others” was "exploring relationship with self.” This suggests that respondents recognized the clinical indication of both interpersonal and intrapersonal connection for those with SUDs. Low self-esteem has been suggested to be related to individual tendencies towards addiction and substance abuse (Alavi, 2011). Moreover, individuals with SUDs often derive sense of self and identity through their using and substance of choice. There is often a “mourning” stage as the recovering individual grieves their loss of identity as a substance user (Dingle et al., 2015), hence the need for exploring and reconstructing the individual’s relationship with themselves.

As the individual detoxes through the bio-physical, entering the psycho-emotional/spiritual stages of recovery (Borling, 2011), the clinical need for examining the person’s relationship with themselves becomes an important aspect of recovery. Further, novel insight into the self can lead to a deeper understanding of not only the underpinnings which propelled the addictive cycle of substance abuse, but also a person’s sense of identity, values, aspirations, and what it is that they are seeking to achieve in their lives. Music therapy as an experiential treatment modality can afford individuals in recovery not only opportunities to practice being in connection with others, but also to “reconnect with their mind, body and spirit” (Murphy, 2013, p. 365).

A secondary analysis of a randomized control trial was conducted for individuals with opiate use disorders (OUDs), comparing the effects of two FDA-approved medications on opioid abstinence (Harvey et al., 2020). Individuals receiving OUD medications during the 24-week trial could also attend 12-step meetings and were offered both individual and group therapy. The secondary analysis found a significant interaction between individual counseling and 12-step meeting participation (Harvey et al., 2020). Increased hours of 12-step meeting attendance
combined with increased hours of individual therapy predicted greater abstinence outcomes for participants at the trial’s conclusion (Harvey et al., 2020).

The findings of Harvey and colleagues (2020) parallel the most popular spiritual goals of connection with others and exploring relationship with the self, found in this current study. While one-to-one counseling works to assist people to explore the dimensions of the self, how these influence tendencies towards substance abuse, and the development of strategies for individual recovery, 12-step meeting attendance provides people with avenues of connection with others via social networks. The significance of Harvey et al.’s (2020) results which support the combination of individualized therapy and 12-step participation mirror the findings of this study, which suggest that music therapists working in the treatment of SUDs place great value in working to cultivate connection with others and exploring relationship with oneself.

Enhancing a sense of wellbeing yielded the third most responses (n=126). Wellbeing has recently been defined as “the state of being healthy, happy, or prosperous; physical, psychological or moral welfare” (Oxford English Dictionary, 2023). The resulting feelings from prolonged substance abuse can lead to what Borling (2011) characterizes as “emotional remoteness, chronic negativity, despair, depression or a sense of being fragmented” (p. 60). The consequences mentioned above among others can lead to a damaged sense of well-being for individuals with SUDs. Such feelings can be sustained through early stages of recovery, in which the individual is still acclimating to sobriety. Music therapist respondents of this survey seem to agree that helping enhance well-being in their clients was important to their clinical work.

Close in popularity to the goal of “enhancing sense of wellbeing” was “cultivating sense of meaning” (n=121). Author Cornell West likens alcoholism to nihilism, both as “diseases of the soul” (West, 1993, p. 76). West (1993) writes:
“it (alcoholism) can never be completely cured, and there is always the possibility for relapse. But there is always a chance for conversion—a chance for people to believe that there is hope for the future, and a meaning to struggle” (p.76).

The disease of addiction can permeate into all aspects of a person’s life. As it spirals into increased patterns of reaping harm, the satisfaction and maintenance of substance abuse becomes the sole purpose and meaning for the afflicted individual. When one enters a life of sobriety, they must find new meaning in their lives as they work to understand past experiences, their true selves, as well as obtaining a sense of hope for the future. Thus, the clinical need for music therapists to consider ways to use music to help foster experiences into the spiritual domain of cultivating meaning in one’s life.

Noteworthy findings for selected spiritual health goals were the lack of responses for “exploring spiritual principles as found in the 12 steps” (n=54), as it was the second least selected spiritual goal. This suggests that many respondents may not directly align or apply 12-step work into their clinical practice for people with SUDs. That said, the top two spiritual health goals can be understood from a 12-step lens. For instance, “connection with others” is paramount to 12-step foundations. This can be analyzed in terms of the principle of service, as expressed in Step-12. In the chapter “Working with Others,” Bill W. writes:

“Life will take on new meaning. To watch people recover, to see them help others, to watch loneliness vanish, to see a fellowship grow up about you, to have a host of friends—this is an experience you must not miss. Frequent contact with newcomers and with each other is the bright spot of our lives” (Alcoholics Anonymous World Services, 2001, p. 89).
Underlying the 12-steps and meeting attendance are the principles of connecting with and helping others to achieve sobriety.

Cultivating sense of meaning by helping individuals who are still suffering from active addiction is suggested to be important for many in recovery from SUDs (Galanter et al., 2013b; Kelly, 2022). Therefore, though clinicians might not be directly informed or prioritize principles as found in the 12 steps in their music therapy practice, many spiritual goals including connection with others/the self and cultivating sense of meaning are in fact related to 12-step philosophies.

Respondents were invited to add additional comments across several questions. For instance, participants were able to provide additional spiritual health goals and music therapy methods as “other (please specify)” if a desired response was not listed. The last question of the survey invited respondents to share any other information about their work around spiritual needs for individuals with SUDs. These responses provide some insight into the subjective nature of spiritual constructs. For instance, one respondent noted that they

“strongly disagree that ‘connection with others’ is a spiritual goal.”

This speaks to the fact that though spirituality is generally understood through a broad spectrum of terms and practices, there is not a unified consensus on what is and what is not deemed spiritual. For instance, though exploring relationship with self was listed, some individuals chose to share more specific expressions of the goal, such as

“exploring self identity and self esteem.”
One respondent shared that:

“the term "Spiritual" is not often used in my sessions. These spiritual concepts we use and discuss but defining them as "spiritual" has a bit of a religious connotation, even though spirituality and religion are not synonymous.”

This might explain why the spiritual goal of “exploring prayer” was the least popular. Perhaps prayer is too closely associated with religion, which might create boundaries and resistance to treatment for individuals with pre-conceived ideas or adverse experiences related to religiousness. Though the 12-step program is one of spirituality and not religion, it might be difficult for patients to distinguish and separate between the two constructs as it relates to their recovery. One respondent shared:

I do not always have "meeting spiritual needs" as a defined goal for my clients, but that spiritual needs may become met in a reflexive group or individual music therapy session/experience because the experience assists the client to be more open and allowing for it to occur. If there has a been resistance our difficulty aligning with a Higher Power or connecting to surrender, music experiences can foster that connection and relationship.”

Therefore, it seems that clinicians at times might feel the need to cater their treatment in a way that is void of the term “spiritual” to prevent resistance. Some have voiced that addressing goals using any language related to spiritualism is out the scope of practice for music therapists, while others embrace it as an important clinical concept. Though the difficulty to reach a consensus as to what is and what is not considered in the scope of “spiritual health needs,” the results of this survey indicate that there is at least some common understanding behind the facets
of clinically indicated health goals related to spirituality in persons with SUDs, even if some might choose to not frame them under the umbrella of “spiritual needs.”

**Music Therapy Methods to Meet Spiritual Health Goals**

Lyric analysis was the most utilized music therapy method to meet spiritual health goals for individuals with SUDs, followed by song discussion. This is consistent with Murphy’s (2017) systematic review of the literature for music therapy in addictions treatments in which lyric analysis was the most common method across 12 studies. However, song discussion was more popular for addressing individual spiritual health goals. As per Bruscia’s (2014) definition of the methods, the two were distinguished in the survey questionnaire for how the lyrics of the selected song are utilized (see Appendix B). In lyric analysis, the therapist helps the individual(s) to analyze the lyrical content of a song as the basis for a discussion of relevant therapeutic issues (Bruscia, 2014). Song discussion offers a broader experience, in which various elements of a song including, but not limited to, lyrics and musical qualities (tempi, instrumentation, arrangement, etc.) are utilized as a springboard for a discussion of relevant clinical themes (Bruscia, 2014).

The popularity of these receptive methods for addressing spiritual health needs could be due to several factors. One possible reason might be related to the efficiency of utilizing these therapeutic music experiences, particularly in group settings. There is an abundance of songs that speak to the experiences of addiction, connection, and other related themes. When working in groups, music therapists can facilitate a song discussion or lyric analysis surrounding spiritual themes within the context of a single session. These music experiences can offer group members with opportunities to collectively explore, connect and bond over therapeutically salient subject matter contained in a song.
Additionally, perhaps the receptive methods of song discussion and lyric analysis could be perceived by clients as less threatening or invasive than music experiences which invite participants to engage in active musicking (i.e., improvisational and/or recreative methods). Music therapists might be aware of the potential for resistance from their clients when being asked to participate in music experiences which might be looked upon as more taxing or “high risk.” Hence the popularity for offering song discussions and lyric analysis, as the client’s involvement with the experience is limited to listening to, interpreting, and discussing a song.

Noteworthy is that the two most popular methods (song discussion and lyric analysis) were not exclusive to the 2nd most popular spiritual goal of “exploring relationship with self.” Instead, lyric analysis was used more to address the goal of “cultivate sense of meaning” than “exploring relationship with self.” Song discussion yielded similar results, in which “exploring relationship with the self” was the 3rd most addressed goal, behind “cultivating sense of meaning” and “connection with others.”

A possible explanation for such findings might also be related to group music therapy being the most commonly used treatment format. Music therapists might be striving to address goals related to connection with others and meaning-making as they are more conducive to treating group-as-a-whole needs, rather than the personal nature of relationship with the self. This of course is speculation, as it not possible to say what treatment format each method was used in most based on the current data and survey structure.

The third most popular method was songwriting, a compositional method. Notably, songwriting was the most used method for addressing the least popular spiritual health goal of “exploring prayer,” though not by much (n=14). Music therapists engaging individuals in a songwriting experience can help the person to express themselves and salient topics related to
their recovery. Perhaps therapeutic songwriting is being practiced by music therapists to address the spiritual practice of prayer as it is brought up as a need that the client wishes to explore. Working with individuals to write a song that expresses their relationship with prayer can help them to explore a spiritual practice that is of value to their recovery. There also seems to be a potential for songwriting to help individuals to reframe their experience of prayer, as the musical accompaniment and structure may provide a container to safely explore what the practice means for them, their relationship with a Higher Power, and their recovery.

As stated earlier, lyric analysis, song discussion, and songwriting were the most popular methods across most spiritual health goals. A music therapy method to significantly exceed lyric analysis and song discussion in number of responses for a single spiritual goal was Music Assisted Relaxation. The method was most used to “explore meditation” (n=50). Music Assisted Relaxation (or Music Relaxation) is a method in which music listening is used “to reduce stress and tension, to reduce or counter-condition anxiety, to induce body relaxation, or to facilitate entry into altered states of consciousness” (Bruscia, 2014, p. 136).

Studies from the past decade which examine Music Assisted Relaxation found that the method was effective in assisting initiation of mechanical ventilation for Motor Neuron Disease patients (Tamplin et al., 2017), decrease pain in pediatric patients (Scheufler et al., 2021) and patients in a hospital emergency department (Mandel et al., 2019), and decrease depression symptoms, (Tang et al., 2020), to name a few. None of these studies mentioned the method to be used to address the exploration of meditation. Moreover, there are no studies to date which specifically examine the method with persons with SUDs.

Nevertheless, meditation might be an important aspect of addictions recovery. Not only is meditation mentioned in Step 11 (Alcoholics Anonymous World Services, 2001), several studies
support that meditation might provide health benefits for individuals in addictions recovery such as strengthened autonomic regulation in persons with opiate dependence (Garland et al., 2020), greater rates of abstinence amongst adults with alcohol use disorder (AUD) (Gryczynski et al., 2018) and decreased drug use for women offenders at a residential treatment facility (Witkiewitz et al., 2014). This warrants further examination for music therapy practices to address meditation as a resource for individuals in recovery from SUDs.

Though 14 respondents indicated that they use the Bonny Method of Guided Imagery and Music (BMGIM), with a total of 83 responses as a method to meet all possible spiritual health goals, only 3 participants indicated that they hold the Fellow of the Association of Music and Imagery (FAMI) licensure. BMGIM is a comprehensive imaginal listening method, with several contraindications and potentials for harm if proper training is not received. To ethically practice BMGIM, board-certified music therapists must complete three levels of post-masters training to receive the professional designation “Fellow of the Association of Music and Imagery” (FAMI). The discrepancy between respondents who indicate utilizing the method and those who specified that they obtained appropriate credentials suggests that there might be a lack of understanding as to the specifics of BMGIM versus other imaginal listening methods such as directed and unguided imagery, which do not require advanced certification.

**Assessing Spiritual Growth**

Music therapists seem to mostly assess spiritual growth based on “novel insight shared by their clients” (n=115) as well as “self-report of spiritual growth from the client(s)” themselves (n=111). In other words, the results of this study support the notion that growth in the spiritual domain is assessed mainly by verbal insight shared by the client. It is unclear how much time might have lapsed over music therapy treatment in which such verbal reports and insights can be
received. The results suggest that music therapy might be effective to help clients with SUDs access parts of themselves in which they can verbalize a salient response in the context of the therapeutic space that are deemed as evidence for spiritual growth by the music therapist. Moreover, the treatment modality can help clients have such profound experiences in which they can express how they have progressed spiritually or have had a spiritual experience.

The most common instances of assessed spiritual growth are indicative of what Bruscia (2014) refers to as a “supportive” health change, in which “the changes in therapy give the client the support system and insight needed to fight or live with a health condition” (p. 192). “Recovery” from a SUD differs from other diseases, in that sustained remission is contingent on daily, lifelong maintenance. Relapse is possible, yet spiritual growth might be a helpful means to arrest the disease. The results of this study suggest that assessed spiritual growth and/or change that music therapy might be capable of affecting is related to the insight and self-awareness that the modality elicits in the individuals receiving treatment.

Participant comments expand upon self-reports and novel insights shared related to spiritual progress:

Reported changes in behavior; reports of more empathy/self-empathy and compassion/self-compassion.

Notable change in how they relate with others, how they seem to inhabit their bodies.

Self report of decrease in urges to use or using.

Maturity embodied through accountability without blaming.

It is noteworthy that the least selected option for assessing spiritual growth was “change in musical behavior via music therapy methods” (n=52). Bruscia (2014) proposes that “a musical change that a client makes is probably indicative of a nonmusical change of some kind” (p. 191).
The dataset suggests that though change in patient musicking might be indicative of assessable spiritual growth, it is not as readily available as verbal statements from individuals with SUDs who receive music therapy. Perhaps the challenge of interpreting spiritual growth through musical expressivity is too difficult because of the inability to measure subjective spirituality via music in an objective manner.

Participants shared concerns through text responses about whether spiritual health goals were in the scope of music therapy practice, and if it is the music therapist’s place to assess spiritual growth. Some respondents noted precautions that they take to mitigate harm when attempting to bring focus to spiritual topics. Certain response iterated that the proposed addressing of spiritual goals might be contraindicated for 1) individuals with religious trauma and 2) individuals with psychoses and/or psychotic disorders. Responses which addressed the former clinical consideration discussed how delineating between spirituality and religion was crucial for clients with religious trauma. One individual explained that they found it necessary to address spiritual topics in a manner that was divorced from the 12-steps due to the language used in the literature:

_I found it was easier to address spirituality aside from the 12 steps, as the 12 steps do mention "God," which, despite this meaning any Higher Power, can lead to resistance from clients. I focused on various types of spirituality, including finding one's spirituality from nature or from anything greater than them, and combined this with SMART Recovery for clients with religious trauma._

It is important to take into the account the sentiment expressed by such respondents, in that critical assessment is needed to understand the contraindications for addressing spiritual needs with clients who might have a personal history in which they are unable to move past the
spiritual language utilized in 12-step recovery models. Music therapists may need to find ways to explore spiritual concepts that are relevant to recovery from SUDs whilst finding ways to carefully approach goals which veer towards concepts that the individual might be resistant to (i.e., the concept of a Higher Power).

**Perceived Efficacy**

The majority of respondents found that music therapy was effective in meeting spiritual health goals of individuals with SUDs. The dataset suggests music therapy is perceived as most effective for improving and exploring connection with others and the self, cultivating sense of meaning and enhancing well-being.

**Limitations**

The main limitation of this study was its low response rate, with only 218 responses out of the 9,758 survey invitations sent. After the 22 respondents who did not meet inclusion criteria and the 53 respondents who did not complete the survey were deleted from the data set, only 144 finished the entire survey after initial emails and reminder messages were sent. This could be attributed to survey fatigue in that a surplus of thesis surveys are sent during the early part of the year. Additionally, there might not be many music therapists working in the treatment of SUDs. The 2020 AMTA Workforce Analysis found that 160 music therapist respondents indicated working in the treatment of SUDs (American Music Therapy Association [AMTA], 2020). That said, not all music therapists are members of the AMTA, so it is nearly impossible to get a correct gauge for the number of music therapists working with this population.

The survey being 25 questions might have further contributed to survey fatigue and high number of incomplete responses. Furthermore, the matrix question (question 21) had 10 possible spiritual goals, and 25 possible music therapy methods, which might have been difficult to
navigate for some, contributing to incomplete responses and/or miss-clicks. These factors could have led to discrepancies in the results.

Several survey respondents indicated that addressing spiritual health needs in their clients with SUDs is contraindicated due to potential harm, notably for individuals with psychoses and religious trauma. A limitation of this study is that no questions related to how music therapist’s address and mitigate potential harm when working in the spiritual health domain.

In the United States, there is not a unified taxonomy for music therapy methods. Bruscia (2014) provides a comprehensive list of commonly used music therapy methods and their definitions. Though this list is popular among many practicing clinicians, music therapists in different AMTA regions might refer to the methods they use in contrasting ways. Even though Bruscia’s (2014) definitions were provided for each music therapy method in the survey, it is possible that a lack of understanding or differences in perspectives on therapeutic music experiences might have led to inadvertent bias or inconsistencies in participant responses.

**Future Research**

The results of this study illustrate the myriad applications of music therapy for meeting the spiritual needs of individuals with SUDs. The literature for music therapy in the treatment of SUDs is still scant, with limited inquiry related to the spiritual health domain. Results indicate that “connection with others” and “exploring relationship with self” were the most prominent spiritual goals addressed by music therapists, with song discussion and lyric analysis as the most popular methods. Future research should examine the application of the above methods to meet such goals for people with SUDs.

Individuals in recovery would benefit from a wider range of experiences to meet spiritual health needs. The potential for innovative uses of music and the therapeutic application of the
medium are boundless. One of music therapy’s greatest strengths as an experiential form of treatment is that the clinician can construct meaningful, creative, and remarkably unique experiences to channel the diverse elements of music in such a way that provides their clients with opportunities to meet a multitude of health needs. The results from this study can serve as a call for music therapists to consider how they can employ a greater variety of therapeutic music experiences to address spiritual health goals for those in recovery from SUDs. Future research related to this topic might help to inspire music therapists to investigate the possibilities for expanding upon the offerings of methods.

The most common treatment setting was inpatient settings. Ghetti et al. (2022) found detoxification units to be the most common setting for the studies included in their systematic review. The results of this study necessitate further research for music therapy in addictions treatment within inpatient settings. Quantitative research will help to inform future practice of music therapists who treat people with SUDs within inpatient facilities.

Music Assisted Relaxation, a receptive music therapy method, was found to be a popular intervention for exploring meditation for individuals with SUDs. The current literature does not inquire on how this method can be used for meditative work for individuals within this population. Music therapists should consult the current literature that examines the efficacy of Music Assisted Relaxation amongst several populations. Furthermore, significant research is needed to support the usage of this method to address the method for people with SUDs.

Several respondents described the need to mitigate potential harm when attempting to address spiritual health needs of individuals with SUDs and psychoses, as well as SUDs co-occurring with religious trauma. Future inquiry is needed to understand how clinicians can address possible harms when addressing spiritual goals for individuals with co-occurring issues
that could pose risks for harm. The indications and contraindications of using music therapy methods for individuals with SUDs needs more research, particularly when seeking to meet spiritual needs.

**Conclusion**

Music therapists reported using a variety of music therapy methods to meet relevant spiritual health needs of persons with SUDs. Most respondents reported working from a Humanistic theoretical orientation. Lyric analysis and song discussion were reported to be useful in addressing salient spiritual health goals such as “connection with others,” “exploring relationship with self,” and “enhancing sense of wellbeing.” The compositional music therapy method of songwriting was also commonly used to address popular spiritual goals. Further research is needed to support and demonstrate the efficacy of these popular music therapy methods to meet the spiritual health needs clinicians reported addressing in their practice. The field would benefit from a wider variety of methods to meet spiritual health needs for this population. Spiritual growth is mostly assessed by novel insight and self-reports of spiritual change from the clients themselves. This study provides music therapists and related health professionals with an idea of current trends in music therapy for meeting spiritual needs of individuals with SUDs.
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https://doi.org/10.47513/mmd.v9i1.521


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*Journal of Music Therapy, 5*(3), 69-71. https://doi.org/10.1093/jmt/5.3.69


https://doi.org/10.47513/mmd.v9i1.560


https://store.samhsa.gov/sites/default/files/pep20-02-01-020.pdf


https://doi.org/10.1371/journal.pone.0240862


Appendix A: The 12 Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

(Alcoholics Anonymous World Services, 2001)
Appendix B: Consent Statement and Survey Questions

1. Informed Consent Statement

Title of Research Study: Music Therapy for Treating Spiritual Health Needs of People with Substance Use Disorders: A Survey Study

Principle Investigator: Jonah Pomerantz, Graduate Music Therapy Student, State University of New York at New Paltz, pomeranj2@newpaltz.edu

Faculty Advisor: Dr. Kathleen M. Murphy, Program Director Music Therapy Graduate Studies, State University of New York at New Paltz, murphyk@newpaltz.edu

You are being asked to participate in a research study for the investigator’s master's thesis. Your participation in this research study is voluntary and you do not have to participate. You are receiving this survey invitation as a board-certified music therapist who has consented to allow the Certification Board for Music Therapists, Inc, to share your e-mail for research purposes.

This survey is asking for participation from music therapists who work in or have experience working in the treatment of substance use disorders. If you participate in this study, you will be asked to complete a survey with questions pertaining to the types of music therapy methods you use to meet the spiritual health needs of individuals with substance use disorders. Additionally, demographic and clinical practice questions are included. The survey should take approximately 15 minutes to complete.

Your participation involves no foreseeable risks outside of activities of daily living or filling out a computer-based form. You do not have to answer any questions that make you uncomfortable, and you may stop at any time.

You will not benefit directly from participation, but we hope to learn more about how music therapists address spiritual health needs for individuals with substance use disorders. Your participation will help inform the practice of music therapists and researchers in the future. Furthermore, a hope for this study is that it will inspire music therapists to contribute research on music therapy and spiritual health needs for individuals with substance use disorders.

We will protect your information and make every effort to keep your personal information confidential, but we cannot guarantee absolute confidentiality. No information which could identify you will be shared in publications or presentations of this study. Your answers will be automatically anonymized via Qualtrics.

If you have any questions about this project or your participation, please feel free to contact the principle investigator, Jonah Pomerantz (pomeranj2@newpaltz.edu) or his faculty advisor, Kathleen Murphy, PhD, LCAT, MT-BC (murphyk@newpaltz.edu) at any time.

The SUNY New Paltz Human Research Ethics Board has determined that this study is minimal risk and is exempt from full HREB oversight.
Please take all the time you need to decide whether you would like to participate in this research study. If you decide to participate, your completion of the research procedures will indicate your consent.

This research is only for U.S. residents over the age of 18.

De-identified data from this study may be shared with the research community at large to advance science and health. We will remove or code any personal information that could identify you before files are shared with other researchers to ensure that, by current scientific standards and known methods, no one will be able to identify you from the information we share. Despite these measures, we cannot guarantee the anonymity of your personal data.

Before you begin, please note that the data you provide may be collected and used by Qualtrics as per its privacy agreement. Please be mindful to respond in a private setting and through a secured Internet connection for your privacy. Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

I understand that my responses to survey questions will be collected via the anonymized version of Qualtrics. The researcher will not be able to assign responses to a specific participant. Peer reviewed journals are beginning to ask researchers to upload data into data repositories. Collected survey responses may be uploaded into a data repository as an aggregate; should a peer reviewed journal require data to be uploaded. Individual responses will not be shared. Before agreeing to share aggregate survey data, the researcher will review the security measures of the data repository to ensure it meets federal and state data security laws and regulations.

By responding to this survey, I understand that aggregate survey results may be uploaded to a shared data repository.

Thank you in advance for your input, as it is very much valued and appreciated.

- Agree
- Disagree (if respondent disagreed the survey ended).

Inclusion Criteria

1a) Are you a Board-Certified Music Therapist

- Yes
- No (if the respondent answers no, they will be thanked, and the survey will end)
1b) Do you work within the United States,
   - Yes
   - No (if the respondent answers no, they will be thanked, and the survey will end)

1c) Do you currently work with or have experience working with individuals with substance use disorders.
   - Yes
   - No (if the respondent answers no, they will be thanked, and the survey will end)

1d) Do you understand you can end this survey at any time?
   - Yes
   - No (if the respondent answers no, they will be thanked, and the survey will end)

**Demographics**
2. What is your age?
   - 18-24
   - 25-30
   - 31-35
   - 36-40
   - 41-45
   - 46-50
   - 51-55
   - 56-60
   - 61-65
   - 66-70
   - Over 70
• I prefer not to say

3. What is your gender identity?

• Female
• Male
• Transgender
• Non-binary
• Other
• I prefer not to say

4. How would you best describe yourself? You can select all that apply.

• American Indian or Alaska Native
• Asian
• Black or African American
• Native Hawaiian or Other Pacific Islander
• White
• I prefer not to say

5. Are you of Hispanic/Latino/Spanish origin?

• Yes
• No

6. In what geographical region of the American Music Therapy Association (AMTA) do you practice?

• Great Lakes (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)
• Mid-Atlantic (Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Virginia, West Virginia)
• Mid-Western (Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Wyoming)
• New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)
• Southeastern (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Puerto Rico, US Virgin Islands)
• Southwestern (New Mexico, Oklahoma, Texas)
• Western (Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah, Washington, Guam, American Samoa, Mariana Islands)

7. What is your highest level of education?
   • Bachelor’s Degree in music therapy or related field (please specify):
   • Master’s Degree in music therapy or related field (please specify):
   • Doctoral Degree in music therapy or related field (please specify):

8. Which of the following credentials/licenses/professional designations do you hold? Check all that apply
   • Music Therapist-Board Certified
   • Fellow of the Association of Music and Imagery
   • Analytical Music Therapist
   • Nordoff Robbins Music Therapist
   • Vocal Psychotherapy (Austin Model)
   • NICU Music Therapist
• Hospice/Palliative Care Music Therapist
• Neurological Music Therapist
• Other (please specify):

Clinical Practice

9. How long have you been a practicing music therapist?

• 1 month to 1 year
• 1 to 5 years
• 6 to 12 years
• 13 to 20 years
• 21 to 24 years
• 25 years or more (please specify):

10. How long have you been working with people with substance use disorders?

• 1 month to 1 year
• 1 to 5 years
• 6 to 12 years
• 13 to 20 years
• 21 to 24 years
• 25 years or more (please specify):

11. What is your work setting? Select all that apply

• Inpatient facility
• Intensive outpatient program (IOP)
• Detoxification unit
• Outpatient facility
• Private practice
• Other (please specify):

12. What is the format of your music therapy sessions?
• Group
• Individual
• Group and individual
• Individual and their family

13. What is the average size of your music therapy groups?
• 1-3 participants
• 3-5 participants
• 5-7 participants
• More than 10 participants
• Not applicable

14. If you work in inpatient facilities, what is the average number of music therapy sessions clients receive before discharge (for both group and individual settings)?
• 1-3 sessions
• 3-5 sessions
• Greater than 5 sessions
• Not applicable

15. What is your primary theoretical orientation?
• Behavioral
• Cognitive Behavioral
• Feminist
• Humanistic
• Jungian
• Music-centered
• Neurologic
• Psychodynamic
• Resource Oriented
• Transpersonal
• Other (please specify):

16. What receptive music therapy methods (where the client is listening to live or pre-recorded music) do you use in your sessions? Check all that apply:

• Song Discussion (using a song and its various elements such as lyrics, musical qualities, feelings behind song, etc. as the basis for a discussion of relevant therapeutic issues).
• Lyric analysis (analyzing the lyrical content of a song as the basis for a discussion of relevant therapeutic issues).
• Bonny Method of Guided Imagery in Music (BMGIM).
• Unguided Imaginal Listening (individual generates imagery in response to the music, no imagery script provided by therapist).
• Directed Imaginal Listening (individual generates imagery in response to the music with imagery script provided by therapist).
• Projective writing (individual expresses thoughts, feelings, and images that are stimulated by music through writing). (Bruscia, 2014).
• Projective movement (individual expresses thoughts, feelings, and images that are stimulated by music through movement). (Bruscia, 2014).

• Projective drawing (individual expresses thoughts, feelings, and images that are stimulated by music through drawing). (Bruscia, 2014).

• Physiological Entrainment (using various elements of music, vibrations and sounds to establish synchronicity in bodily responses) (Bruscia 2014).

• Music Relaxation (listening to music to reduce stress, tension, anxiety, facilitate relaxation, or to induce individual into a non-ordinary state of consciousness) (Bruscia, 2014).

• Listening to pre-recorded music.

• Listening to live music.

• Other (please specify):

17. What Recreational music therapy methods (where the client is vocally or instrumentally recreating pre-composed music) do you use in your sessions? Check all that apply:

• Vocal Recreation (the client recreates a pre-composed piece of music vocally to address relevant therapeutic goals/issues) (Bruscia, 2014)

• Instrumental Recreation (the client recreates a pre-composed piece of music instrumentally to address relevant therapeutic goals/issues) (Bruscia, 2014)

• Performance of pre-composed music

• Other (please specify):

18. What compositional music therapy methods (where the client is composing music) do you use in your sessions? Check all that apply

• Songwriting
• Instrumental Composition

• Musical Collage (the therapist helps the client select and sequence sounds, songs, and music to produce a new recording that explores relevant therapeutic issues) (Bruscia, 2014)

• Song Transformation (Lyric substitution)

• Other (please specify):

19. What Improvisational music therapy methods (where the client is improvising music) do you use in your sessions? check all that apply

• Instrumental improvisation

• Vocal improvisation

• Therapeutic drum circles

• Other (please specify):

20. Do you consider spiritual health needs as a part of your work with people with substance use disorders?

• Yes

• No

21. What spiritual goals do you address when working with individuals with substance use disorders? Check all that apply:

• Connection with a Higher Power

• Connection with others

• Cultivating sense of meaning

• Achieving catharsis

• Enhancing sense of wellbeing
• Exploring spiritual principles as found in the 12 steps
• Exploring the theme of “Letting Go” and/or “Surrender”
• Exploring meditation
• Exploring prayer
• Exploring relationship with Self
• Other (please specify):

22. Please indicate which music therapy methods you use to address each identified spiritual goal (see next page):
23. How effective do you perceive music therapy with substance use disorder patients for meeting spiritual health needs?

- -1- not effective
- -2
- -3- somewhat effective

<table>
<thead>
<tr>
<th>Spiritual Goals: (row)</th>
<th>Connection with a Higher Power</th>
<th>Connection with others</th>
<th>Cultivating sense of meaning</th>
<th>Achieving catharsis</th>
<th>Exploring spiritual principles as found in the 12 steps</th>
<th>Exploring relationship with self</th>
<th>Exploring the theme of “sitting go” and/or “surrender”</th>
<th>Exploring prayer</th>
<th>Exploring meditation</th>
<th>Other (please specify)</th>
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<td>Listening to live music</td>
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<td>Performance of pre-composed music</td>
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-4

-5- very effective

24. How do you assess spiritual growth in the clients you work with?

- Notable change in participant's attitude
- Cathartic experiences from participants synonymous with spiritual experience
- Novel insight shared by client(s)
- Ability to reframe an experience.
- Notable affect change
- Change in musical behavior via music therapy methods
- Self-report of spiritual change from the client
- Other (please specify)

25. Is there any other relevant information you would like to share pertaining to your work surrounding spiritual needs with individuals with substance use disorders? Please share:
Appendix C: Survey Invitation Email

Dear Board-Certified Music Therapists,
I am interested in learning more about how music therapists meet the spiritual health needs of individuals with substance use disorders. Your email address was acquired from the Certification Board for Music Therapists. You may opt-out of future research, educational and professional emails by confirming your preference in your online CBMT account. The survey should take between 10 to 15 minutes to complete. The results will identify music therapy methods that are used to address goals related to spiritual health in substance use treatment. I am recruiting participants who meet the following inclusion criteria:

- Board Certified Music Therapist
- Currently work or have experience working with persons with substance use disorders
- Can read and write in English

Your participation in this research study is voluntary and you do not have to participate. Your participation involves no foreseeable risks outside of activities of daily living or filling out a computer-based form. You do not have to answer any questions that make you uncomfortable, and you may stop at any time. There is no compensation for completing this survey. However, your participation will help inform the practice of music therapists who work with individuals with substance use disorders.

This study was determined to be exempt by the State University of New York Human Research and Ethics Board.

If you have any questions about this project or your participation, please feel free to contact the principle investigator, Jonah Pomerantz (pomeranj2@newpaltz.edu) or his faculty advisor, Kathleen Murphy, PhD, LCAT, MT-BC (murphyk@newpaltz.edu) at any time. If you have questions about your rights as a research participant or concerns which you do not feel you can discuss with the principal investigator, you may contact Maryalice Citeria, PhD, Chair, SUNY New Paltz Human Research & Ethics Board at hrebchair@newpaltz.edu

Please click on the link below if you meet the survey’s inclusion criteria and are willing to participate in the study.

(Automatically generated Qualtrics link to survey was inserted here).
Appendix D: HREB Approval

Human Research Ethics Board
Sponsored Programs & Research Compliance
1 Hawk Drive, New Paltz, NY 12561
Faculty Office Building, Office N2

STUDY EXEMPTION

January 16, 2024

Jonah Pomerantz
pomeranj2@newpaltz.edu

Dear Jonah Pomerantz:

On 1/16/2024, the Human Research Ethics Board (HREB) approved the following submission:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Initial Study</th>
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<tbody>
<tr>
<td>Title of Study:</td>
<td>Music Therapy for Treating Spiritual Health Needs of People with Substance Use Disorders: A Survey Study</td>
</tr>
<tr>
<td>Investigator:</td>
<td>Jonah Pomerantz</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>STUDY00004675</td>
</tr>
<tr>
<td>Funding:</td>
<td>None</td>
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<tr>
<td>Grant ID:</td>
<td>None</td>
</tr>
<tr>
<td>Exemption:</td>
<td>104 (d)(2)(i)</td>
</tr>
</tbody>
</table>

The Human Research Ethics Board (HREB) has considered the submission for the project referenced above and determined it to be Exempt under one of the categories specifically waived under Section 104 (d) (1-6) or 101(i) of the Code of Federal Regulations (45 CFR 46).
IRB exemption is given with the understanding that the most recently approved procedures will be followed and the most recently approved consenting documents will be used, if applicable. If modifications are needed, those changes may not be initiated until such modifications have been submitted to the HREB for review and have been granted approval.

As principal investigator for this study involving human participants, you have institutional responsibilities as follows:

1. Ensuring that no subjects are enrolled prior to the study’s approval date.

2. Ensuring that the HREB is notified via PACS IRB module of:
   - All Reportable Information in accordance with the “Reportable New Information” Smart Form.
   - Project closure/completion by the “Continuing Review/Modification/Study Closure” Smart Form in PACS.

3. Ensuring that the protocol is followed as approved by the HREB unless minor changes that do not impact the exempt determination are made.

4. Ensuring that the study is conducted in compliance with all HREB decisions, conditions, and requirements.

5. Bearing responsibility for all actions of the staff and sub-investigators with regard to the protocol.

6. Bearing responsibility for securing any other required approvals before research begins.

If you have any questions, please contact the Human Research Ethics Board (HREB) at either (845) 257-3282 or by email:

HREB Chair: hrebchair@newpaltz.edu
HREB Coordinator: hrebcoordinator@newpaltz.edu
Appendix E: HREB Modification

February 1, 2024

Jonah Pomerantz
pomeranj2@newpaltz.edu

Dear Jonah Pomerantz:

On 2/1/2024, the Human Research Ethics Board (HREB) approved the following submission:

<table>
<thead>
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<th>Type of Review:</th>
<th>Modification / Update</th>
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<tbody>
<tr>
<td>Title of Study:</td>
<td>Music Therapy for Treating Spiritual Health Needs of People with Substance Use Disorders: A Survey Study</td>
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<tr>
<td>Investigator:</td>
<td>Jonah Pomerantz</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>MOD00002667</td>
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<tr>
<td>Funding:</td>
<td>None</td>
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<td>Grant ID:</td>
<td>None</td>
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</table>
|                 | • REVISED Pomerantz, Jonah Survey Invitation email.pdf, Category: Recruitment Materials;  
|                 | • REVISED Pomerantz, Jonah Thesis Survey 2024.pdf, Category: Surveys/Questionnaires; |
| Exemption       | 104 (d)(2)(i)          |

The Human Research Ethics Board (HREB) has considered the submission for the project referenced above and determined it to be Exempt under one of the categories specifically waived under Section 104 (d) (1-6) or 101(i) of the Code of Federal Regulations (45 CFR 46).

IRB exemption is given with the understanding that the most recently approved procedures will be followed and the most recently approved consenting documents will be used, if applicable. If modifications are needed, those changes may not be initiated until such
modifications have been submitted to the HREB for review and have been granted approval.

As principal investigator for this study involving human participants, you have institutional responsibilities as follows:

1. Ensuring that no subjects are enrolled prior to the study’s approval date.

2. Ensuring that the HREB is notified via PACS IRB module of:
   - All Reportable Information in accordance with the “Reportable New Information” Smart Form.
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5. Bearing responsibility for all actions of the staff and sub-investigators with regard to the protocol.

6. Bearing responsibility for securing any other required approvals before research begins.

If you have any questions, please contact the Human Research Ethics Board (HREB) at either (845) 257-3282 or by email:

HREB Chair: hrebchair@newpaltz.edu
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