

Sounds of Strength Towards Recovery:
A Program Proposal for Inpatient Psychiatric Care

by

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Ce qu'on ne peut dire et ce qu'on ne peut taire, la musique l'exprime.

Music expresses that which cannot be said and on which it is impossible to be silent.

-Victor Hugo

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Connecticut Valley Hospital first opened in 1868 as Connecticut's state hospital for the treatment of individuals with mental illness ("DMHAS: CVH – About CVH," 2014). The hospital opened, formally under the name Connecticut Hospital for the Insane, in Middletown, Connecticut in 1868 (Maseda, 2014). It was designed under the Kirkbride Plan, which stressed the role of environment in recovery for patients, providing structure in the physical layout of the campus. This included a sense of normalcy for patients, as rooms contained literature, artwork, and aspects of a typical living environment as a way to lower stigma surrounding mental illness.

There have been several changes to Connecticut Valley Hospital since its opening in 1868. The hospital currently divides patients into three divisions: The Whiting Forensic Division, Addiction Services Division (ASD), and the General Psychiatry Division ("DMHAS: CVH – Adm, Tx, Discharge," 2018). However, it was announced in early 2018 that the Whiting Forensic Division would separate from the hospital to become its own facility (Besthoff, 2018).

Connecticut Valley Hospital operates under the treatment concept of "recovery to wellness" ("DMHAS: CVH – About CVH," 2014, para. 2). With this comes a focus on empowering patients through developing life skills that can assist in the transition to life outside of hospitalization. Further, their mission highlights the belief that "recovery is a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life in the fullest sense" ("DMHAS: CVH – About CVH," 2014, para. 2). Within this model, a strength-based approach is utilized, such that clinical and nonclinical

staff are working with patients to locate inner resources that can be strengthened through treatment that translate to post-treatment success.

Introducing Music Therapy

Music therapy has the ability to enmesh itself into this paradigm seamlessly, as development of practice in certain theoretical orientations lends itself to this strength-based approach (Rolvjord, 2010). The American Music Therapy Association (AMTA) defines music therapy as “the clinical and evidenced-based used of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program” (AMTA, 1999). Of particular importance for this proposal in this definition is the emphasis on the individual within the therapeutic relationship.

In acute inpatient psychiatric settings, an understanding of the wide array of symptomology and diagnoses, and evidence-based approached to address these are crucial components of delivering competent care. The therapeutic use of music has a long history of presence in medical and behavioral health settings, going back to the 1800s, even prior to its development as a clinical field (AMTA, 1999). Since then, the profession has been present and heavily involved in a growing literature base to support its use in psychiatric settings.

Personal Statement

My interest in music therapy came about in early adulthood. I started playing violin at the age of 8 and knew that music would be forever a part of my life. Though violin was a strong passion of mine, I pursued the field of psychology during my undergraduate studies as I had a growing fascination with the human brain. I studied psychology and cognitive science for the majority of my undergraduate studies, continuing to play violin. While I took classes and focused

my academic studies on the cognitive neuroscience of music, I realized that my true interests were in the therapeutic implications of music. I knew I wanted to explore the clinical aspects of psychology while still taking into consideration the growing research on music and the brain. Through some research, I located the field of music therapy. It felt like a perfect marriage. I completed my undergraduate studies, which culminated in two bachelor's degrees, one in psychology and one in music and soon after began my graduate studies in music therapy. It was during my 9-month clinical internship with the Louis Armstrong Center for Music and Medicine at Mount Sinai Beth Israel in New York City that I became interested in working on the inpatient psychiatric unit.

During my internship, I had the opportunity to work in several units within the hospital network, including the neonatal intensive care unit, surgical intensive care unit, pediatric unit, pediatric emergency room, general medical units, and in an outpatient clinic working with adults in a music psychotherapy paradigm. My introduction to the inpatient psychiatric unit appeared to be a coincidence at first glance. I received a referral to work with a young gentleman on the general medical unit. The medical team shared that he was admitted for altered mental status, was "catatonic" and "not responsive," and had not provided any personal information about himself during his 9-day stay at the hospital.

Upon our first meeting, he did not speak, but appeared open to engage in music as I handed him an egg shaker and moved into a warm-up. Within seconds, I could tell this person was musical through the way he played. He explored several other instruments, sang along to familiar music, and eventually engaged in verbal communication. By the end of the session, I had found out his name, age, where he was from, and had a list of his preferred music. When I passed this information along to his medical team, they appeared genuinely shocked. His resident

put me on speakerphone as she asked me to recount the events of the session to the team.

Through music and the music psychotherapeutic process, I was able to glean information about this young man that other members of his team were trying to discover for days. I continued to follow this patient's care, eventually moving my work with him to the inpatient psychiatric unit when he was transferred. We continued to create music within the therapeutic milieu until his discharge soon after his transfer.

Following his discharge, I returned to the department a few days later to a referral from the inpatient psychiatric unit for another gentleman who had seen me on the unit when I worked with the previous patient. The new patient appeared drastically different from the patient I had seen before. He was an older gentleman with a long history of psychiatric illness (schizophrenia) and displayed violent, threatening behaviors. However, within the first session I noticed that this gentleman responded to music therapy in a novel way, unlike how he responded to other interventions utilized on the unit. The intensity of his affect softened when we would sing together. I worked with this gentleman for three months and, during this time, promoted grounding, managing of emotions, and behavioral control. Staff recognized that music therapy was the first thing that appeared immediately effective with this individual, as within his first month of music therapy they had seen more positive changes than his three months of hospitalization that occurred prior.

My love of this work grew as more referrals came into the music therapy department. I had the opportunity to work with patients along this vast spectrum of psychiatric presentation. With every patient I met, I was witness to a process within the music therapy session – whether it be through music making or conversation that was brought out from the music experience – that illuminated what I have seen mirrored in the literature, such as decrease in positive symptoms (in

his case, fixed delusions) (Tseng et al., 2016; Geretsegger et al., 2017; Markovitch & Tatsumi, 2015), negative symptoms (Geretsegger et al., 2017; Tseng et al., 2016; Mohammadi, Minhas, Haidari, & Panah, 2012; Ulrich, Houttmans, & Gold, 2007; Gold et al., 2013) and cognitive symptoms (Ceccato, Caneva, & Lamonaca, 2006). During a post-credential fellowship position, I had the opportunity to pilot music therapy programming in the inpatient psychiatric unit. This involved attending interdisciplinary rounds and patient intake interviews, seeing patients individually on the unit, and working collaboratively with other treatment providers on the unit through co-leading of groups and informing group practices.

One aspect of the inpatient acute psychiatric work I struggled with was the fast-paced nature of the care, as the unit is housed within a medical hospital. This at times meant I would work with someone only once prior to discharge, as lengths fell within the range of national averages of around 4-10 days, depending on diagnosis (Agency for Healthcare Research and Quality, 2015). These numbers are a stark contrast to Connecticut Valley Health's average patient stay, which is about 50 days ("American Hospital Directory: Connecticut Valley Hospital (074003)," 2017). Though the severity of presentation and dedication to quick stabilization may still be present, the greater length of stay can translate to greater opportunities for continuous, long-term services. Further, more sessions of music therapy has been associated with stronger outcomes for patients in psychiatric settings (Gold, Solli, Krüger, & Lie, 2009).

A psychiatric hospital is a high-stress environment populated by individuals with a myriad of presenting needs, ranging from depressive to acute psychotic symptomatology. In an adapted model that values and highlights comprehensive, integrative care, programming needs to be reflective of this. This paper outlines a proposal for a program *Sounds of Strength Towards*

Recovery– a music therapy program within the General Psychiatric Division of Connecticut Valley Hospital.

Statement of Need

The Office of Disease Prevention and Health Promotion (2016) states its 2020 national goal for mental health and mental disorders as to “improve mental health through prevention and by ensuring access to appropriate, quality mental health services,” (para. 1) with objectives of reducing the suicide rate and reducing the proportion of adults aged 19 years and older who experience major depressive episodes. When a patient is admitted into a psychiatric hospital, it insinuates that adequate needs for prevention have not been met and the nature of one’s presentation is acute, requiring stabilization. Thus, the topic of prevention is something to be addressed during hospitalization – what resources can be provided to a patient during this time to prevent the need for a future hospitalization? How can we empower patients to access quality mental health services available to them?

The Connecticut Department of Mental Health and Addiction Services (DMHAS) has laid out several goals and objectives for 2016-2018 (DMHAS: Strategic Goals, 2016). *Sounds of Strength Towards Recovery* will address the following goals in alignment with the current strategy:

1.c. Improve quality of services and supports; identify and respond to emerging trends in health care.

Improve patient experience in hospitalization through psychotherapeutic venues for creative expression. Music therapy will address improvements in quality of life for patients who participate in group and individual sessions through

participation and engagement within a community cultivated within the hospital environment.

3.b. Develop workforce across the system of care; expand and support peer staff

Develop a “Caring for the Caregiver” (J. Loewy, personal communication, 2016) program for staff members to address caregiver burden, stress, and burnout.

4.a. Promote integration and continuity of care; provide holistic, person-centered, culturally and spiritually responsive, and integrated mental health, addiction, and primary care, including prevention, health promotion, and alternative and complementary approaches

Implement several music therapy groups that align with a holistic, person-centered approach and address the various components of patient care. Patients who participate in music therapy will identify and create internal and external resources to address prevention strategies, coping mechanisms, and an understanding of their mental health.

Theoretical Orientation

The approach in my music therapy practice, and what I will bring to patient care at Connecticut Valley Hospital, is one that combines my training in medical music psychotherapy at the Louis Armstrong Center for Music and Medicine with philosophical influences from Rolvsjord’s (2010) Resource-Oriented Music Therapy (RoMT) and Ryan and Deci’s (2000) Self-Determination Theory (SDT). Medical music psychotherapy is a holistic approach that involves assessment of the individual (what is their unique mind-body connection?), “treatment of the rhythms, resonances, tones and timbres of the body to promote harmonic balance,” addressing the comprehensive needs of the patient (physical, emotional cognitive,

developmental, social, and spiritual), and promoting self-initiative as an impetus for empowerment (The Louis Armstrong Department of Music Therapy, 2018, para. 4).

RoMT is based on four main tenants: “the nurturing of strengths, resources, and potentials,” “collaboration rather than intervention,” “views the individual within their context,” and music itself is a resource (Rolvsjord, 2010, p. 74). In the purest sense of its practice, RoMT challenges several components of the medical model, such as the pathogenic lens in which mental health is viewed and defined, the hierarchy imposed and power dynamics that follow, and the approach of providing interventions to impart change. Terminology such as patient and intervention are almost rejected, as they imply hierarchical, unmoving relationships; the clinician treats the patient based on the clinician’s expert understanding of the patient’s diagnosis.

Although avoidance or eradication of the medical model may not seem productive in a state psychiatric hospital setting – treatment is a foundational tenant to the advent of psychiatric facilities – themes and broader depictions of this orientation can be extracted and influence the dynamic and culture of practice. Thus, though the action of providing therapeutic interventions continues based on the structure created and upheld by Connecticut Valley Hospital, music therapy sessions would stress the co-creative process of empowerment and movement towards health. Though at first glance these two models may seem starkly contrasting, the broad tenants of RoMT are connected to Connecticut Valley Hospital’s treatment goals, such as holistic, person-centered care and integrated mental health.

Major influences of RoMT are empowerment philosophy and positive psychology. With average lengths of stay being comparatively longer at Connecticut Valley Hospital than in acute psychiatric settings, there is an opportunity to cultivate a culture of community. For many, the hospital replaces the home and needs are addressed and met in ways that very well may differ

from one's schema of home. For example, medication is monitored, schedules are created, meals are prepared, and beds are assigned. However, within these structures and this ecology, there is the capability of promoting empowerment.

Though not rooted within music therapy theory, Self-Determination Theory (SDT) lends itself well to inpatient psychiatric work and the overall goal of providing and creating resources for patients. Similar to RoMT, SDT is heavily influenced by positive psychology and is a theory of motivation centered on the concepts of autonomy, competence, and relatedness that lead to optimal function through intrinsic motivation (Ryan & Deci, 2000). During a hospitalization, all three of these needs may be compromised. For instance, a patient's sense of autonomy may be impacted by an involuntary stay and a schedule that the patient is not able to determine or create for him or herself. A patient's sense of competence is affected by the need for inpatient hospitalization. Lastly, relatedness can be difficult to navigate in a fast-paced environment where the opportunity to be and relate to others does not mirror the world outside the hospital.

Music therapy provides a unique venue to bolster and enhance these components of well-being. Autonomy can be explored within the music making process, where the patient has the ability to independently define their musical expression within a parameter negotiated within the therapeutic space. Competence can be facilitated through creating musical contexts that support a successful musical interaction. Lastly, relatedness is built within the therapeutic relationship, such that the act of engaging in music therapy involves the creation and exploration of a relationship between the patient and music therapist.

Perlman et al. (2017) found that, when looking through the lens of SDT, relatedness was the number one predictor of resilience in adults with severe mental illness. Further, Sánchez, Rosenthal, Tansec, Frain, and Beyzak (2016) found that patients with higher levels of social

competence and social support tended to have a higher quality of life. These findings provide the foundation for music therapy in this treatment milieu. If the end goal is to inspire recovery, such that patients are able to transition to a place of support and resources to avoid future hospitalizations and live successfully within their communities, then it seems that the best course of action would be to provide patients with skills and confidence that they can take beyond their hospitalization and use in their everyday life.

This program aims to tap into the pillars of medical music psychotherapy, RoMT, and SDT while continuing to respect the manner in which care is provided to patients that has led to the success and continuity of Connecticut Valley Hospital since 1868. This music therapy program, focused specifically on empowerment and locating and creating internal and external resources, would address these needs and goals. Music therapy can address these components of treatment through services that will be outlined in the section, *Detailed Description of Actual Program*. However, it is first important to outline current literature that supports the implementation of music therapy programming in psychiatric settings.

Review of the Literature

Common acute inpatient diagnoses. Psychotic and mood disorders were cited as the two most common diagnoses under the umbrella of mental or substance use disorders amongst hospitalized individuals in 2011 (Agency for Healthcare Research and Quality, 2015). This is also reflected in the Connecticut DMHAS (2017) 2017 Annual Report, citing depressive disorders and schizophrenia spectrum and other psychotic disorders, as the highest non-substance abuse-related primary diagnosis amongst all Connecticut psychiatric hospitals. Music therapy has been proven effective as a mode of treatment in these disorders (Aalbers et al., 2017; Geretsegger et al., 2017; Tseng et al., 2016).

Music therapy and psychotic disorders. Psychotic disorders are characterized by a collection of symptoms including delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms (American Psychiatric Association, 2013). Music therapy has been used as a treatment modality to target and work with these symptoms both through individual therapy (Solli, 2008; Havkoort, Bogaerts, Thaut, & Spreen, 2015; Solli & Rolvsjord, 2015) and in group work (e.g. Deatrigh, Prout, Boyer, & Yoder, 2016; Kavak, Ünal, & Yılmaz, 2016; Markovitch & Tatsumi, 2015; Schuman, Kennedy, DeWitt Edelblute, & Wamboldt, 2016; Silverman, 2011; Silverman, 2014; Mohammadi, Minhas, Haidari, & Panah, 2012). Research has supported the use of music therapy in addressing several goal areas specific to symptomatology of schizophrenic and psychotic disorders (see Table 1).

Music therapy and mood disorders. Mood disorders are a collection of diagnoses in which mood is the underlying feature (American Psychological Association, 2013). Under the umbrella of mood disorders fall the classifications of depressive disorders, bipolar disorders, and substance-induced disorders. Music therapy has also been widely used in the treatment of these diagnoses to address symptomatology associated with mood disorders (see Table 2). Aalbers et al. (2017) found in their Cochrane Review that music therapy in addition to treatment as usual was superior to treatment as usual for anxiety, and had short-term beneficial effects in reducing depressive symptoms and anxiety, as well as helped to improve social functioning.

The literature supports the use of music therapy as part of treatment for individuals with mood disorders. However, it is important to take into consideration the specific modalities and approaches to music therapy that yielded these results.

Table 1

Literature Outcomes for Music Therapy and Psychotic Disorders

Negative Symptoms	Positive Symptoms	Cognitive Symptoms	Global State	Mood
Tseng et al. (2016)	Tseng et al. (2016)	Ceccato, Caneva, & Lamonaca (2006)	Solli (2008)	Markovitch & Tatsumi (2015)
Geretsegger et al. (2017)	Geretsegger et al. (2016)		Gold, Solli, Krüger, & Lie (2009)	Silverman & Rosenow (2013)
Kavak et al. (2016)	Markovitch & Tatsumi (2015)		Geretsegger et al. (2017)	Tseng et al. (2016)
Markovitch & Tatsumi (2015)				Kavak, Ünal, & Yilmaz (2016)
Carr, Odell-Miller, & Prieve (2013)				
Mohammadi, Minhas, Haidari, & Panah (2012)				
Ulrich, Houttmans, & Gold (2007)				
Gold et al. (2013)				

Table 2

Literature Outcomes for Music Therapy and Mood Disorders

Depressive Symptoms	Anxiety Symptoms	Global Function	Quality of Life
Aalbers et al. (2017)	Aalbers et al. (2017)	Aalbers et al. (2017)	Deatrich, Prout, Boyer & Yoder (2016)
Bidabadi & Mehryar (2015)	Bidabadi & Mehryar (2015)	Gold, Solli, Krüger, & Lie (2009)	Silverman (2013)
Gold, Solli, Krüger, & Lie (2009)	Kerr, Walsh, & Marshall (2001)		
Murphy (2012)			
Silverman (2013)			
Silverman (2014)			

Music therapy techniques in psychiatric settings. As the literature above demonstrates, music therapy is an effective method to address symptomatology associated with psychiatric diagnoses one may encounter in a state hospital setting. However, it is important to note that music therapy can be used as a blanket term that encompasses countless techniques, interventions, and strategies to meet these aforementioned goals. Music therapy as a practice is evidence-based in nature, which requires a degree of reflection on the techniques utilized in care.

Bruscia (2014) outlines four broad types of music therapy practice: improvisational, re-creative, receptive, and compositional. Improvisational methods involve creation of music, instrumentally or with the voice and/or body. Within this method are several levels of structure, however these are all unified by the act of extemporaneously creating melody, rhythm, song, or an instrumental product. In re-creative methods, the patient(s) and therapist re-create a pre-

composed piece of music. Similar to improvisational methods and the two methods to follow, there are degrees of structure that can be realized. Further, there is a fair amount of flexibility. A song can be realized close to its original form, utilizing its original melodic, harmonic, percussive, and instrumental components. However, it can be re-created in ways that could be unrecognizable from its original form. An example of this is demonstrated in the technique of song sensitization, which involves the process of locating a song of importance, locating key themes within the song lyrically, and re-actualizing the song in a unique and process- and group-oriented manner, such that the final product carries a new meaning contextualized to the therapeutic space (Loewy & Frisch-Hara, 2002). Receptive music therapy involves the act of listening to music in the therapeutic milieu. One of the many ways this can be demonstrated would be lyric analysis, where the music therapist or patient(s) locates a song with themes related to the space, listens to the song, and uses the lyrical content as an impetus for discussion about clinically relevant themes (Bruscia, 2013). Lastly, compositional music therapy involves the creation of a piece of music that is sustained beyond its creation. This is different from improvisational music therapy, where musical themes may come and go and the emphasis is on the act of music. Compositional methods lead to an end product. This can be realized through techniques including songwriting.

Because of the creative process of music creation and its seemingly incompatibility with collection of quantitative data, much music therapy literature highlights the actual techniques used within the music therapy sessions documented and studied (see Table 3). Certain techniques have been shown to lend themselves to specific therapeutic goals. For example, drumming is a technique commonly used for anger management (Slotoroff, 1994) and reducing stress (Fancourt et al., 2016). Lyric analysis and songwriting lend themselves well to psychoeducational activities

through the careful use of therapeutic themes integrated into these techniques (Silverman, 2014, 2014a, 2016, 2016a).

Caring for the caregiver. The concept of caring for the caregiver was illuminated by Loewy and Frisch-Hara (2002) as they developed a program at Beth Israel Medical Center following the tragedy of the 9/11 terrorist attacks. The staff who created this program recognized the importance of self-care on the end of the caregiver; the better caregivers take care of themselves, the better care they can provide. Burnout in psychiatric settings has been found to be associated with inadequate staff support and involvement with the organization (Melchior, Bours, Schmitz, & Wittich, 2003). The inpatient psychiatric unit is fast-paced and requires a degree of activity that may not be present for medical units. Inpatients are generally ambulatory and interact with nursing staff the most, due to the requirement of hourly check-ins, medication administration, and the sheer physical presence nurses have on the unit, as they circulate primarily in the nursing station as opposed to private offices.

Sounds of Strength Towards Recovery would implement a caring for the caregiver group specifically for caregivers on the unit to address the issues cited above. Bittman, Bruhn, Stevens, Wetengard, and Umbach (2003) demonstrated significantly decreased burnout and mood dimension scores in long-term care workers who engaged in a 6-session Recreational Music-Making protocol. During my clinical internship at Mount Sinai Beth Israel, I coordinated with a member of the spiritual care team to lead a guided meditation group for staff members and with a member of the hospital system's human resource team to create a group for staff members to learn self-care techniques through music making. Additionally, during my fellowship at the same hospital, I worked with a member of the Human Resources department to oversee a group for staff members throughout the hospital geared towards introducing and using music as a resource

and self-care mechanism. The recognition of importance of staff members within the hospital ecology will be a prominent component of this program.

Table 3

Music Therapy Techniques Utilized in Psychiatric Settings

Improvisational	Re-creative	Receptive	Compositional
Solli (2008)	Deatrich, Prout, Boyer, & Yoder (2016)	Mohammadi, Minhas, Haidari, & Panah (2012)	Deatrich, Prout, Boyer, & Yoder (2016)
Mohammadi, Minhas, Haidari, & Panah (2012)	Silverman (2011)	Kavak, Ünal, & Yılmaz (2016)	Silverman (2016)
Murpy (2012)	Silverman & Marcionetti (2004)	Deatrich, Prout, Boyer, & Yoder (2016)	Silverman (2016a)
Slotoroff (1994)	de l'Etoile (2002)	Silverman (2014)	Silverman (2013)
Deatrich, Prout, Boyer, & Yoder (2016)		Silverman (2014a)	Silverman (2011a)
Stefani & Biasutti (2016)		Silverman (2016)	Silverman & Marcionetti (2004)
Nolan (2012)		Silverman (2016a)	de l'Etoile (2002)
Silverman & Marcionetti (2004)		Silverman (2011a)	
Hakvoort, Bogaerts, Thaut, Spreen, (2015)		Silverman & Marcionetti (2004)	
de l'Etoile (2002)		Hakvoort, Bogaerts, Thaut, Spreen, (2015)	
		Bibadi & Mehryar (2015)	
		de l'Etoile (2002)	

Detailed Description of the Program

Sounds of Strength Towards Recovery will utilize a three-prong approach in programming which mirror the values of Connecticut Valley Hospital as well as the goals and objectives for 2016-2018. The resource-oriented influence and empowerment-minded conceptualization will address the goals of treatment through three different mechanisms, namely individual sessions with selected patients, group sessions, and a caring for the caregiver initiative for staff members.

The format of this program is influenced in part by the Louis Armstrong Center for Music and Medicine (J. Mondanaro, personal conversation, 2017). The structure of this programming allows for the individualized nature of music therapy services within a large hospital system with a focus on care that contributes to successful outcomes in and outside patient experiences of therapy. These specific foci are represented in a weekly schedule (Appendix A) that includes these three prongs.

Group Sessions

Due to the size of the General Psychiatric Division of Connecticut Valley Health, group sessions will be the most effective way of ensuring that as many patients as possible are able to participate in music therapy. These groups have been designed in response to the extant literature of current evidence-based practice in psychiatric music therapy, while addressing the goals of identifying, developing, and nurturing the strengths and resources of patients. These groups will imply a collaborative process, such that I as the music therapist, and all of the patients present in the group are working with one another on goals and themes that are flexible and mutually formulated. Further, they operate on the underlying understanding that music is a resource (Rolvsjord, 2010). Thus, the use of these developed and realized resources will not be limited to

the group itself. Rather, emphasis will be placed on how music can be used as a resource outside of music therapy sessions and into the patients' lives as members of a larger community and context.

Connecticut Valley Hospital hosts a diverse group of patients with varying needs. Thus, I would lead a diverse set of groups aimed at approaching common treatment goals outlined in the review of literature. Group sizes would vary depending on census and interdisciplinary assessment on appropriateness of presence for each patient.

Drum It Out. This group would occur twice per week and is focused on the use of drumming as an agent for mood management, social cohesion, and self-expression. Due to the nature of my improvisatory-based approaches in music therapy groups, no two occurrences of this group will be identical. The focus and direction of the group will depend on an initial assessment of the group as a whole. See Figure 1 for potential group outcomes. This group would be appropriate for patients along the spectrum of psychological states, as contribution can range from providing a simple beat to overt musical expression.

Drumming as a group activity inherently requires some degree of cohesion. For example, a simple, stable beat provides the container in which rhythmic exploration can occur. The act of internalizing this beat displays some degree of relatedness and recognition of others within the space. Creating the container in which this experience can occur highlights the collaborative nature of a resource-oriented influence and the relatedness component of SDT.

Though the groups would vary on which drumming techniques and/or interventions are used, they would be structured according to a protocol, always beginning with a warm-up experience, which allows for a quick assessment of where the group is currently (J. Loewy,

personal communication, 2016) and time for closure. The closure component would allow patients to share their experience of the session and extract themes that may have arisen.

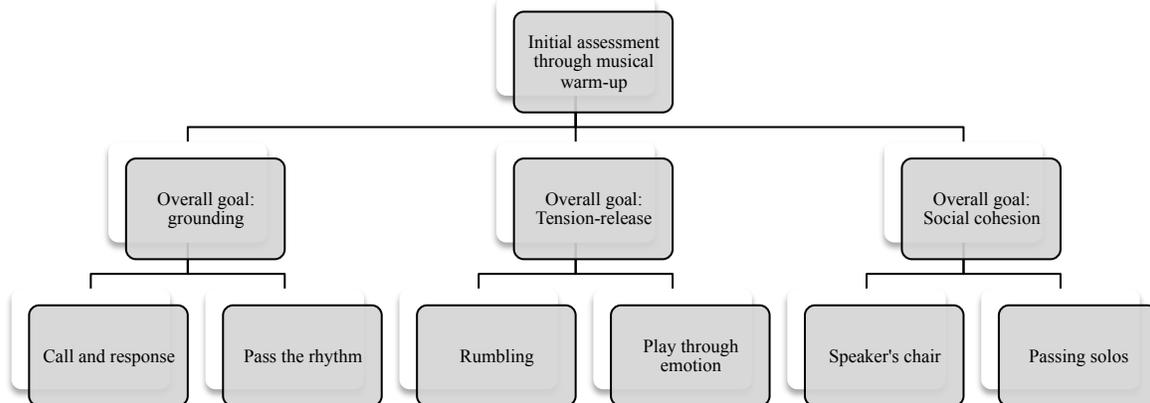


Figure 1. Drum It Out group outcomes. This figure illustrates the potential direction(s) for the Drum It Out group.

Creative Expression. This group would be focused more on the collaborative process of music making. This group, contrasting from Drum It Out, would offer melodic instruments (if indicated), and more room for vocal expression. The nature of the music making could be recreation of familiar songs, spontaneous improvisation of new melodies, or involve percussive and melodic instruments (without singing). The instruments in this group would be purposely predetermined in order to provide safety. For example, the use of melodic instruments tuned to a pentatonic scale provide a harmonic container that is conducive to musical success (i.e. the experience of no “wrong notes”). Through creating this “no fail” space, patients are able to recognize their competence – their ability to contribute to a group initiative.

Similarly to Drum It Out, this group would begin with a musical warm up to assess and decide the direction of the group as well as time at the end to close and discuss. For a group of patients who vary in terms of level of groundedness, a possible intervention that would be utilized in this group would be singing familiar songs. For patients who require a bit more grounding, adhering to the melodic and lyrical structure can be a platform to explore the here-and-now. For those who are more grounded, there could be possibilities of improvising within the song through improvising spoken or sung word in between verses, harmonic variation, or implementing instrumental solos.

Music Meditation. This group would be focused on receptive methods of music therapy paired with psychoeducation. The therapist would provide live or pre-recorded music to the group with a guided relaxation script or activity. In keeping with the philosophy of my music therapy approach, how patients receive the music will vary based on preferences and/or needs of the group. This could include mandala drawing, guided movements, or simply engaging in a mindfulness exercise. The mindfulness exercises will utilize mindfulness principles which have been shown to be effective in inpatient psychiatric settings for perceived helpfulness and applicability to extra-therapeutic environments (Heriot-Maitland, Vidal, Ball, & Irons, 2014). The music-guided mindfulness exercises would address the use of mindful breathing and recognition of somatic experiences in a two-fold manner: to promote relaxation and to provide psychoeducation on how to use mindfulness and mindful techniques in their own life to promote a sense of calm. Imagery may be included as well, as Moe, Roesen, and Raben (2000) found that an adaption of Guided Imagery and Music (GIM) was beneficial for patients with schizophrenia in improving global functioning and promoting a positive emotional experience. This group,

unlike the two outlined above, would consist of a verbal check-in to determine how patients envision their meditation for that group. It would end with a closing through a verbal check in.

The psychoeducation component of this group would help prompt dialogue about using attunement to the body and music listening as a resource. Though the group allows the opportunity to explore these resources in a supportive setting, many components of this group could be translated to outside of the therapy setting. For instance, a patient could listen to preferred music while drawing a mandala as a way to address anxiety symptoms or engage in mindful breathing exercises while listening to music.

Songwriting. This group would be open to patients who have displayed the ability to work with others without major conflict. Songwriting is a technique that has been used and studied throughout music therapy literature (see Table 3). This group would be more structured in order to allow time for development of theme, creation of lyrics, creation of music, and performing the song.

There are several ways in which the group can be structured based on presentation of patients in the moment (see Figure 2). The first stage is assessment, such that I would locate any presentations requiring attention during the group. This would also inform which level of structure would best fit the group as a whole. Silverman (2014, 2014a, 2016, 2016a) demonstrated that a psychoeducational approach can also be adapted within this type of music therapy experience, addressing topics such as illness knowledge and potential coping skills.

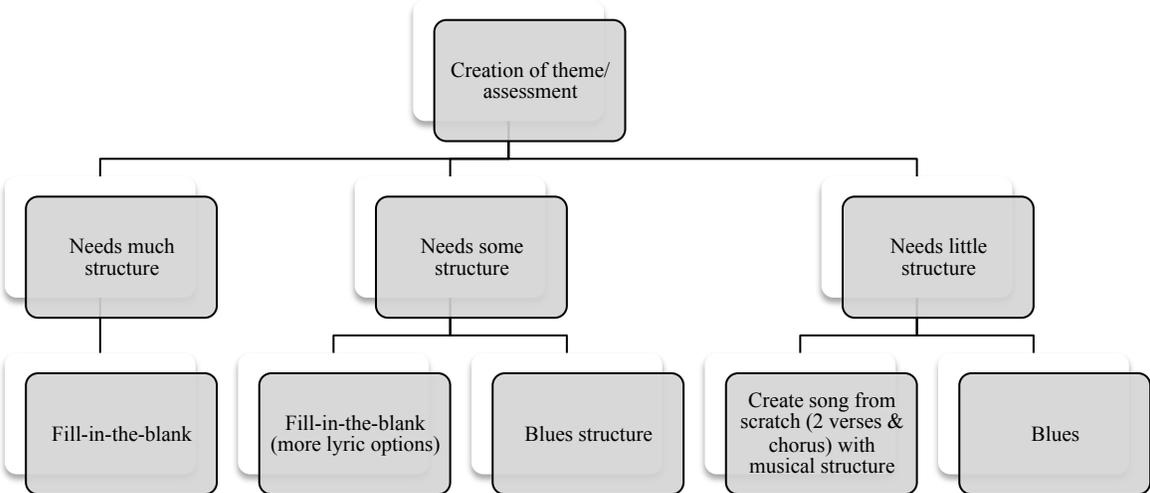


Figure 2. Songwriting group outcomes. This figure illustrates the potential direction(s) for the Songwriting group.

Music and Meaning. This group would be focused specifically on lyric analysis. The group would begin with a verbal check-in to see what themes patients would like to explore in the group. As such, ability to attend to the task of listening to a song, reading lyrics, and extracting themes would be indicated for group members. I would have a collection of songs in a library organized by thematic content and diverse in genre. Depending on the relatedness within the group environment, patients may decide amongst themselves which song they would like to explore. However, if the group requires more structure, I would provide either a small list of songs from which the group could decide or utilize my clinical judgment in locating a song that validates the themes introduced by group members if opening up the choice for a song within the group is not feasible in the moment.

Lyric analysis can be performed in a myriad of ways, but for the purpose of this group it would be structured to involve the following: The group would begin with the theme (either

group initiated or therapist initiated) and then listen to the song while reading the lyrics. Patients would be encouraged to circle or mark any words or phrases that spoke to the theme or to their personal experience. After listening to the song, I would facilitate a group discussion on the lyrics patients noted as particularly salient and contextualize within the group, as individuals and as a cohort, how this translates within their recovery.

Similar to songwriting, lyric analysis can also be a venue for psychoeducation (Silverman, 2014, 2014a, 2016, 2016a). For example, a particular song may be chosen because of relevant themes for the group, such as “Lean on Me” by Bill Withers (1972) to discuss social support or “Don’t Let Me Get Me” by P!nk (Moore & Austin, 2001) to address self-destructive behaviors. Engaging in lyric analysis could also be a resource for patients outside of the therapy group. Listening to a song and concentrating on the lyrical content and meaningful themes is something that can be done independently or in non-therapist-led groups.

Community Choir. Lastly, and perhaps most closely related to community integration within the hospital and post-discharge, would be the community choir group. This group would be focused on creating a community-based venue for choral collaboration, creation, and performance within the hospital while working on goals that can be translated to community involvement endeavors outside the hospital. Mezey, Durkin, and Krljes (2015) found that patients who participated in a community choir within a forensic psychiatry unit displayed benefits of improved happiness and well-being, increases in self-confidence and self-esteem, greater emotional connectedness to others, and a reduced sense of stigma.

Due to the average stay length at Connecticut Valley Hospital, this group would meet weekly and work towards scheduled performances at the hospital. I would create vocal arrangements for those who choose to participate for songs that adhere to themes of recovery and

are contextualized within the time of year. For example, there would be a winter concert featuring songs related to winter and holidays. Patients would experience collaborating in a structured and adjusted environment that has learning and skill-building implications for life outside the hospital. Community choirs exist outside of the hospital setting and can be a venue for continuity of skill utilization as well as community integration.

Through participation in this group and its performances, the patients have the ability to provide something to the community. Many facets of the hospitalization experience involve patients being given something from staff. They are given medication, assigned to groups, provided therapy, given meals prepared for them, assigned beds, etc. This group provides a forum in which the patients can contribute to the community, such that they are the ones giving and the staff are the ones that are receiving. This is an opportunity to lessen the hierarchy inherently present in a psychiatric hospital setting.

Individual Sessions

Not all patients on the unit may be at the stage in their recovery to be attending group sessions. This could be due to violence, provocative behavior, or physical illness. For these patients, individual music therapy would serve as a connection to the community through exposure to and engagement in music therapy whilst still respecting the boundaries of the facility.

Patients who receive individual sessions would be determined by highest level of need, as my schedule would allow for me to see eight or nine patients individually per week. Goals for individualized music therapy would be determined through initial communication with the medical team and after conducting a music therapy assessment (see Appendix B). Though individual goals would vary (for example, self-regulation, anger management, improvement in

communication, etc.), the overall goal would be to bring the patient closer to being able to attend groups.

The assessment process will be grounded in Loewy (2000)'s 13 areas of inquiry. These include (a) awareness of self, others, and of the moment; (b) thematic expression; (c) listening; (d) performing; (e) collaboration/relationship; (f) concentration; (g) range of affect; (h) investment/motivation; (i) use of structure; (j) integration; (k) self-esteem; (l) risk taking; and (m) independence (Loewy, 2000, pg. 49). While all of these elements will be taken into consideration for the assessment process, the components most important to assessing readiness for inclusion in group music therapy settings are listening ("receptivity, ability to hear others"), collaboration/relationship ("willingness to interact in activity together"), and investment/motivation ("willingness to build musical experience or conversation") (Loewy, 2000, pg. 49). While observing these areas, a major focus would also be on recognizing the patient's strengths, as a strength-based approach is one of the tenants of care at Connecticut Valley Hospital.

Music and verbal processing of the music experience will be the container in which strengths will be realized and areas of improvement will be exercised and strengthened. For instance, a possible reason a patient is withheld from music therapy groups could be difficulty adhering to boundaries. Music can provide a space in which to negotiate boundaries without verbal prompting (Solli, 2008). The act of making music within the therapeutic milieu can thus serve as a resource for addressing areas that can be strengthened.

Evaluation of individual music therapy sessions would be a collaborative process, such that the patient and I would be open about what is perceived as helpful. However, I would revisit the relevant areas of inquiry from the initial assessment to assess the trajectory of the individual

sessions. For example, if a patient in the initial assessment displayed difficulty interacting in music together, I may revisit this again after three sessions. I would consider such factors as, “Is the music-making a collaborative, communicative process?” If so change of context may be indicated (through invitation to group sessions) to allow for assessment of how the patient collaborates musically with others.

Caring for the Caregiver

The third and final prong of this program is a Caring for the Caregiver group for staff members. This group would occur weekly and would be open to all staff members within the hospital, clinical or nonclinical. This would not be considered a music therapy group, as I would not be providing music therapy services to the staff members. Instead, it would be informed by my knowledge as a music therapist to provide therapeutic experiences for staff members to reduce experiences of caregiver burden, burnout, and stress.

Similar to my approach in the patient music therapy groups, there would be flexibility for this group. I would have two different types of staff groups (active and receptive), allowing for staff members to choose from an array of therapeutic and self-protective experiences that aligns with their perceived needs. How the group is structured would be dependent on the theme: unwind with music or music meditation.

Unwind With Music. This staff group would be focused on live and collaborative music making to promote tension-release. I would provide several instruments from which staff members could choose to play. The structure would be loose, allowing for free improvisations, song recreations, or drumming exercises. Bittman et al. (2003) found that recreational music-making, specifically Group Empowerment Drumming, was effective in improving mood states and decreasing indicators of burnout in long-term healthcare workers. This group would be

higher in energy, allowing for expression of different emotions through active music making. The focus would be primarily on the music, though space would be provided for verbal processing of the experience.

Music Meditation. This group would involve a guided relaxation with live, entrained music. I would provide a relaxation script based on a quick verbal check-in at the beginning of the group to determine any trends in tension. Staff members would be invited to engage in mindful breathing, progressive muscle relaxation, or simple movement exercises.

This venue would provide staff members to use the concepts of music as a resource and mindfulness as a tool and skill to address their own sources of tension that may arise in the workplace. Wilson, Bungay, Munn-Giddings, and Boyce (2016) found that healthcare workers perceived arts activities in healthcare systems to decrease stress, improve mood, improve job performance, reduce burnout, improve patient/staff relationships, improve the working environment, and improve well-being. I am a firm believer in the concept that in order to care for others, one must care for themselves. Thus, Music Meditation and Unwind With Music would be a space to allow staff members to use music as their own resource to promote wellness.

Financial Justification

See Appendix C for an itemized budget. This includes salary, beginning operating costs, and maintenance costs. While initial operating costs may seem high, this is because higher quality instruments will allow for less maintenance throughout the course of the program. As the music therapist at Connecticut Valley Hospital, I would be active in locating different grants for instrument purchase and further program development as a way to ensure that quality, comprehensive care is being provided without a large burden on the facility. Within the budget is

a hierarchy of instrument needs. This demonstrates the need for certain instruments directly used in the programs outlined above while providing options for expansion of the instrument library.

After one year in the position, I will be eligible to apply on behalf of the program to become a National Roster Internship placement (AMTA, 2018). As a full-time music therapist at Connecticut Valley Hospital, I would be able to train two interns at a time, which allows for expanding the reach of services across the hospital.

One of the goals I outlined earlier from Connecticut Valley Hospital is the utilization of alternative and complementary approaches to care. Music therapy, as demonstrated by the literature outlined earlier, offers a non-pharmacological approach to management of symptoms for patients in a psychiatric setting. Stefani and Biasutti (2016) found that music therapy was an effective treatment modality in decreasing amounts of neuroleptic and anti-depressant medications when compared to patients who did not participate in music therapy. Medication is a contributing cost to hospitalization. Thus, music therapy has the capacity to reduce need for certain commonly prescribed medications within the hospital, providing an alternative mode of treatment while potentially cutting costs.

Larger Facility Context

With the modern healthcare model moving towards holistic approaches in medicine and behavioral health, music therapy programming would allow the opportunity to contribute to a culture of truly comprehensive care. By delivering individualized treatment for patients with the goal of inspiring recovery, music therapy has the ability to fit seamlessly into a program that is actively working within that mission.

Sounds of Strength Towards Recovery would fit into Connecticut Valley Hospital's programming as part of the interdisciplinary care currently being provided. I have experience

working in a team environment alongside psychiatrists, nurses, social workers, occupational therapists, and more. Through this experience, I have recognized the compatibility amongst these specializations and the potential for collaboration and integration. For example, I would be able to work with the occupational therapy team in combining the concept of development and strengthening of life skills through co-creating a group that utilizes music as a tool to remember and utilize life skills. Further, I would stay informed with community music programs that outside of the hospital to be able to work with social work in creating a successful environment and community outside of the hospital into which patients can transition after their hospitalization. My knowledge of pharmacological interventions in psychiatric settings would inform my practice in how I work with individuals and their medical professionals prescribing medication, and how to work with potential negative side effects to promote medication adherence.

This program, with its influences from RoMT, also provides an opportunity to create a culture of community. For some patients, Connecticut Valley Hospital may become a place considered to be a temporary home. *Sounds of Strength Towards Recovery* emphasizes the community nature of the facility, such that patients have an opportunity to contribute back to the facility and engage actively in this setting of promotion of well-being.

Outcomes and Assessment

Sounds of Strength Towards Recovery would allow for an additional step towards comprehensive psychiatric care. As cited previously, the literature points towards the efficacy of the music therapy modality as part of treatment for psychiatric inpatients. Besides standard documentation through developing assessments and documenting individual and group sessions, music therapy would be part of the team dialogue about treatment goals for patients. A holistic

approach to care recognizes the patient beyond the diagnosis. Music therapy, specifically engagement in services offered through *Sounds of Strength Towards Recovery*, can contribute to painting the entire picture of who a patient is. Thorough documentation of progress in individual and group music therapy sessions will allow for tracking of individual outcomes.

Regarding evaluation of the program, patients will be invited to fill out a survey about their experience with music therapy as part of their discharge. Responses would be collected and discussed at monthly core team meetings as a way to strengthen and improve the program in place. This survey can be found in Appendix D. This survey will allow for quality assurance of the program as perceived by patients who engaged in services.

Conclusion

The hospital experience is gradually moving towards a more holistic, comprehensive, approach. This is no different for behavioral health, as patients are becoming more active consumers of wellness and taking greater charge in determining how wellness is experienced. Music therapy and the program *Sounds of Strength Towards Recovery* lends itself effortlessly to the culture and community of Connecticut Valley Hospital. Through creation of this program, patients will have an outlet to further explore their potential, strengths, and ability to navigate their mental health experience into a successful integration into the world of their choosing.

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Appendix A – Proposed Weekly Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
9:00-10:00	Rounds/Team Meeting	Rounds/Team Meeting	Rounds/Team Meeting	Rounds/Team Meeting	Rounds/Team Meeting
10:00 - 11:00	Music Therapy Group (Drum It Out)	Individual Session	Music Therapy Group (Drum It Out)	Individual Session	Music Therapy Group (Music and Meaning)
11:00 - 12:00	Individual Session	Music Therapy Group (Songwriting)	Documentation/ Other Site Requirements	Music Therapy Group (Creative Expressions)	Individual Session
12:00 -1:00	Lunch	Lunch	Lunch	Lunch	Lunch
1:00-2:00	Music Therapy Group (Creative Expressions)	Documentation/Other Site Requirements	Music Therapy Group (Community Choir)	Documentation/ Other Site Requirements	Individual Session
2:00-3:00	Individual Session	Music Therapy Group (Music and Meaning)	Individual Session	Music Therapy Group (Songwriting)	Documentation/ Other Site Requirements
3:00-4:00	Documentation/ Other Site Requirements	Individual Session	Documentation/ Other Site Requirements	Individual Session	Music Therapy Group (Creative Expressions)
4:00-5:00	Music Therapy Group (Music Meditation)	Documentation/Other Site Requirements	Music Therapy Staff Group	Documentation/ Other Site Requirements	Documentation/ Other Site Requirements

Appendix B – Music Therapy Assessment

Music Therapy Assessment

Name: _____

DOB: _____ Age: _____ MRN: _____

Referred by: _____

Diagnosis/Differential: _____

Reason for referral: _____

Communication: _____

Instruments/Activities: _____

Affect (initial): _____

Description of session:

Affect (post-session): _____

Areas for treatment: _____

Follow-up plan: Group () Individual ()

Date: _____

Time: _____

Appendix C - Budget

Annual Budget	
Item	Amount
Salary (Derived from 2017 average salary of Music Therapist in the state of Connecticut)*	\$55,000
Instrument Maintenance/Repair	\$500 [†]
Total: \$55,500	

Initial Expenses – Necessary Instruments	
Item	Amount
Guitar [‡]	\$205
Yamaha 76-Key Portable Keyboard	\$249.99
Percussion set (Includes ocean drum, cabasa, 6 egg shakers, 6 sleigh bells, 12 scarves, 6 pairs of rhythm sticks, 8" tambourine, 6 large maracas, 10" frame drum, 12" frame drum, 2 mallets, disinfectant spray, carrying bag)	\$219
16" Ocean Drum	\$57
Remo Medium Drum Circle Kit (Includes 2 14" x 21" Bahia Bass Drum, 2 Arthur Hull 12" x 25" Key-Tuned Ashiko, 2 Remo Large Festival 12" x 21" Djembe, 2 Remo Medium Festival 10" x 20" Djembe, 1 Remo Small Festival 8" x 14" Djembe, 1 Remo Leon Mobley 12" x 24" Key-Tuned Djembe, 2 Remo 10" x 26" Pre-Tuned Tubano, 2 - Remo 12" x 26" Pre-Tuned Tubano, 2 - Remo 14" x 26" Pre-Tuned Tubano, 2 Remo Valencia Series 2-Tone Agogo Bell, 2 Remo 8" Maple Claves pairs, 2 Remo 8" Double Row Headless Tambourine, 2 Remo Samba Shakers, 16 Remo 3/8" x 8" White Plastic Beaters with Red End Caps, and 4 Remo 5/8" x 16" Wood Foam Head Mallet with Soft Black Cover)	\$3,640.40
6" & 7" Bongos	\$100
Soprano Xylophone	\$420
Bluetooth Speaker	\$69.99

Total: \$4,961.38

* Salary includes benefits, such that 62.6% (\$34,430) of cost is wage/salary and 37.4% (\$20,570) is benefits. Numbers derived from Bureau of Labor Statistics (<https://www.bls.gov/news.release/pdf/ecec.pdf>)

[†] Number estimated includes cost of guitar string replacement, drum head replacement, and individual instrument replacement. This cost is not fixed and may vary year-to-year.

[‡] All instrument prices derived from West Music (www.westmusic.com)

Other Instrument Options	
Item	Amount
Wireless Microphone § (AKG WMS40 Mini Vocal Wireless Set, Band A)	\$99
3-Piece Recorder Set – 50 pack	\$126.91
3/4-Size Classical Guitar	\$194.94
22” Ocean Drum	\$78.25
Sonor Meisterklasse WEST-X Bass Bar Set of 5 (Includes mallets)	\$2,158.20
Boomwhackers BWDG 8-note C Major Diatonic Set	\$21.50
Basic Beat BBA25 25-note Resonator Bells w/ Case	\$157.95

§ All instrument prices derived from West Music (www.westmusic.com)

Appendix D – Evaluation

Music Therapy Satisfaction Survey

Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I was treated with respect by the music therapist.					
2. The music therapy sessions made me feel relaxed.					
3. I enjoyed participating in music therapy groups.					
4. I learned skills from music therapy that I can use outside of the hospital.					
5. I felt supported in music therapy.					
6. The music therapy sessions made me feel anxious.					
7. I noticed a positive change in my mood after music therapy.					
8. I felt safe to express myself in music therapy sessions.					
9. I did not enjoy music therapy.					
10. I felt more connected to other patients during music therapy.					
11. I improved my self-confidence or self-esteem in music therapy.					
12. The music therapist listened to me.					
13. I am glad I participated in music therapy.					

14. What was your overall experience with music therapy?

15. What was your overall satisfaction with your hospitalization?

16. What did you find most helpful in music therapy?

17. What did you find least helpful in music therapy?

18. Do you have any suggestions for the music therapy program?

19. Do you have any additional comments?

Appendix E – Annotated Bibliography

Carr, C., Odell-Miller, H., Priebe, S. (2013). A systematic review of music therapy practice and outcomes with acute adult psychiatric in-patients. *PLoS ONE*, 8(8): e70252.

This article examined 35 research papers to identify how music therapy was used within acute inpatient psychiatric settings and the outcomes of these. The authors looked specifically at papers that identified music therapy within its professional definition as well as papers that focused on music as an active experience involving a therapeutic relationship. The authors found that there were reductions in positive and negative symptoms and in psychiatric symptoms as well as increased interpersonal functioning in participants who engaged in group music therapy versus control groups.

MacDonald, S. (2015). Client experiences in music therapy in the psychiatric inpatient milieu. *Music Therapy Perspectives*, 33(2), 108-117.

In this phenomenological study, MacDonald identified themes of client experiences of music therapy during inpatient psychiatric treatment. MacDonald uncovered 16 themes: releasing stress, a healing balm, concentration, safe space, shared experiences, mutual desire for support, the intrinsic value of music, music learning, coping with here and now/hospitalization, motivation/hope, connection to others, self-awareness, lessons from the future, value of listening and trust, self-expression, and negative experiences.

Slotoroff, C. (1994). Drumming technique for assertiveness and anger management in the short-term psychiatric setting for adult and adolescent survivors of trauma. *Music Therapy Perspectives*, 12(2), 111-116.

In this article, Slotoroff outlines a trauma-informed drumming technique for survivors of trauma who, due to the trauma experience, had difficulty being assertive with their

feelings. Her reasoning for development of this technique came from the recognition in his clinical experiences that drums were “symbols of power” (pg. 112) and could be beneficial in expressing anger in a safe manner. The intervention works within a Cognitive Behavioral Therapy (CBT) model but also utilizes the therapeutic relationship and communication through music, such that there is a building of trust in playing together that is determined by boundaries set by the therapist and patient. The end goal involves self-awareness and self-reflection. This technique works within a short-stay model.

Deatrich, K. G., Prout, M. F., Boyer, B. A., & Yoder, S.E. (2016). Effectiveness of group music therapy in a psychiatric hospital: A randomized pilot study of treatment outcome. *International Journal of Group Psychotherapy*, 66(4), 592-617.

This study measured the effectiveness of group music therapy compared to control (standard of care) groups. The hypotheses were that patients in the group music therapy conditions would show a greater change in depression through increased mood scores, an increase in quality of life, a decrease in negative mood, an increase in hope scores, display more engagement and less conflict and avoidance during therapy groups, and express more satisfaction and perceived helpfulness regarding group therapy than those who received standard of care. They found significant increases in quality of life in those who were in the music therapy group compared to the control group. They also found that there were higher conflicts in group but less avoidance during therapy groups.

Silverman, M. J. (2014). Effects of a live educational music therapy intervention on acute psychiatric inpatients' perceived social support and trust in the therapist: A four-group randomized effectiveness study. *Journal of Music Therapy*, 51(3), 228-249.

This study looked at four conditions (live educational music therapy, recorded educational music therapy, education without music, and recreational music therapy without education) for psychiatric inpatients. The author found that participants in the live educational music therapy condition reported significantly higher perceived support from friends compared with the recreational music therapy condition.

Silverman, M. J. (2011). Effects of a single-session assertiveness music therapy role playing protocol for psychiatric inpatients. *Journal of Music Therapy, 40*(3), 370-394.

This study examined the use of single-session assertiveness music therapy for psychiatric inpatients. Silverman had three conditions: assertiveness music therapy (which involves teaching appropriate assertive behaviors through acting out certain situations in an assertive manner using “Get Up, Stand Up” and a “rock opera” medium), no music assertiveness (which involved just teaching the assertiveness behaviors without music), and music with no assertiveness (a recreational music activity of rock and roll bingo). Silverman found that patients rated assertiveness music therapy as the most helpful group.

Hakvoort, L., Bogaerts, S., Thaut, M. H., Spreen, M. (2015). Influence of music therapy on coping skills and anger management in forensic psychiatric patients: An exploratory study. *International Journal of Offender Therapy and Comparative Criminology, 59*(8), 810-836.

This study looked at the question “can music therapy treatment contribute to positive changes in coping skills, anger management, and dysfunctional behavior of forensic psychiatric patients?” (pg. 816). The authors investigated this question through comparing an experimental condition (standardized music therapy anger management for

6 months of weekly individual sessions) to a control condition (treatment as usual without individual music therapy sessions). The experimental condition had the goal of training a patient to regulate and control his or her reactions to irritation or anger. The music therapy was organized into 4 stages: introduction to anger management techniques, learning techniques for tension reduction and discerning different phases of anger, discovering situations that arouse anger and instructing patient to use techniques to reduce tension, and patient learning to apply personalized techniques independently. They found that, when compared to the control group, patients who received music therapy displayed less avoidance of coping skills, a significant increase in the use of positive coping skills, a significant increase in self-management of psychiatric symptoms, and an improvement in interpersonal skills.

Silverman, M. J. (2016). Effects of educational music therapy on illness management knowledge and mood state in acute psychiatric inpatients: A randomized three group effectiveness study. *Nordic Journal of Music Therapy*, 25(1), 57-75.

This study aimed to determine the effects of educational music therapy on illness management knowledge and mood in acute psychiatric patients. Silverman created three conditions: educational lyric analysis, educational songwriting, and a wait-list control. In both the lyric analysis and songwriting groups, questions and dialogue were focused on illness management knowledge (coping skills, importance of psychosocial interventions, avoiding drugs and alcohol, supports in the community, and medication management). In the lyric analysis group, the group used the song “Desperado” by The Eagles to explore these themes and guide discussion. In the songwriting condition, patients wrote a song within a 12-bar blues format where lyrics were focused within the illness management

knowledge. Silverman found that there was a significant difference in illness management knowledge for the songwriting group when compared to the wait-list control group.

Silverman, M. J. (2016). Effects of educational music therapy on illness management knowledge and mood state in acute psychiatric inpatients: A randomized three group effectiveness study. *Nordic Journal of Music Therapy*, 25(1), 57-75.

This study looked at patients' perception of immediate effects of a single music therapy intervention within an inpatient psychiatric setting. The interventions included facilitated group drumming, songwriting, lyric analysis, music game, and music listening. The authors found that patients rated music therapy as immediately improving aspects of psychiatric deficit areas in 39 of the 40 trials performed.

Tseng, P., Chen, W., Lin, P., Tu, K., Wang, H., Cheng, Y., Chang, Y., Chung, W., Wu, C. (2016) Significant treatment effect of adjunct music therapy to standard treatment on the positive, negative, and mood symptoms of schizophrenic patients: A meta-analysis. *BMC Psychiatry*, 16(16), 1-11.

This article is a meta-analysis looking at adjunctive music therapy in patients diagnosed with schizophrenia. After locating 12 studies that included comparisons of treatment effect in schizophrenic patients with music therapy and those without music therapy, the authors found that there was a significantly better treatment effect for patients that received music therapy compared to those who did not, regardless of duration, frequency, or amounts of sessions. Further, patients who received adjunctive music therapy displayed significantly better treatment outcomes in regards to negative symptoms, mood symptoms, and positive symptoms.

Bidabadi, S. S. & Mehryar, A. (2015). Music therapy as an adjunct to standard

treatment for obsessive compulsive disorder and co-morbid anxiety and depression: A randomized clinical trial. *Journal of Affective Disorders, 184*, 13-17.

This study examined patients receiving treatment for obsessive-compulsive disorder (OCD). The authors had two groups: those receiving individual music therapy and those receiving standard care. Patients who received music therapy had three sessions per week over the course of 4 weeks and received receptive music therapy. The authors found that those who received music therapy displayed significantly lower levels in total obsessive score, particularly in checking and slowness. Additionally, music therapy was significantly more effective in reducing anxiety and depressive symptoms.

Stefani, M. D. & Biasutti, M. (2016). Effects of music therapy on drug therapy of adult

psychiatric outpatients: A pilot randomized controlled study. *Frontiers in Psychology, 7*(1518).

This study compared the effects of group music therapy as an adjunct to drug care compared to drug care and non-expressive group activities in patients utilizing outpatient psychiatric services. Patients ranged in diagnoses, presenting with depression, schizophrenia, schizoaffective disorder, bipolar disorder, depressive episode, and specific personality disorders. Those receiving group music therapy had 48 weekly sessions lasting two hours. The authors found that participants who received group music therapy had a decrease in the necessary dose of neuroleptics compared to the control group, which showed an increase in the dose. Further, those who were taking antidepressants in the music therapy group showed consistency in dose, while those in the control group showed an increase in the dosage of antidepressants.

Solli, H. P. & Rolvsjord, R. (2015). "The Opposite of Treatment": A qualitative study of how patients diagnosed with psychosis experience music therapy. *Nordic Journal of Music Therapy*, 24(1), 67-92.

This qualitative study investigated how psychiatric inpatients experiencing psychosis experienced music therapy. The authors interviewed 9 patients, male and female, primarily with a diagnosis of paranoid schizophrenia under a compulsory hospitalization. The music therapy provided was humanistic and resource-oriented in nature. The sessions were individual (30-60 minutes weekly) and group based (45 minutes weekly) and consisted of interventions including structured and free improvisation, learning to play instruments, playing and singing from songbooks, music listening, recording, production of CDs, songwriting, and uploading songs to the internet. From the interviews, the authors extracted four main themes: freedom (from illness, from stigma, and from treatment), contact (with oneself, aliveness, emotions, and other people), well-being (enjoyment and satisfaction, motivation, mastery, hope), and symptom relief (the psychotic state, disturbing thoughts and voices, visual hallucinations).

Lai, C., Su, Y., Lin, S., Yu, C., & Lin, Y. (2010). Music and restraint: Emotional control effects on psychiatric patients kept in seclusion. *Journal of Nursing and Healthcare Research*, 6(4), 308-318.

This study compared the effects and differences of music and restraint on psychiatric patient's emotional control in a seclusion room in an acute psychiatric setting. While this study did not have access to music therapy services, they did have access to music. The authors found that using music was significantly more effective in reducing anxiety and

hostility of patients who were isolated in a seclusion room. Further, they found that music had a more prolonged effect than restraint on emotional control.

Geretsegger, M., Mössler, K. A., Bieleninik, L., Chen, X., Heldal, T., & Gold, C. (2017).

Music therapy for people with schizophrenia and schizophrenia-like disorders. *Cochrane Database of Systematic Reviews*, 2017(5). doi: 10.1002/14651858.CD004025.pub4

This article examined 18 studies involving music therapy and people with schizophrenia and related disorders with a total number of 1215 participants. The authors found that there was a positive effect on global state found for music therapy when compared to standard care. Specifically, they found improvements in negative symptoms, mental state endpoint scores on positive and negative symptoms, scores for the Brief Psychiatric Rating Scale, and improvement in social functioning and quality of life.

Silverman, M. J. (2003). The influence of music on the symptoms of psychosis: A meta-analysis. *Journal of Music Therapy*, 40(1), 27-40.

This article is a meta-analysis of 18 studies that looked at the impact of music on symptoms of psychosis. Across the studies, the author found that music was proven to be significantly effective in suppressing and combating the symptoms of psychosis. The author also compared music genres, finding that nonclassical music (compared to classical music) shows a better response in reducing psychotic symptoms. It was found that popular music had a greater influence and that therapist-selected and patient-selected music displayed the most effect.

Kerr, T., Walsh, J., & Marshall, A. (2001). Emotional change processes in music-assisted reframing. *Journal of Music Therapy*, 38(3), 193-211.

This study looked at 40 anxious adults and examined the specific use of a music-assisted reframing intervention to increase affective modification and emotional restructuring. The experimental group receiving music-assisted reframing, which involved a classical music program chosen by a music therapist, paired with cognitive reframing exercise within the practice of cognitive behavioral therapy. The control group received just the cognitive reframing intervention with no music. The authors found that the music-assisted reframing intervention was more effective than the control in reducing anxiety, modifying affect, and promoting imagery vividness.

Heriot-Maitland, C., Vidal, J. B., Ball, S., & Irons, C. (2014). A compassionate-focused therapy group approach for acute inpatients: Feasibility, initial pilot outcome data, and recommendations. *British Journal of Clinical Psychology, 53*, 78-94.

In this article, the authors provided compassion-focused therapy (CFT) for adult inpatients on an acute psychiatric unit. CFT is an approach created for people with severe mental illness and is applicable to "transdiagnostic, group-based therapy" (p. 80). In this mixed methods study, 57 participants received CFT group therapy and were tested for within-session changes in distress and calmness and tested post-session for understanding and perceived helpfulness. Further, some of the patients participated in semi-structured interviews to observe qualitative experience of the CFT. The themes in CFT included psychoeducation, mindfulness, compassion, and imagery. The authors found that participants understood the content and found them helpful and relevant to everyday life. Additionally, they displayed a significant decrease in levels of distress during group session and significant increases in levels of calmness (especially during imagery component). In the qualitative component, the authors identified within the patients the

themes of common humanity and affiliative relating, understanding compassion, activating positive affect, and experiences of the group.

Appendix F – Music Therapy Fact Sheet

Music Therapy Fact Sheet

What is music therapy?

Music therapy is the clinical and evidenced-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program.

Who is qualified as a music therapist?

In order to be a music therapist, one must graduate from an approved music therapy program, complete 1,200 hours of clinical work, and pass an exam administered by the Certification Board of Music Therapists (CBMT). A music therapist carries the credential Music Therapist- Board Certified (MT-BC). Music therapists demonstrate musical competence in a minimum of guitar, piano, and voice, but many may also have skills in other instruments. In Connecticut, a music therapist can hold a Bachelor's, Master's, or Doctoral degree in music therapy.

What does a music therapy session look like?

It varies depending on the patient. Because music therapy is an individualized practice, no two sessions are identical. A session may consist of active drumming as a form of tension-release or relaxing, breath-entrained music with guided breathing for anxiety. An individual music therapy session begins with an assessment, which locates strengths and areas for improvement, which informs treatment planning.

What is the difference between music therapy and therapeutic music?

The biggest distinction between music therapy and therapeutic music is that music therapy involves a therapeutic relationship between a credentialed professional and a patient. Therapeutic music is generally pre-recorded and determined by a person *for*, not *with*, the patient. Music therapy is also safer, as there is room to make in-the-moment adjustments as patient needs move. Music therapy is an evidence-based profession with a growing literature base. The American Music Therapy Association has two academic journals and publishes several texts devoted to the practice of music therapy.

Does someone need to know how to play an instrument to be involved with music therapy?

No! There is no need for prior musical instruction to be able to reap the rewards of music therapy. Music therapists are able to tailor sessions to the level of exposure to and expertise in music, addressing needs of people ranging from musical beginners to seasoned music professionals.

How does music therapy fit within the treatment team dynamic?

Part of music therapy training is recognition of treatment modalities that are present in various settings. A music therapist in an acute inpatient psychiatric setting would be present as part of the general treatment team, using interventions specific to the practice to address goal areas set forth by the medical team as a whole.

Appendix G - Resume**Gabrielle Bouissou, MT-BC**

301 W. 151st St, Apt. 4B, New York, NY 10039 • (203)739-5574 • gbouissou@gmail.com

Education

State University of New York at New Paltz

Masters of Science in Music Therapy (May 2018)

Graduated with Departmental Honors

Bachelor of Arts and Sciences (Graduated May 2015)

Major: Contemporary Music Studies

Concentration: Pre-Music Therapy

Graduated with Departmental Honors

Major: Psychology

McGill University

Bachelor of Arts (Attended 2011-2013)

Major: Psychology

Minor: Cognitive Science

Professional Experience

Music Therapy Research Fellow, Mount Sinai Beth Israel, Louis Armstrong Center for Music and Medicine, New York, NY

(August 2017 – Present)

- Overseeing ongoing research endeavors in the Neonatal Intensive Care Unit and Surgical Intensive Care Unit, including IRB applications and renewals
- Program building in inpatient psychiatric units
- Run individual music therapy sessions in NICU, SICU, inpatient psychiatric, general medical, and palliative care units
- Ran group music therapy sessions in the inpatient psychiatric unit and for staff

Music Therapy Intern, Mount Sinai Beth Israel, Louis Armstrong Center for Music and Medicine, New York, NY

(August 2016 – June 2017)

- Ran individual music therapy sessions for patients in settings including Neonatal Intensive Care Unit, Surgical Intensive Care Unit, Pediatric Emergency Room, Maternity, Inpatient Psychiatric Unit, and Outpatient Music Psychotherapy Clinic
- Conducted and organized Caring for the Caregiver groups for hospital staff during hospital merger
- Assisted in department related tasks including execution of annual fundraising event *What A Wonderful World Gala*

Music Therapy Practicum Student, Health Alliance of the Hudson Valley, Adolescent Partial Program, Kingston, NY

(September 2014 – December 2014)

- Ran music therapy sessions in a group setting with three to twelve patients
- Ran individual music therapy sessions
- Consulted on budgeting for music therapy resources

Music Therapy Fieldwork Student, Hudson Valley Hospice, Poughkeepsie, NY

(January 2015 – May 2015)

- Prepared music for Remembrance ceremonies each week
- Lead and co-lead music therapy sessions with hospice patients

Music Therapy Fieldwork Student, Elizabeth Seton Pediatric Center, Yonkers, NY
(August, 2015 – December, 2015)

- Conducted two group sessions specific to infants and children and adolescents with Passy-Muir® Valves
- Lead individual music therapy sessions with residents ranging in age and medical presentation

Graduate Assistant to Dr. Maria Montserrat Gimeno, Dr. Joanne Loewy, Dr. Concetta Tomaino, Dr. Heather Wagner, Brian Harris, MA, MT-BC, LCAT, New Paltz, NY
(August 2015 – May 2017)

- Aid in organizing class, presentation, and research materials
- Collaborate on presentations for conferences

Presentations

Trauma Theory & Treatment: Somatosorial Implications of Resilience, May 2018, Mount Sinai Beth Israel, New York, NY

- Caring for the Caregiver – Utilizing Preventative Strategies in Creative Arts Therapies in the Workplace (with Joanne Loewy, DA, LCAT, MT-BC and Mari Umpierre, PhD, LCSW)

Mid-Atlantic Region of the American Music Therapy Association Music Therapy Conference, April 2018, Pittsburgh, PA

- Environmental Music Therapy in ICU Settings: Considerations for Research and Practice (with Gabriela Ortiz, MA, MT-BC, LCAT, NRMT)

Music and Medicine Grand Rounds, April 2018, Mount Sinai Beth Israel, New York, NY

• Sounds of Strength and Resilience: Medical Music Psychotherapy in Acute Psychiatric Settings
“Music and the Brain: A Case for Music Therapy,” August 2017, Baruch College, New York, NY

- Guest Lecture

SUNY Undergraduate Research Conference, April 2015, SUNY Brockport, Brockport, NY

- Case Study of BA1: Prescribing Playlists for Pain

Mid-Atlantic Region of the American Music Therapy Association Music Therapy Conference, March 2015, Harrisburg, PA

- Communication Through Music with Spanish Speaking Clients (with Maria Montserrat Gimeno, EdD, MT-BC, LCAT)

Leadership Activities

Founder & President, Undergraduate Music Student Association, SUNY New Paltz (May 2014 – May 2016)

Student Advisory Board Member, School of Fine and Performing Arts, SUNY New Paltz (September 2014-May 2015)

Parliamentarian, Music Therapy Club, SUNY New Paltz (September 2014-May 2017)

Co-President, Classical Music Club, McGill University (2011-2013)

Trainings and Affiliations

Board-Certified Music Therapist (MT-BC) (July 2017 – present)

Member, American Music Therapy Association (September 2015 – present)

Neurologic Music Therapist

RBL NICU Training