

Benedictine, Bridge Back, and Beyond:
A Proposal for an Integrated Music Therapy Program
Involving Graduated Levels of Substance Misuse Treatment

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Dedication

I dedicate this work to my wonderful friend, Paula Cochran, who supported me throughout the early process of writing this thesis, and to Ian Bell who was there until the end.

And to my inspiring children,
Ian, Nathan, Thaddeus and Abigail

Thank you for believing in me.

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You can outdistance that which is running after you,
but you cannot outdistance that which is running inside
you.

- *African proverb*

Table of Contents

Title Page _____	1
Acceptance of Thesis _____	2
Acknowledgements _____	3
Dedication Page _____	4
Table of Contents _____	5
I. Summary Statement _____	8
II. Statement of Need _____	9
II. Literature review _____	11
Avenues to Addiction _____	11
Experienced Trauma: One Source of Substance Abuse _____	11
Entering a Drug Treatment Program _____	12
Music Therapy _____	13
Comparative reviews of Music Therapy and Addiction _____	15
Music Therapy and Patient Retention _____	17
Music Therapy to treat Comorbid Disorders _____	17
Music Therapy to Address Women’s Needs _____	17
Music Therapy and Emotion Modulation _____	19
Replacing Drugs with Music _____	19
Harm Reduction Model in Music Therapy _____	20
Trauma Work with Body Awareness _____	21
Drumming and Substance Abuse _____	22
Music Therapy and Depression _____	23
Music Therapy and ADHD _____	23
Literature Review Conclusion _____	24
IV. Proposed Music Therapy program at HealthAlliance _____	25
Mission Statement _____	25
Courage, Dignity, Strength, Hope _____	26
Music Therapy at the First Step Program at Benedictine Hospital and Bridge Back _____	26
Definition of Music Therapy _____	27
IV. Detailed Description of Music Therapy program _____	32
Target Population _____	32
Benedictine Hospital _____	32
Bridge Back Outpatient _____	32
Overview of the Program _____	33

First Phase _____	33
Second Phase _____	34
Third Phase _____	34
Components of the Proposed Program _____	35
Benedictine Hospital _____	35
Bridge Back Outpatient _____	36
Music Therapy Methods _____	37
Music Therapy Techniques at HealthAlliance Addiction Treatment Services _____	39
Music Assisted Relaxation _____	40
Song Communication _____	40
Lyric Analysis _____	41
Instrumental Improvisation _____	42
Song Discussion _____	43
Songwriting _____	44
Imaginal Listening _____	45
Music and Movement _____	46
Creating Song Lists _____	46
Re-creative _____	47
Personnel Responsibilities _____	48
Work Schedule _____	48
Number of Patients Served _____	50
Anticipated Positive Outcomes _____	50
Reduced Anxiety, Depression and Stress _____	50
Increased Patient Engagement _____	50
Positive Marketing _____	51
Emotional Balance _____	51
Increased Understanding of Pain _____	51
Increased Understanding of Relaxation and Sleep Hygiene _____	51
Increased Positive Sense of Self _____	51
Increased Sense of Connection and Hope _____	52
Increased Sense of Health and Wellness _____	52
Contraindications _____	53
V. Financial Justification _____	54
Personnel Expenses _____	54
Instruments and Equipment _____	54
Timeline of Implementation _____	58
VI. Larger Facility Context _____	59
VII. Outcomes and Assessments _____	60
Data _____	60
Referrals and Assessments _____	61
VIII. Conclusion _____	62

IX. References	63
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IX. Appendix:

A. Referral Forms	73
B. Group Session Assessment	74
C. Individual Session Assessment	76
D. Group Music Therapy Session Assessment	77
E. Individual Music Therapy Session Assessment	78
F. Music Therapy Exit Assessment	79
G. Music Therapy Fact Sheet	80
H. Resume	83
I. Annotated Bibliography	86

Tables and Figures:

Table 1 Proposed Music Therapy Schedule	49
Table 2 Yearly Expenses	54
Table 3 Equipment and Instruments Already Available	56
Table 4 Required Equipment	56
Table 5 Year Two Equipment	57
Table 6 Instruments for Long-Term Planning	57

Summary Statement

The following document is an in-depth proposal for expanding a part-time music therapy program in a medical setting focused on the needs and concerns of people who are struggling to recover from an addiction to drugs and/or alcohol. The enlarged program would include a full-time music therapist with expanded responsibilities. This proposal has been designed for the HealthAlliance programs in Kingston, New York: First Step Detoxification Program and the First Step Rehabilitation Program at Benedictine Hospital, the Outpatient Program at Bridge Back South.

The needs of patients recovering from alcohol and drug misuse are specific to their stage in the recovery process, detoxification, early rehabilitation, or longer-term rehabilitation. This proposed music therapy program addresses the specific needs of the patient at each stage of the recovery process. This proposal focuses on the needs of the patients, describes details of the actual program, and shows how the music therapy program integrates into the larger context of the medical program. Finally, it lays out the financial needs of the proposed music therapy program and its expected outcomes. This proposal will demonstrate how a strong, integrated music therapy program can assist in the care and healing of people suffering from substance misuse and how to address its underlying causes.

Statement of Need

Substance abuse is a serious issue that impacts families across all socio-economic levels of society (Hari, 2015; Lewis, 2015). A new concern in social health are the growing diseases of despair (Case & Deaton, 2015; Schuckit, 2017; Scutchfield & Keck, 2017). The diseases of despair are the combination of deaths from alcohol, suicide and controlled substances which are resulting in the lowering of life expectancy in white, middle-aged people in the United States. (Case & Deaton, 2017; Schuckit, 2017). Alcohol, heroin, cocaine, marijuana, methamphetamine, ecstasy, opioid painkillers, benzodiazepines, fentanyl and nicotine are some of the abused substances used by Americans. Data from The National Institute on Drug Abuse (NIDA;2017) found that more than 47,000 Americans died as the result of opioid overdose, including prescription opioids, heroin, and illicitly manufactured Fentanyl, a powerful synthetic opioid.

Americans throughout the country are impacted by substance abuse. Every day throughout the year at least 130 people die of opioids alone (NIDA, 2019). These opioid deaths include the misuse of legal and illegal opioids, including heroin, prescription painkillers, and synthetic opioids such as fentanyl. This is a national crisis that affects the social and economic welfare of Americans in addition to public health (NIDA, 2019). It is estimated that the economic costs of prescription opioid misuse in the United States is at least \$78.5 billion a year, and rising (NIDA, 2019). These costs include the expenses connected with addiction treatment, lost employment, the involvement of the criminal justice system, and the costs of healthcare. It does not include the extensive emotional and financial damage done to children and other family members who are impacted by the addiction (NIDA, 2019).

The rate of alcohol use disorder has risen by 49% in the last ten years (Schuckit, 2017). As of 2017, the percentage of adults diagnosed with alcohol use disorder in the United States is 12.7% or approximately one in eight American adults (Schuckit, 2017). It is estimated that around 88,000 people die of alcohol related causes each year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). Additionally, nearly one in four adults under the age of 30 meet the criteria for alcohol use disorder (Schuckit, 2017). In 2018, approximately 20.3 million people in the United States had a substance use disorder, using either alcohol or illicit drugs (SAMHSA, 2019).

Music therapy is a practice that can counteract some of the sources of addiction which are disconnection, physical pain, and the pain resulting from trauma and sense of lost agency in this world (Hari, 2015; Horesh, 2006; Miller, 2017; Punkenen, 2006; Quentzel, 2013). Music therapy in a substance abuse treatment center supports the nursing staff by helping patients cope with their pain (Quentzel, 2013). Music therapy can also lessen anxiety (Hammer, 1996), and supports a feeling of community among the patients and their peers, lessening their sense of isolation (Silverman, 2010). Music therapy also provides a space to share patient's concerns and may find that others have had similar experiences as themselves (Silverman, 2015). The following literature review will address the ways that music therapy can be used to meet the needs of persons with substance abuse issues.

Literature Review

Avenues to Addiction

Before discussing music therapy and its role in assisting those with substance use disorders, it is important to review a short history of addiction in order to put the treatment of substance abuse in context. During the nineteenth century and the first half of the twentieth century there was a belief that addiction in an individual was due to a moral failing. The offending person was therefore punished in some manner, usually a sentence to jail or prison (Heather, 2017; Matano & Wanat, 2000). In the mid-twentieth century, understanding had shifted, referring to addiction as a disease. (Heather, 2017; Matano & Wanat, 2000). However, people with a substance abuse disorder continue to be sentenced to jail or prison for their substance use (Hari, 2015; Lewis, 2015; Matano & Wanat, 2000).

In the late twentieth and early twenty-first century, there has been a great increase in the use of pharmaceutical drugs to dampen the sensation of pain which has led to physical and psychological addiction to prescribed drugs (Tetsunaga et al., 2018). When the addicted individual no longer receives their prescribed medication, they often turn to illicit drugs which they must find on the streets, steal from family members, or exchange for favors from those who have the drugs which are being sought (Rash et al., 2016).

Experienced Trauma: One Source of Substance Abuse

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental reason for increasing public mental health and substance abuse services and has supported the development and expanding trauma-informed systems of care (SAMHSA,

2014). In numerous studies on the effect of trauma in childhood, adverse childhood experiences (ACE), it has been found that the more numerous negative childhood experiences an individual experiences, the greater their risk for chronic health conditions and health-risk behaviors such as addiction, as adults (Felitti et al., 1998).

Examples of adverse childhood experiences (ACE) are physical, sexual, and emotional abuse; childhood neglect; living with a family member with mental health or substance use disorders; sudden, unexplained separation from a loved one, poverty, racism, discrimination, and oppression; violence in the community, war or terrorism (Felitti et al., 1998). If an individual experiences four or more adverse childhood experiences they are seven times more likely to consider themselves an alcoholic, ten times more likely to use injected street drugs and twelve times more likely to have attempted suicide (Felitti et al., 1998).

Those who have experienced trauma may attempt to cope with the processing of their emotional or physical pain through unhealthy behaviors such as unhealthy eating, tobacco use, or drug or alcohol use (van derKolk, 2014; SAMHSA, 2014; Felitti et al., 1998). These attempts to cope may provide temporary relief but they can also lead to anxiety, social isolation, and chronic disease (Felitti et al., 1998). An expert on trauma, van der Kolk (2014) found that most victims of child abuse suffer from terrible shame, guilt, and confusion, which can lead to self-medication through alcohol and drugs.

Entering a Drug Treatment Program

The individuals who enter a drug treatment program may enter on their own volition, by court order, or by pressure from others (Chandler, et al., 2009). When a patient enters a substance abuse facility, the initial treatment is focused on physical symptoms. The patients may

exhibit nausea and vomiting, tremors, hallucinations, aching muscles, stomach pain, and diarrhea and secondary symptoms which are the result of their habit may include a damaged liver, HIV/AIDS, malnourishment, disorientation, and memory loss (APA, 2013). In addition to nursing care, treatment at this phase is typically through psychoeducation programs designed to educate the patients on the risks of substance misuse and the ways to reduce harm or to stop their use (HealthAlliance, 2019).

Other symptoms upon admission may include anxiety, depression, and agitation, which may be symptoms of substance use disorder (APA, 2013). These symptoms need to be addressed during the treatment of the patients. Psychological, emotional, and spiritual symptoms are complex issues, and more difficult to treat than physical symptoms (Murphy, 2015). These issues can be best addressed through therapy, such as music therapy, rather than in psychoeducational programs.

Drug-free, alternative treatments like music therapy, are increasingly sought by patients, and are used as a supplement by facilities who work with individuals diagnosed with a substance use disorder (Aletraris et al., 2014). As such, music therapy is uniquely poised to address the emotional, psychological, and practical needs of individuals diagnosed with a substance use disorder.

Music Therapy

The American Music Therapy Association (AMTA) defines music therapy as “the clinical and evidence-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” (AMTA 2020). Important facets of this definition are the therapeutic

relationship and the individual goals of the patient or client, using music to realize these goals.

The relationship must be built on complete trust, deep listening, and creativity, all the while held within a therapeutic presence on the part of the therapist (Geller & Greenberg, 2012; Punkenen, 2006, van der Kolk, 2015, van Dernoot Lipsky & Burk, 2009).

Music therapy is delivered by four main types of music experiences or methods: receptive experiences, improvisation, re-creation and composing (Brusica, 2014). The receptive methods include listening to music and experiencing the music in a variety of ways, internally, verbally or in conjunction with another modality. In improvisational experiences the patient creates music by singing or playing an instrument. The patient may improvise a complete composition spontaneously or supply a rhythm or melody. Re-creative experiences give the patients an opportunity to sing or play a familiar or new piece of pre-composed music. Performance is not usually an aspect of this experience. The music therapist can also help the patient to compose lyrics, songs, or instrumental pieces of music (Bruscia, 2014).

In a substance abuse treatment program, the immediate needs of the patient may include dealing with pain, staying in the program, complying with medical advice, emotional support, moving toward understanding and accepting oneself and others, and later, finding avenues toward personal growth (Murphy, 2015). Music therapy can be used to create a space for addressing each of these needs, as a form of communication. Music therapy in the treatment of addiction is a growing field in which music and the therapist can be a part of the healing culture of the treatment program. Within the literature there are quantitative and qualitative music therapy studies which describe therapists working among the substance abuse disorder population in groups and in individual sessions.

Comparative Reviews of Music Therapy and Addiction

There have been several comparative reviews of the literature examining the efficacy of music therapy and addiction. In a review of the literature, Megranaham et al. (2018) found that an underlying problem that music therapy may address in addiction work is the limitation of life options that is inherent in addiction. Murphy (2018) noted the use of music therapy to address interpersonal problems, the lack of a sense of coherence, a sense of guilt, shame, loss, and depression. The studies examined by Megranahan (2018) followed the impact that the creative arts had upon reducing substance misuse, motivation for readiness, contemplation, action, helpfulness, treatment readiness, locus of control, and total motivation. Vega (2017) found that the creative arts helped patients to identify and express feelings and exposed the various masks that individuals hide behind. Silverman (2016) explored the subject of the working alliance between music therapists and patients in the world of substance abuse and found that the relationship which the music therapist creates with the patient is as important as the intervention used. Silverman (2009) found that communication, coping skills, emotional expression, decision making, and self-esteem were the most common clinical objectives of music therapists in the field.

In the comparative studies, various music therapy interventions were used. Among the interventions were music and imagery, lyric analysis, songwriting, improvisation, and re-creational music therapy (Murphy, 2017). Silverman (2009) found that lyric analysis and music assisted relaxation were the most common music therapy interventions. In some cases, dance, drama and movement therapies were used in addition to music therapy (Megranahan et al., 2018).

The use of songs have been found to be successful in substance abuse treatment.

Silverman (2010) found that single session music therapy using lyric analysis and verbal therapy significantly increased the locus of control. A blues songwriting intervention used in a group setting, significantly improved motivation and readiness for treatment (Silverman, 2012).

Silverman (2015) also found that lyric analysis with verbal processing in a group setting led to significant improvement in measures of problem recognition, desire for help, treatment readiness and motivation using the Texas Christian University Treatment Motivation Scale.

Other methods of music therapy have proven effective in treatment with persons with substance abuse problems. Hammer (1996) found that Guided Imagery and Music (GIM) significantly reduced anxiety. GIM was also found to significantly decrease depression and increase a sense of coherence (Heiderscheit, 2009). An important conclusion to be drawn from these comparative studies is that the music therapist must carefully consider what intervention to use for the issue that they are addressing, and to choose one which has proven to be effective both in the research and in their own experiences.

Silverman (2003, 2010, 2012) has conducted numerous single session studies focusing on specific attributes of music therapy. He found that music therapy is less intrusive and less threatening to the patients than other therapies, making music therapy an ideal therapy for treating substance use disorders. In one study, Silverman (2003) compared the use of music games, relaxation training, lyric analysis, and songwriting versus the other therapies at the facility at the study site. He found that regardless of the music therapy technique used, music therapy was seen by the patients as a particularly effective means of therapy.

Music Therapy and Patient Retention

The issue of patient retention in treatment is an ongoing matter of concern (Dingle et al., 2008; Silverman, 2015). Dingle et al. (2008) found that patients dropped out of programs because they often find the programs too controlling, with no freedom of expression. Silverman (2015) found that after a single session of music therapy using lyric analysis, patients were more motivated to stay in their rehabilitation program. Dingle et al. (2008) also used lyric analysis, as well as songwriting, improvisation, and singing to engage the patients in the groups. These authors found that the music therapy groups helped the patients learn the abstinence material and stay engaged.

Music Therapy to Treat Comorbid Disorders

Comorbidity is a common occurrence among the patients within substance abuse facilities. Depression, anxiety, ADHD, bi-polar disorder, schizophrenia, schizoaffective and mood instability are common secondary diagnoses (Gallagher & Steele, 2002). Gallagher and Steele (2002) found that through engagement in music therapy, including playing instruments, participating in relaxation exercises, and verbal processing, patients were able to learn about recovery issues and identify their daily state of being. At the end of a nine-month program of music therapy treatment, the patients were found to have acquired a new set of skills to use in their lives: coping skills to manage stress, recovery skills, mental health stability, and relapse prevention (Gallagher & Steele, 2002).

Music Therapy to Address Women's Needs

In considering the needs of individuals with substance abuse issues, gender may play a role in the treatment process. Cevalco et al.(2005) found that women were more likely to have

been raised in homes with drug use, physical, and sexual abuse than men, and that women had more severe life problems, lower mean incomes, less employment, and education than men. Women were often single parents, and engaged with child protective services and managed the home. One of the greatest differences in the initiation of substance abuse between genders, was that males initiated substance abuse to create positive affective states and females initiated use to cope with negative affective states, especially physical and emotional pain, depression, stress, anxiety, and anger (Cevasco et al, 2005).

Miller (2017), while leading music therapy groups for females, used mindfulness techniques and a philosophy that connects to the AA principle of “one day at a time.” The author found that music therapy experiences gave individuals an opportunity to connect meaningfully with the self and others, validated the experiences of individuals, and gave the women a sense of control. The author found that mindfulness reinforced present-focused awareness, and encouraged the participants to see the bigger picture instead of being caught by narrow, habitual behavior (Miller, 2017).

Gardstrom (2017) described four needs that relate to women in recovery: safety, inclusion and connectedness, emotional expression and validation, and self-respect and empowerment. She concluded that women in recovery need to have their voices heard. Gardstrom (2017) used song re-creation, music listening, and improvisational music therapy methods with female patients. She found that music therapy was a useful modality with this population, including the music techniques used and the intrapersonal aspects of the work.

Music Therapy and Emotion Modulation

Baker et al. (2007) used cognitive behavioral music therapy with patients in a long-term detoxification-rehabilitation program to explore the possibility of reducing emotional responses to the experience of feelings which often drive them to use their substance of choice. Baker et al. (2007) used song writing, song analysis, group singing, cognitive problem solving through music, instrumental improvisation, as well as dealing with feelings that arise in combination with depression, anger and shame. The authors found that the music interventions employed helped the patients to understand that they can tolerate difficult emotions without resorting to the use of their drug of choice.

Replacing Drugs with Music

Music processing is located in the same part of the brain as the experience of euphoric drugs. This connection makes an interesting challenge to those who work with patients with a substance use disorder. Fachner (2017) discussed the scientific, and chemical links between the euphoria of certain music to that of drugs and the reduced effect over time of the drug's use. The reduced effect prompts the substance user to increase the quantity of their drug of choice (Fachner, 2017).

Horesh (2006) observed the clear relationship between using music and using drugs to ease, stimulate, give context to, and to forget parts of their lives. Horesh (2006) saw that her patients were struggling to move from their culture of addiction to the culture of recovery, which can be even more difficult than the initial phase of substance withdrawal. After an instrumental improvisation, patients took on regressive behaviors from their former lives of drug use. The

patients were able to integrate the experience through verbalizing about it, and to move on to a greater understanding of their vulnerabilities and to the process of change (Horesh, 2006).

Music used in therapy can help to reframe the emotions of the drug's effect by the patient, replacing the drug with music (Fachner, 2017). The music may be used as an addition to mental health drugs already in use by the patient, therefore reducing the need for the medications (Fachner, 2017). Loewy (2017) supported the theory that there is power in music to access the brain and has the potential to create an altered state without the use of a substance.

Harm Reduction Model in Music Therapy

The abstinence model of substance abuse treatment demands total abstinence from substances in a substance abuse facility and beyond, according to the precepts set down by the AA 12-step model (HealthAlliance,2020). Under this model, when a patient has relapsed, or taken an illicit substance of any kind or amount, it is often seen as a serious setback, which can draw punishment and shame of some kind in the legal or recovery systems. There are, however, other options, such as the harm reduction approach to recovery.

The harm reduction model works to modify behavior and life styles to support a healthier way of living with the intention of reducing the poor quality of life and choices, and moving the individual toward greater wellness and reduced use (and possibly the eventual elimination) of controlled substances (Smith, 2017; Ghetti, 2004). Harm reduction psychotherapy, and music therapy, meets the client where they are, accepts the individual as they are, explores why they “use”, and allows the clients to set their own goals, working collaboratively with social workers and therapists and community members. Ghetti (2004) found that music therapy works well within the context of harm reduction as the therapist can effectively work with groups to modify

responses and group dynamics, discuss musical references, work with emotional content, address damaged self esteem, teach new ways to cope, and increase motivation without the fear of judgement or punishment. In her approach, Gheti (2004) used lyric analysis, improvisation, and musical group work to rebuild social skills and the self-discipline of the individuals that she worked with within a harm reduction context. In his work, Smith (2017), a music therapist, sought individuals who were the most at risk for health and social concerns. Instead of requiring a person with a substance use disorder to go to a facility to seek help with their disorder, Smith (2017) went out into the community to find and support those who had a substance use disorder. He worked with other mental health workers and community members to build a community-based, harm reduction program with substance users on the streets. He used group jam sessions, songwriting and empowerment through peer leadership and community involvement to support individuals with substance use disorders.

Trauma Work with Body Awareness

Dealing with felt trauma, safety, frozen emotions and potential long-term recovery from substance abuse, Punkanen (2011) outlined the four phases of addiction as: withdrawing from our bodies, attempting to control experiences and situations through denial, rejecting all negative feelings, and finally, ultimately, using drugs. Punkanen (2011) focused on helping clients to learn to cope with their emotions which had formerly seemed impossible to tolerate, through creating a safe place within the client (using anchors, music, and chosen memories), and integrating past experiences. Punkanen used a three-fold method of dealing with these frozen states: verbal conversation, physioacoustic treatment, and listening to music carefully chosen by the therapist. The session ends with verbal discussion of the experience. He found that by

carefully working with patients, he was able to bring them to a greater state of self-awareness and health. This trauma-based work is strongly supported by the work of Bessel van de Kolk (2014) who stated that the essence of trauma is “feeling godforsaken, cut off from the human race” (van der Kolk, p. 357). The work of Punkanen brings the client back into their body, restores their memories and integrates them into a tolerable whole.

Felitti, (2012) the leader of the ACE study group said that:

Although widely understood to be harmful to health, each adaptation [such as smoking, drinking, drugs, obesity] is notably difficult to give up. Little consideration is given to the possibility that many long-term health risks might also be personally beneficial in the short term. We repeatedly hear from patients of the benefits of these “health risks”. The idea of the problem being a solution, while understandably disturbing to many, is certainly in keeping with the fact that opposing forces routinely coexist in biological systems. What one sees, the presenting problem, is often only the marker for the real problem, which lies buried in time, concealed by patient shame, secrecy and sometimes amnesia - and frequently clinician discomfort.” (pp. 149-150)

Drumming and Substance Abuse

As van der Kolk observed (2014), it is important for people who have experienced trauma and those who are dealing with a substance use disorder to move from their minds into their body, being aware of their somatic experience. Drumming is an effective music therapy intervention which draws the patient out of their mental ruminations into their bodily experience.

Winkelman (2003) worked with patients in recovery facilities and found that drumming was effective at promoting relaxation, brain synchronization, pleasurable experiences, awareness

of pre-conscious dynamics, release of emotional trauma and reintegration of self. Hill (2017) found that drumming helped patients to express their emotions through the playing of their snare drum without verbal communication, and that developing emotional intelligence through drumming can assist drug-addicted individuals with their coping strategies.

Winkelman (2003) found that drumming helped patients to reconnect with their healthy self and others, creating community. This is particularly important with individuals who have a substance use disorder since addiction grows out of, and creates, a deep sense of disconnection (Winkelman, 2003). Through the drumming experiences and its relationship with shamanic traditions, patients have been able to make a connection with their higher power and altered states of consciousness without the use of drugs (Winkelman, 2003).

Music Therapy and Depression

Albornoz (2011), studied the effect of improvisational music therapy on 24 Spanish-speaking patients who are being treated for substance abuse at a treatment facility. They each took part in the Beck Depression Inventory and the Hamilton Rating Scale for Depression. Albornoz (2011), found that the members who took part in the improvisational music-making were found to be significantly less depressed than the control group. Improvisational music therapy had a clinically significant impact. (Fachner, et al., 2013).

Music Therapy and ADHD

ADHD, like depression, and anxiety is a common diagnosis among patients who are substance use dependent (Wilens, 2004). The symptoms of ADHD are distractibility, unpredictability and physical activity to the point that the person is not able to sit still or follow

directions. In recent years, researchers have been pursuing the possibility that ADHD is actually an individual's response to harbored anxiety and depression due to trauma (Vrijsen et al, 2018).

It is common for the patients in a substance use clinic or in-patient facility to exhibit the traits of ADHD (Wilens, 2004). McFerran (2009) studied music therapy and participants with ADHD, focusing on choice, control, creative engagement, and authentic expression. The author found that when the therapist focused less on behavior and more on emotional direction, music was a helpful tool in that it focused on the client's strengths instead of their deficits (McFerran, 2009).

Conclusion

As Johan Hari said in his TED Talk, (July 9, 2015), the opposite of addiction is not sobriety. The opposite of addiction is connection: connection with your life history, with your complete self, an accepting relationship with your former addictive habits, and with healthy others. Positive connection can guide one to create a new life of hope and wellness. Music therapy may be one way to help foster these positive connections.

Proposed Music Therapy Program at HealthAlliance
Addiction Treatment Services of Benedictine Hospital and the Bridge Back Outpatient
Program

This program proposal is designed to add an expanded music therapy program to the services already provided by the Addiction Treatment Services of HealthAlliance, a subset of the Westchester Medical Center health network. The divisions of the Addiction Treatment Services are the First Step Inpatient program, with the detoxification and short-term rehabilitation programs. These are the first two phases of care which are found at Benedictine Hospital in Kingston, New York. The third phase of care, long-term rehabilitation, is found at the Bridge Back Outpatient facility in Kingston, New York.

The First Step program includes a detoxification unit and a short-term rehabilitation unit which are both housed within a locked wing of the hospital. The detoxification program is focused upon the physical well-being of the patients, helping the patients to carefully withdraw from the drugs or alcohol which necessitated hospitalization. Patients who are in the detoxification unit and have been medically cleared, are expected to take part in the daily programs and activities. After detoxification, a patient can continue their care in the rehabilitation level of care, also in this unit of Benedictine Hospital. The rehabilitation phase can last up to twenty-eight days, depending upon need, desire, and insurance coverage.

Mission Statement

The mission statement on the website of the First Step program is:

The HealthAlliance Substance Abuse Programs are 12-step-based, multidisciplinary programs dedicated to serving the chemical dependency needs of the community. This is

accomplished with dedicated staff providing non-judgemental, accessible and non-disciplinary, patient-focused care, for the commitment of continuous performance improvement. First step programs use the AA 12-step philosophy and believe that addiction is a treatable disease and follows a medical model. Patients attend daily meetings, and First Step believes in the importance of these meetings to recovery.

(HealthAlliance, Addiction and Substance Abuse Services, 2020)

Courage, Dignity, Strength, Hope

The First Step program has developed a system of medical care that is committed to providing up-to-date treatment, responds quickly to an individual's call for help, and to treat each patient with respect and in a confidential manner (HealthAlliance, Addiction and Substance Abuse services, 2020). They aspire to restore each patient to complete and long-term health of body, mind and spirit. The First Step program includes a wide variety of groups, and addresses various special needs such as pregnancy, mental health issues, domestic violence, or challenges with child protective services. These services include 12-step meetings, mental/psychiatric services, individual counseling, aftercare planning, and referral services. They also offer family counseling sessions, music therapy, suggestions for medical care, HIV/AIDS advice, pregnancy counseling, methadone maintenance, as well as daily walks, spiritual guidance, nutritious meals, and pet therapy. (HealthAlliance, Addiction and Substance Abuse Services, 2020)

Music Therapy at the First Step Program at Benedictine Hospital and Bridge Back

Currently, there is a limited music therapy program within the First Step program at Benedictine Hospital and at Bridge Back. It is staffed by a part-time music therapist who works 25 hours a week, runs 4 group sessions and meets with 6 individuals weekly. The expanded

music therapy program will address the three stages of institutional care for patients diagnosed with Substance Use Disorder: detoxification, early rehabilitation, and long-term rehabilitation and recovery.

Definition of Music Therapy at HealthAlliance

There are many definitions of music therapy throughout the world (Bruscia, 2014). Music therapy is a discipline which combines music and therapy. In music therapy practice, it is important to incorporate the needs of the client, the roles of the patient and therapist, the responsibilities of the therapist, the relationship formed between the therapist and client, the goals of therapy, and the therapeutic process itself (Bruscia, 2014).

The definition of music therapy from the Greek Association of Music Therapists seems to resonate most fully with the approach of the First Step Program. This definition focuses on three aspects of music therapy: pain, relationship, and growth. These closely align with the three stages of institutional care directed in recovery: detoxification, early rehabilitation, and long-term rehabilitation. The Greek definition of music therapy is:

The use of music as a therapeutic instrument, a psychotherapeutic activity involving music and often verbal activities to increase self-awareness through the subconscious, ultimately guiding the patient to behavior which meets his needs. It is an educational and psychotherapeutic tool used to discover the undeveloped capacities and intellectual status of the patient and to facilitate more rational thinking. Through both educational and psychotherapeutic interventions, the patient's personality is addressed. In the definition of the Greek association, both music and therapy are defined because each has a specific function with music therapy. Therapy is supported by sounds and music of all kinds: 1)

to alleviate the patient's pain both physically and psychologically, 2) to bring the patient into a more harmonic relationship with himself and his environment, and 3) to give him, through musical education, a greater personal self-awareness and a discovery of his hidden capabilities. (Prinou 1993, p. 241)

The Greek definition delineates the three aspects of music therapy which correspond neatly with the three stages of recovery in the Benedictine-Bridge Back program. Each stage has therapeutic tasks which are inherent at each stage of recovery and within the therapeutic experience.

Detoxification. The first stage, detoxification, addresses the pain of withdrawal: physically, emotionally, psychologically and mentally. For many patients there is acute physical pain which is addressed by the nursing staff, the emotional and psychological pain of loss, anxiety and depression (SAMHSA, 2015).

Early Rehabilitation. The second phase of recovery is early rehabilitation, which is found in the programming of the Benedictine Hospital rehabilitation program. As the Greek definition of music therapy states, the work of this stage is to bring the patient "into a more harmonic relationship with himself and his environment" (Prinou, 1993, p. 245). The music therapist can carefully help the patient examine intrapersonal relationships, interpersonal relationships, develop emotional awareness, develop an understanding of the influence of past experiences, and develop healthier coping skills. It is recommended that a music therapist working within the field of substance use disorders use a trauma-informed approach that is aligned with the philosophy of the AA 12-Steps. This can be facilitated through various music therapy methods, including lyric discussion, songwriting, and community music making (Borling, 2011; Murphy, 2015).

Long Term Rehabilitation. When a patient moves into a longer-term facility or to other post-care treatments, the patient shifts into the third phase of treatment. This third phase of music therapy at the Bridge Back Outpatient facility will entail work which can create a deeper self-awareness and a new or re-discovered sense of self. In a long-term facility there can be opportunities to learn new skills such as how to play an instrument, discover inherent positive qualities, or create pieces of art with other individuals. These are the three phases of music therapy which will be offered by the integrated music therapy program at the Bridge Back outpatient facility.

Theoretical Orientation. The integrated music therapy program at Benedictine Hospital's First Step program and Bridge Back's Outpatient Program will be built upon a creative, holistic, psychodynamic, person-centered theoretical orientation. This program will use a variety of music therapy methods and their variations. The music therapy program will include music making opportunities in both individual, and group formats. It is important that this program be implemented by a music therapist who is adept at creating a therapeutic alliance in order to fully support patients' growth, sense of safety, and recovery (Geller, 2015). The music therapy program will be integrated within three parts: detoxification, and both short, and long-term rehabilitation levels that are focused on individualized treatment to help each patient achieve physical, emotional and spiritual health (HealthAlliance, 2020).

Borling's (2011) and Murphy's (2015) research in this field support the design of a three-part program and the different levels of care required within each level. They discussed the three, major levels of care as the biophysical, psycho-emotional, and psycho-spiritual aspects of recovery. Murphy (2015) outlined the biophysical issues of the detoxification phase of recovery

as physical withdrawal from the drug, and the accompanying symptoms of pain, insomnia, and the emotional response of uncomfortability. Murphy (2015) and Borling (2011) found that the pressing issues during the early rehabilitation phase are the emotional topics of depression, anxiety, anger, sense of loss, and an awareness of their state of being, as well as addressing faulty thinking, denial, self-esteem issues, change, acceptance and forgiveness.

Borling (2011) used stress management, physical movement, and drumming to deal with the first stage of recovery, and lyric discussion, songwriting and structured imagery work in conjunction with the 12-step literature during the second stage of recovery. He added that at some point the patient arrives at a true desire to stop the cycle of using, and to begin building a new life and self, looking for peace, joy and serenity.

Borling (2011) and Murphy (2015) address the spiritual recovery of an individual in the third stage of recovery. This includes finding one's Higher Power following the 12-step AA philosophy, and a deep sense of well-being. Murphy (2015) also includes connecting to the intrinsic goodness within each individual and the interconnectivity of all humankind in their understanding of spirituality and wholeness. Borling (2017) finds that musical rituals, therapeutic singing, drumming, clinical improvisation, song discussion, composition, and movement are all ways in which an integration of the whole person can occur for emotional affective growth. He also believes that music imagery can help in healing trauma, leading a patient to long-term recovery.

In her instructive articles on the construction of a music therapy group session, Murphy (2013, 2015) discussed the steps that a skilled music therapist in the field of addictions might take during a group session. She starts with a check-in, then a short warm-up exercise, followed

by the main activity and ends with a closing experience which brings the session to a clear ending. Within her sessions she also includes verbal processing. Her sessions attempt to connect the patients with a positive relationship with their bodies, minds and spirits.

Detailed Description of Proposed Program

Music Therapy and the Addiction Treatment Services of Benedictine Hospital and the Bridge Back Outpatient program

Target Population

The target population for this proposed music therapy program is patients in the Westchester HealthAlliance facilities of the First Step Detoxification Program and the First Step Rehabilitation Program at Benedictine Hospital and the rehabilitation program at the Bridge Back Outpatient facility. Patients in these programs either abuse or are addicted to alcohol, opioids, prescription medications, marijuana, and other illegal substances.

Benedictine Hospital

Patients in the initial phase of the Addiction Treatment “Step One” program at Benedictine Hospital are men and women who are 18 years of age or older, undergoing detoxification. An incoming patient of the detoxification program must be actively under the influence of alcohol or drugs. The length of stay in the detoxification program is two to ten days, depending on the substance abused and the general health of the patient. Once the acute phase of the detoxification program has been completed, detoxification patients move to the First Step early Rehabilitation Program at Benedictine Hospital. The rehabilitation program at Benedictine Hospital is one to four weeks in length, depending on insurance coverage, interest, availability of beds, and need.

Bridge Back Outpatient

Patients who have completed the detoxification program and the early stages of a rehabilitation program at Benedictine Hospital or elsewhere, may attend the outpatient substance

abuse treatment program at Bridge Back (Bridge Back Outpatient of HealthAlliance). Patients in this program are men and women who are 18 years of age or older who are not in need of detoxification, but who have been using an addictive substance within the last 90 days.

Prospective patients are interviewed before being admitted into the program. The potential patient needs to have insurance which is accepted by the facility, and be able to explain in what way(s) their life has been negatively impacted by their substance use. Patients come into the program from a variety of previous experiences and referral sources, such as Benedictine Hospital, Drug Court, other rehabilitation facilities, self-referrals, probation programs, and prison. Typically, they receive services at the Bridge Back Facility for four hours each day, five days per week.

Overview of the Program

This proposed music therapy program will expand the current music therapy offerings in the substance abuse programs at Benedictine Hospital and Bridge Back from a part-time position covering two full days and two half days to a full-time position. The extended hours will allow for a more complete music therapy program, from assessment through treatment to discharge. Within a full-time position, the music therapist will be able to treat the patients on a more individual basis and be more fully engaged in their progress through their entire recovery process at the facility.

First Phase

The Detoxification program is the first phase of the integrated music therapy program. In the detoxification program, music therapy can offer respite from the physical and psychological

pain, and the music therapist can provide psychoeducation on the use of music self-care while dealing with anxiety, agitation, and their acute emotional experience.

Second Phase

The second phase of the music therapy program at Benedictine Hospital is designed to focus on relating to oneself, to others, and to the world. The goals which are included within this phase of music therapy are: to increase the ability to empathize, to develop autonomy, to increase attention, to facilitate group cohesion and/or a feeling of group membership, to encourage interactive response, to develop self-awareness and insight, to improve self-esteem, to establish a sense of self with others, to develop responsibility for self, to develop support systems, and to facilitate verbal and non-verbal communication (Punkenen, 2011; SAMHSA, 2014). This work will be framed through a trauma-informed approach.

Third Phase

As the program progresses into the third phase of recovery at Bridge Back, the domains shift to self-discovery and wellness. Goals addressed include the development of spirituality, (Murphy, 2015; Borling, 2017) adjustment to life changes, developing impulse control, developing coping skills, developing executive functioning, preparedness for stressful situations, improving quality of life (SAMHSA, 2014), and instilling hope (Borling, 2017; May et al., 2015). As the music therapist works in both the Benedictine Hospital program and the Bridge Back program, the patients often welcome seeing the music therapist in both locations, creating continuity of care.

Components of the proposed program

The proposed program will require the full-time employment of one board-certified music therapist. The music therapist will serve both facilities, providing treatment for patients throughout the continuum of care from detoxification, through early rehabilitation, to long-term outpatient rehabilitation. The program components at each facility will differ depending on the needs of the patients at each level of care.

Benedictine Hospital

It is proposed that music therapy be scheduled in this facility 28 hours per week. The music therapist is part of the interdisciplinary treatment team, taking part in staff meetings, sharing observations made on the rounds, and other related team interactions. Other informal meetings and communications will occur on an as-needed basis.

There is a need for the various factions of a substance abuse treatment team, especially the therapists and nurses, to create an even more collaborative alliance for the benefit of the patients. This could be expanded to include all of the members of the treatment team, such as the psychiatrists, doctors, counselors, therapists and administrators (Loewy, 2017).

Large Group Sessions. The large group sessions will include all of the patients on the unit who are well enough to attend, as determined by the nursing staff. The large sessions usually begin with a check-in, meditation, and cover a recovery topic such as triggers, relationships, shame, or forgiveness through music therapy experiences, and end with a closing ritual. These groups are a regularly scheduled part of the treatment program.

Small Group Sessions. A small group will be convened when a specific need is discerned by a member of the treatment team or by the music therapist. The music therapist will

meet with the small group to address their needs or concerns through music therapy experiences. These will be scheduled on an as-needed basis.

Individual Sessions. Patients may be referred to the music therapist by members of the treatment team for an individual music therapy session. The music therapist will meet with the referred patient to address their needs and concerns through music therapy experiences. These will be scheduled on an as-needed basis. Bedside sessions.

Bedside Music Therapy. Bedside music therapy will be available for patients who are unable to attend group sessions for health reasons and for those who are isolated in their rooms due to disruptive behavior. Music therapy interventions will be chosen based on assessed needs, and the stated preferences of the patient during the bedside music therapy session. These will be scheduled on an as-needed basis.

Documentation. The music therapist will evaluate each group and individual session, and document the assessments and progress notes in the facility's computerized record-keeping system. See Appendices A-F for sample forms.

Bridge Back Outpatient

It is proposed that music therapy be assigned to the facility for 12-15 hours per week. The music therapist will be part of the Bridge Back interdisciplinary treatment team. As such, the professional will be part of the staff meetings, including rounds and other related team meetings. Informal meetings and communication will occur on an as needed basis.

Individual Sessions. At Bridge Back, the music therapist will meet with each new member of the group shortly after they arrive in order to assess the needs and inner resources of each patient. If deemed clinically appropriate, individual music therapy sessions may be

scheduled to meet the individual needs of patients, utilizing various music therapy experiences. These will be scheduled on an as-needed basis.

Large Group Sessions. The large music therapy group sessions are included in all patient's treatment plans at Bridge Back. After a short music-assisted meditation, one of a variety of music therapy experiences will be led by the music therapist to meet the goals and needs of the patients, followed by an open discussion of the experience, followed by a closing experience.

Documentation. Individual sessions will be documented on the secure access website, available to all of the treatment staff, under the administrative umbrella of HealthAlliance.

Music Therapy Methods

The four methods of music therapy are receptive, improvisation, re-creative, and composition (Bruscia, 2014). The music therapist will use all four of the methods in group and individual music therapy sessions held at Benedictine Hospital and Bridge Back. The choice of music therapy method will be based on the clinical needs of the patients.

Receptive Music Therapy Methods. Receptive music therapy methods involve the patients' listening and responding to a musical selection chosen by the therapist or the client (Bruscia, 2014). The music may be presented live or in a recording. The music chosen and the method of processing the experience are designed by the therapist to address a particular emotional, physical, aesthetic or spiritual need of the patient(s). This method may be used to reduce stress, pain, tension or anxiety by guiding the patients in music listening with an introduction (induction) designed to lead the patients into a state of relaxation. Receptive music therapy methods include song discussion, music and imagery experiences, music and movement, music assisted meditation, and projective drawing to music (Grocke & Wigram, 2007).

Improvisational Music Therapy Methods. Improvisational music therapy methods make a space for the patients to create music by singing or playing an instrument, with or without the participation of the music therapist. The music can be created with instruments, the voice, or body percussion, and individually or in groups. The therapist can guide a referential improvisation by inviting the patients to suggest a title for the improvisation, thereby giving a structure to the composition, as well as an emotional mood to the piece. Conversely, the group or an individual can determine the direction of the piece, giving them agency. The music therapist can introduce instruments to the members of the group or allow a member who has an aptitude in a particular instrument to guide an improvisation. A non-referential improvisation can allow the beat and the texture of the piece to appear as the music unfolds within the group (Bruscia, 2014).

Re-creative Music Therapy Methods. Recreative music therapy methods utilize pre-composed pieces of music to engage the patients in the singing or playing of familiar songs,

inviting patients to interact with the piece of music using drums, physical movement, or use a familiar piece of music and alter it by shifting the rhythm, tempo or mood. Re-creative music therapy can be a musical activity or game which the patients can participate in at the hospital to help them interact, and adapt to the feelings of others, create a sense of agency, develop specific skills or meet common goals (Bruscia, 2014).

Compositional Music Therapy Methods. Composition music therapy methods give patients another avenue for expressing themselves by rewriting a familiar song, or adding words to more precisely express their own experience. The client may compose a simple melody which the therapist supports by writing the harmony or the clients may write the lyrics while the therapist creates a melody to go along with the lyrics. Music therapy composition includes, writing original songs individually or in groups, or instrumental composition. The goals of composition are to develop organizational skills and a sense of self-responsibility, to encourage creativity, to learn to record thoughts or creative ideas in a comprehensible way, to explore themes of addiction which the patients have been introduced to in other programs in their schedule.

Music Therapy Techniques at HealthAlliance Addiction Treatment Services

Within each method of music therapy, there are many techniques and variations. The techniques that will be most commonly employed in this program are music-assisted relaxation, song communication, lyric analysis, instrumental improvisation, song discussion, song writing, imaginal listening, music and movement, song-lists, and re-creational music therapy. A description of each, including sample goals, format, and length follow.

Music Assisted Relaxation

Description: Using music to guide a patient into a relaxed state while the patient(s) are in a comfortable space. The music is on a low volume, in a quiet classical or meditation style.

Format: group, individual, bedside.

Length: 10-30 minutes.

Required Equipment: keyboard, djembe, voice, iPhone, amplifiers.

Level of Recovery: detoxification, short-term rehabilitation, long-term rehabilitation.

Possible goals addressed:

- To facilitate reducing stress in a patient.
- To facilitate reducing tension in a patient's body and mind.
- To facilitate reducing anxiety in a patient's body and mind.
- To facilitate producing an altered state of consciousness in the patient.
- To facilitate specific body responses.
- To promote receptivity.
- To evoke imagery and experiences.
- To Stimulate peak and spiritual experiences
- To facilitate imagery and imagination.

Song Communication

Description: The client shares music of their own choosing which expresses something about the patient which is relevant to therapy. The therapist and patient engage in conversation about the music and patient's life.

Format: Small group, individual, bedside.

Length: 15-30 minutes

Required equipment: CD player, iPhone, keyboard

Stage of Recovery: Detoxification, early rehabilitation, long-term rehabilitation.

Possible Goals addressed:

- To facilitate memories relating to their past
- To facilitate a state of relaxation
- To facilitate the processing of a stage of the patient's life.
- To facilitate a connection with the here-and-now.
- To facilitate a sense of agency.
- To create a sense of community when shared in a group.
- To facilitate a learning experience.
- To facilitate a sense of connection with the therapist.
- To facilitate creating an anchor for the patient's therapy

Lyric Analysis

Description: Listening to songs which illicit a personal response from the patient(s) or identification with the subject matter.

Format: Large or small group, individual

Length: 30-45 minutes

Required Equipment: CD player, iPhone, amplifiers, lyric sheets

Stage of Recovery: Early rehabilitation, long-term rehabilitation

Possible Goals Addressed:

- To facilitate the patient's emotional awareness
- To facilitate the patient's empathizing with others
- To see their experience in the life experience of others
- To facilitate forgiving oneself and/or others
- To facilitate learning how a song's lyrics are constructed for future song-writing possibilities
- To facilitate group cohesion and active listening skills
- To facilitate the growth of patient with self and others
- To facilitate the growth of tolerance for different cultural expressions
- To facilitate increased verbal expression

Instrumental Improvisation

Description: The patient creates original music while playing or singing, creating a lyric, rhythm, a complete song, or instrumental improvisation. The patient may improvise alone or with the therapist and/or other patients. The therapist may provide the instruments, give instructions or demonstrations, give a title to the piece, or the patient may do so.

Format: large or small group, individual, bedside.

Length: 5-15 minutes.

Required Equipment: guitar, djembe, shakers, bells, thumb piano, keyboard, singing bowl, rhythm sticks, tambourine, bongos, electronic drum set.

Stage of Recovery: Early rehabilitation, long-term rehabilitation, individual, bedside

Possible Goals Addressed:

- To facilitate group skills

- To facilitate stimulating and developing the senses
- To facilitate perceptual and cognitive skills
- To develop self-expression
- To develop creativity
- To develop interpersonal intimacy
- To explore aspects of self in relation to other
- To facilitate the formation of identity
- To facilitate non-verbal channels of communication
- To facilitate verbal communication
- To facilitate a sense of fun
- To facilitate risking something new and allowing others to see oneself.

Song Discussion

Description: the therapist chooses songs to listen to, to illustrate the meaning of one of the 12-steps, or other issues relating to addiction confronting the patient(s). Recovery education.

Format: Large or small group, individual.

Length: 30 minutes.

Required Equipment: Keyboard, guitar, CD player, iPhone, amplifiers, song sheets

Stage of Recovery: Early rehabilitation, long-term rehabilitation.

Possible Goals Addressed:

- To facilitate the learning of the 12-step principles.

- To facilitate addressing underlying issues with which the patients are dealing.
- To facilitate the development of empathy among the group members.
- To facilitate providing a space for the patients to hear their own voices, to have conversations with their peers.
- To facilitate relating the content of the song with the patient's life stories.
- To provide an opportunity for frank discussion about the 12-steps.
- To deepen self-awareness

Songwriting

Description: Therapist helps the patient write lyrics, songs, instrumental pieces, in a written form. The patient may create the lyrics and rhythm for a new song while the therapist takes care of the technical aspects of writing and determines the patient's skill and participation level.

Format: Small or large group sessions, individual sessions,

Length: 45 minutes

Required Equipment: paper and pen, iPhone, internet access, instruments

Stage of Recovery: Early rehabilitation, long-term rehabilitation

Possible Goals Addressed:

- To facilitate the promotion of a sense of responsibility.
- To facilitate skills in creative problem solving.
- To facilitate self-responsibility.
- To facilitate the learning of planning activities.

- To facilitate communicating inner experiences
- To facilitate integrating the value of parts into a whole.
- To facilitate self-expression
- To facilitate self-awareness
- To facilitate expanding language skills

Imaginal Listening

Description: The patient(s) listens to a piece of music chosen by the therapist and then draws what comes to mind, often abstract images. This is a supported, inner process which may be guided by an opening dialogue by the therapist, or unguided. Dialogue follows.

Format: Group, individual

Length: 45 minutes

Required Equipment: Large-scale art paper, oil pastels, CD player, iPhone, amplifiers

Level of Recovery: Early rehabilitation, long-term rehabilitation

Possible Goals Addressed:

- To facilitate being attentive to one's inner world
- To facilitate connecting the patient with their creativity
- To facilitate the willingness of the patients to try something new.
- To facilitate the patient's ability to concentrate in a group without deferring to what others are doing.
- To facilitate the patient's ability to make choices
- To facilitate the patient's sense of agency.
- To facilitate a sense of community without requiring conversation.

Music and Movement

Description: Using music to support patients as they reacquaint themselves with their bodies and what their bodies are capable of doing, through simple Tai Chi, stretching, and simple dance movements

Format: Group, individual

Length:

Equipment Required: CD player, iPhone, amplifier,

Level of Recovery: early rehabilitation, long-term rehabilitation

Possible Goals Addressed:

- To facilitate body awareness
- To facilitate improved bodily movement
- To facilitate a sense of enjoyment (sober fun)
- To facilitate a sense of community
- To facilitate a sense of creativity
- To facilitate a willingness to try something new (uncomfortableness)
- To facilitate a healthier physical life-style, (exercise)
- To facilitate increased bodily function

Creating Song Lists

Description: In this activity the patient(s) learns the importance of being aware of the effect that various types of music has on oneself. They learn that some music can support a more healthy state of being and some music can encourage a depressed or anxious state. The patients learn how to build a healthy song-list.

Format: Small group setting

Length: 45 minute-1 hour. Two sessions

Required Equipment: Paper and pens, iPhone, amplifier, keyboard, CD player.

Level of Recovery: Early rehabilitation, long-term rehabilitation

Possible Goals Addressed:

- To facilitate the processing of memory
- To facilitate working with others
- To facilitate identify feelings
- To facilitate a sense of agency
- To facilitate an awareness of musical details (tempo, instrumentation, voice quality)
- To facilitate a growing sense of self
- To facilitate a willingness to learn about new songs and genres

Re-creative Music Therapy

Description: The patients learn to sing or play music which they already know, or become familiar, or take part in structured musical activities, games. Re-creating musical productions may be included as re-creative music therapy.

Format: Early rehabilitation, long-term rehabilitation.

Length: 45 minutes to one hour, per session.

Required Equipment: Chairs, white board, CD player, iPhone, amplifiers, keyboard, sheet music

Level of Recovery: Early rehabilitation, Long-term rehabilitation

Possible Goals Addressed:

- To facilitate a sense of community
- To facilitate interactional and group skills
- To facilitate skills in interpreting and sharing ideas and feelings
- To facilitate the promotion of identification
- To facilitate the development of memory skills
- To facilitate the improvement of attention and reality orientation
- To facilitate the development of flexibility and schedule-oriented behavior
- To facilitate the development of sensorimotor skills

Personnel Responsibilities

The full-time music therapist will be committed to fully prepare for each group and individual session, to arrive at work in a timely fashion, and to keep materials and equipment carefully filed and in good condition. The full-time music therapist will also attend the monthly professional training, to attend the weekly staff meetings at both facilities, to document each session on a daily basis, to keep professional affiliations up-to-date, to keep medical requirements up-to-date, and to approach all people with unconditional positive regard.

Work Schedule

The current music therapy program is scheduled from 9 a.m. until 1 p.m. on Thursdays and Fridays at Bridge Back, and from 11 a.m. until 8 p.m. on Mondays and from 8 a.m. until 5 p.m. on Wednesdays at Benedictine Hospital. Currently, the music therapist does not attend staff meetings or have sufficient time for complete documentation. The proposed full-time work schedule can be found in Table 1.

Table 1

Proposed Music therapy Schedule at Benedictine Hospital and Bridgeback Outpatient Facility

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning 9AM-1PM	<i>Bridge Back</i> (4 hr) Group Session 2 Individual sessions Documenta- tion	<i>Benedictine</i> (4 hrs) Staff Meeting Group Session	<i>Bridgeback</i> (4 hrs) Group Session Individual Session Staff Meeting	<i>Bridge Back</i> (4 hrs) 2 Individual Sessions Group Session	<i>Bridgeback</i> (4 hrs) Group Session 2 Individual Sessions Documentation
Afternoon 2:00-6PM	<i>Benedictine</i> (4 hrs) Group Session 2 Individual Sessions Document- ation	<i>Benedictine</i> (4 hrs) Group Session 2 Individual Sessions Documenta tion	<i>Benedictine</i> (4 hrs) Planning Documenta- tion	<i>Benedictine</i> (4 hrs) Group Session 2 Individual Sessions Documenta- tion	<i>Benedictine</i> (4 hrs) Group Session 2 Individual Sessions Documentation

The proposed music therapy program will require a full-time music therapist. The therapist will work within the current daily schedule of the Benedictine Hospital's unit and the Bridge Back facility. The increased coverage and individual attention will amplify the program to address the personal needs of more patients and clients than is currently the case.

Number of Patients Served

There will be large and small group sessions for music therapy. Typical group sessions will have 10-18 participants. Currently, the part-time, per diem music therapist provides approximately 54 patient contacts/encounters per week across both facilities. If the proposed Integrated Music Therapy Program is implemented, one full-time position will provide approximately 153 patient contacts/encounters per week. This is a dramatic increase in the level of services available to patients in these facilities.

Anticipated Positive Outcomes

Through the utilization of music therapy with the patients of Benedictine Hospital and Bridge Back Outpatient program, several positive outcomes are anticipated.

Anxiety, Depression, and Stress

It is expected that an effective integrated music therapy program will decrease anxiety, depression and stress levels for some patients on the unit as a result of taking part in music-assisted meditation, instrumental improvisation, group and individual sessions where the patient are given the opportunity to share their pain and feelings, and the underlying reasons why they misuse substances (Cevasco et al., 2005; Gallagher & Steele, 2002; Geller & Greenberg, 2015; Lauer & Van der Vennet, 2015; Miller, 2007; Treleaven, 2018).

Increased Patient Engagement

It is expected that an effective integrated music therapy program will decrease premature departures (against medical advice) because patients will become more fully engaged (Cevasco et al., 2005; Gallagher & Steele, 2002; Miller, 2007; Treleaven, 2018)

Positive Marketing

A full-time and popular music therapy program can be a marketing advantage. Patients and families may be attracted to the idea that music will be part of their treatment (Silverman, 2009; Silverman, 2016).

Emotional Balance

It is expected that patients participating in music therapy will become more emotionally balanced (Baker et al., 2007; Horesh, 2006).

Increased Understanding of Pain

Patients participating in music therapy will have a greater awareness of their pain (emotional, physical, psychological), its source, and learn how to minimize the pain through alternatives to medications and or substance abuse (Borling, 2011; Cevasco et al., 2005; Flentroy, 2015; Gellen & Greenberg, 2015; Hari, 2018; May et al., 2015; Mondanaro & Sara, 2013; Quentzel, 2007).

Increased Understanding of Relaxation and Sleep Hygiene

Music therapy sessions will offer patients the chance to discuss and experience meditation, relaxation, and music as a sleep aid. It is anticipated that some patients will report improved sleep (Brach, 2003; Geller & Greenberg, 2015; Hari, 2018; Miller, 2017; Treleaven, 2018).

Increase Positive Sense of Self

The long term rehabilitation patients will be expected to gain a deeper understanding of their strengths and have the courage to risk sharing their strengths with the world. Music creation and performance allows patients to build courage, skills, confidence, and feelings of

accomplishment to replace their former negative self-beliefs (Baker, 2007; Cevalco et al., 2005; Dickerson, et al., 2012; Gallagher, 2002; Ghetti, 2004; Horesh, 2006; Megrnahan & Lynskey, 2018; Rogers, 1993).

Increased Sense of Connection and Hope

Through taking part in the music therapy program at the substance abuse unit of Benedictine Hospital and The Bridge Back program, the patients will be expected to have a greater sense of interconnection, confidence and hope, giving him or her the tools needed to continue along the road of recovery (Baker, 2007; Cevalco et al., 2005; Ghetti, 2004; Heiderscheit, 2009; Megrnahan & Lynskey, 2018; Rogers, 1993).

Music therapy is able to address one of the most insistent issues of substance abusers, the profound need to have healthy human connection (Hari, 2018). A music therapy program is uniquely poised to help patients connect with themselves and others through choosing and sharing musical preferences, analyzing lyrics together, creating music together improvisationally, and sharing pre-composed music (Laurer & Van der Venet, 2015; Silverman, 2012). Each person's musical style is different. By sharing that part of themselves, a healthy and safe space for intimacy is created.

Increased Sense of Health and Wellness

Music therapy can improve a patient's health and wellness. According to HealthAlliance (2019), "Early recovery means so much more than readjusting to life without alcohol or other drugs. Living in recovery means improving your health and wellness. It means recovering your sense of self and of purpose, striving to reach your full potential, and learning to live differently" (p. 2).

Contraindications

There are many reasons to include music therapy in a comprehensive substance abuse program. There are also circumstances when music therapy is not an appropriate option when caring for patients in detoxification. The concept of dangerous music should be considered (Horesh, 2006). Dangerous music is seen as music that triggers emotion for patients and recreates a reminder of experiences that they have had during their days of profound addiction as well as people and locations, thus re-traumatizing them. Sometimes it is important to remind patients where they have come from, but there is a fine balance between reminding and challenging versus overloading a patient's emotions, causing a patient to leave the hospital against medical advice. A sensitive and highly trained music therapist will be skilled in responding to these needs and circumstances (Horesh, 2006).

Financial Justification for the Integrated Music Therapy Program

The current part-time music therapy program is often recognized as an attractive therapy among the patient population. It can make the difference between a potential client choosing Benedictine Hospital and Bridge Back over other facilities. Music therapy is a comparatively inexpensive and safe way of treating pain and trauma that does not include the complexities and risks of medication.

Personnel Expenses

The estimated cost of a full-time music therapy employee is found in Table 2.

Table 2

Yearly Expenses

Salary 1 music therapist New York	\$52,000/year
Estimated benefits	\$15,000/year
Updated books/music/instruments	\$750/year
Instrument and equipment maintenance	\$500/year
Total yearly expenses	\$68,250/year

It should be noted that currently, the cost of a part-time music therapy employee is \$22,000 annually. Thus, the expansion to full-time is an actual addition cost of \$46,250.

Instruments and Equipment

To fully equip a full-time music therapy program, an initial investment of equipment is required for effectiveness of musical experiences. It is proposed to split this initial cost into two fiscal years. Table 3 represents the instruments already in place. Table 4 presents the equipment and costs that are required to start the program. Table 5 presents that equipment to be purchased

in the second year of the program. It is important to note that these are one-time expenses, only requiring maintenance after equipment is purchased.

The music therapist will be responsible for the care and maintenance of musical instruments and electronic equipment. The therapist will also be responsible for organizing the many files of song lyrics used in music analysis interventions and the files of educational topics of discussion which the music therapist shares with the patients on a regular basis.

Table 3*Equipment and Instruments Already Available*

Bongo Drums
Cowbells
Shakers
Tambourine
Yoga mats
2 Ukuleles
2 Guitars
Banjo
Electric drum set

Table 4*Required Equipment*

Djembe	4 items, \$39.99 each
Treeworks Small Student Model Chimes	2 items, \$49.99 each
Keyboard	2 items, \$349.99 each
Music Stand	4 items, \$26.99 each
iPad	\$399.99
Laptop computer	\$1,299.99
Cordless Mic	2 items, \$69.99 each
CD Player	2 items, \$44.97 each
Headphones	2 items, \$19.99 each
Total required initial expenses	\$2,880.72

Table 5*Year Two Equipment*

Guitar	2 items, \$129.99 each
Ukulele	2 items, \$67.99 each
Kalimba	2 items, \$63.99 each
Tambourine	2 items, \$16.99 each
Singing Bowls (set of 3)	2 items, \$179.00 each
Ocean drum: Remo Ocean Drum Clear	2 items, \$49.92 each
Rain Stick: Pearl 32 in. Bamboo Rainstick in Hand-painted Hidden Spirit Finish	2 items, \$23.47 each
Total optional year two expenses	\$ 3,992.44

Other instruments that are not required to facilitate music therapy programming, but would be highly beneficial in long-term planning for the program can be seen below in Table 6.

Table 6*Instruments for long-term planning*

Digital Piano	\$649.99 - \$3,499.00
Orff Instruments	\$100 - \$1,000.00
Sonor Deep Bass Chime Bars (set of seven)	\$220
Total	Range from \$969.99 - \$4,719.99

Timeline of Implementation

When the expanded music therapy program begins, the music therapist will add the additional clinical hours at Bridge Back on Mondays from 9 a.m. - 2 p.m., to her current part-time schedule at Bridge Back. The music therapist will also add additional hours on Tuesdays from 9 a.m. - 6 p.m., at Benedictine Hospital. When the full-time program begins, the therapist will set up the new music therapy room at Bridge Back, order supplies, and organize the intake and assessment schedules. She will also organize the schedule and supplies at Benedictine Hospital and begin attending the weekly staff meetings at both facilities.

One month later, the music therapist will incorporate the additional clinical hours at the Benedictine Hospital unit to this schedule. The added clinical hours will be 2 - 6 p.m. on Monday, Wednesday, and Friday afternoons. The music therapist will make monthly plans for the established groups and begin to coordinate with her colleagues, such as the counseling staff, and the art therapist. The music and art therapist will work together on planning holiday events and other shared projects.

Once the program becomes fully established, the music therapist will start a clinical training program for music therapy students following the AMTA Standards of Education and Clinical Practice (AMTA, 2020). She will develop a university-affiliated training program with the State University of New York at New Paltz which would benefit both the music therapy community and the treatment program.

Larger Facility Context

The music therapist is one of many professionals working together to treat the substance use disorder patients at Benedictine Hospital and Bridge Back Outpatient Facility. Among these professionals are counselors who are assigned to a specific roster of patients, medical doctors who attend to the patients on a daily basis, psychiatrists who prescribe medications, insurance professionals, program coordinators who arrange for post-hospital care, spiritual leaders, cleaning staff, AA speakers, a pet therapist and several administrators. The music therapist will adapt the program to meet the expectations of the Benedictine Hospital unit, the Bridge Back facility, and the code of ethics as outlined in the hospital's Statement of Ethics.

The music therapist is included in small staff consultations, and takes part in staff meetings and decisions regarding the assessment and prognosis of individual patients. The therapist works from a well- equipped office for administrative duties, and for the storage of equipment. The music therapist cooperates with other staff members to schedule access to the treatment room for meeting patients one-on-one, and for small groups desiring to make music, and schedules access to the large group room for larger gatherings. The music therapist will confer with her supervisor regarding the care and maintenance of musical instruments and electronic equipment, required trainings, and other administrative details. The music therapist will attend all gatherings required by Benedictine hospital's administration Benedictine Hospital for health and safety. She will also attend any meetings with her colleagues held at Bridge Back Outpatient Facility.

Outcomes and Assessments

Music therapy at the First Step Detoxification program and the First Step Rehabilitation program of HealthAlliance at Benedictine Hospital was added to its program in 2016. Music therapy was added to the Bridge Back Outpatient program of individualized treatment in 2018. Within the Detoxification program, music therapy is an invaluable tool to relieve anxiety, assuage pain, and to help patients feel more at ease in the hospital setting.

When each patient moves from the detoxification program to the rehabilitation program, the music therapist will routinely meet with each patient for an assessment. The music therapist will administer tests to those patients who have been assessed with anxiety or depression, (when applicable) in order to have a more in-depth understanding of the patient's state of being. The music therapist will also administer a ten-question Adverse Childhood Experiences (ACE) assessment in order to have an understanding of the patient's past history. The therapist will administer her own music therapy assessment in order to provide a baseline assessment of all domains, including the musical domain.

Data

Through investing in an enhanced music therapy program at Benedictine Hospital and the Bridge Back Outpatient program, patients will receive therapy which is free of medication, and taps into the creative depths of each individual. The program at Benedictine Hospital compiles data each month to record the patient's level of satisfaction with the program, and the number of patients who have left against medical advice.

It has been noted that patients who have participated in music therapy experiences have expressed appreciation in their exit surveys for the music therapy that they have received at

Benedictine Hospital and at Bridgeback. With the enhanced number of music therapy hours at each facility, these positives will be increased due to increased exposure.

For those patients who complete their program, the music therapist will administer exit assessments of the patient's level of anxiety, and depression (when applicable) on completing the program. The patient will complete an exit survey (see form 6 in Appendix F) regarding their music therapy experience.

Quarterly intake and exit data will be presented to the music therapist's supervisor during the quarterly professional review, in order to assess whether projected outcomes are being achieved. The music therapist and her supervisor will meet on a semi-annual basis for a personnel review of the music therapist at which time they will review and amend goals, and update the resources and professional goals of the music therapist. The supervisor will share the collected data and information with the director of the program.

Referrals and Assessments

Currently, individual music therapy referrals are made verbally from the staff to the music therapist. Within the full-time program, the music therapist will use the referral form found in Appendix A. The Benedictine Hospital group form may be found in Appendix B. Each individual session at Benedictine Hospital is included in the electronic record (found in Appendix C). The contents of the sessions are available to the other professionals on the treatment team. The assessment form for Bridge Back is on their own electronic record, under the same HealthAlliance system as Benedictine Hospital. The music therapist's own planning forms and assessments (found in Appendix D and E) will be completed and maintained in the therapist's paper files.

Conclusion

A full-time, integrated music therapy program addressing the three stages of recovery in the HealthAlliance of the Hudson Valley System would enhance the recovery programs already in place at Benedictine Hospital and Bridge Back Outpatient Facility. Music therapy is a holistic alternative to the pharmacological treatment of substance abuse disorders. The various underlying causes of substance abuse disorders such as trauma, family of origin experiences, and mental health disorders such as depression and anxiety can be addressed through music therapy interventions which are cost effective and enjoyed by the patients.

HealthAlliance of the Hudson Valley is committed to offering quality and compassionate care for their patients, their families and the community. They are now embarking upon a \$92.9 million, 127,000 square foot expansion of the facility on Marys Avenue in Kingston, New York (HealthAlliance, 2020). As they upgrade the physical aspect of the medical facility, it is hoped that they will augment the First Step Programs with enhanced programming, in particular, a new, comprehensive music therapy program. A larger, well-staffed music therapy program would improve the chances of the patients' full recovery from substance abuse disorder by easing their experience of pain, helping the patients to learn about themselves and their life stories, and to begin to build new, healthier lives benefiting themselves, their families and the community at large.

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Appendix A**Forms concerning the music therapy program at Benedictine Hospital and Bridge Back****Outpatient Program***Referral Form for Individual Music Therapy Session*

<i>Name of patient</i>	
<i>Date</i>	
<i>Diagnosis</i>	
<i>Reason for referral to music therapy</i>	

Appendix B

Group Session Assessment for Benedictine Hospital's Secure Website

Daily Focus Assessment for _____ I.D. _____ Location _____

Unit Type Detox/Substance Abuse Rehabilitation

Behav / BehavInterv / CWA/ Opiates/ Pain / Falls / ADL's / Diabetes / Nut-TF / Skin
/Musculo/ Neuro / Cardio / Resp / Transfer / Groups / **EduGRP** / DIAB / Stroke / Transfusion
/ Communication Barriers / CareGiver / Integrat Health Svce / Pharm / Detox / Rehab Education

Date: _____

Time In

Time Out

Group Title	Method of Teaching
Music	<input type="checkbox"/> Verbal Instruction
	<input type="checkbox"/> Demonstration
Education Objective	<input type="checkbox"/> Video / DVD
<input type="checkbox"/> Relationships / Boundaries	<input type="checkbox"/> Audio CD /Tape
<input type="checkbox"/> Sober Living Skills	<input type="checkbox"/> Worksheet Handout
<input type="checkbox"/> Relapse Prevention	<input type="checkbox"/> Teach-Back
<input type="checkbox"/> Sleep Habits	
<input type="checkbox"/> Diet and Nutrition	
<input type="checkbox"/> Hygiene and Self Care	Participation
<input type="checkbox"/> Self Awareness	<input type="checkbox"/> Listened attentively
<input type="checkbox"/> Stress Management	<input type="checkbox"/> Attempts suggested Task

___ Support System

___ Daily Living

___ Healthy Emotions

Objective Met

___ Yes

___ No

Participation

___ Listened attentively

___ Attempts suggested Task

___ Attended - did not Participate

___ Sedated/ Nodding

___ Spoke on issue

___ Supported others

___ Patient not present

___ Attended- did not participate

___ Sedated / Nodding

___ Spoke on issue

___ Supported others

___ Patient not present

Affect

___ Angry

___ Anxious

___ Childlike

___ Flat / No Expression

___ Interested

___ Irritable

___ Motivated

___ Provocative

___ Relaxed

___ Sad / depressed

___ Withdrawn

Additional Notes:

Appendix C*Individual Session Assessment for Benedictine Hospital's Secure Website*

Benedictine Hospital, Spellman 1	
Coded Date and Time	
Patient's Name	
Presenting problem	
Patient's History	
Prose description of the session, music therapy description, outcome	

Appendix D*Group Music Therapy Session Assessment*

Date	
Number of patients	
Theme of the group session	
Materials needed for the group	
Warm-up activity	
Meditation	
Activity #1	
Activity #2	
Activity #3	
Music selections used	
Evaluation of session	

Appendix E

Individual Music Therapy Session Assessment

Date	
Name of Patient	
Age of Patient	
Preferred drug	
Family Constellation	
Musical Preferences	
Musical Experiences (education, concerts etc.)	
Drug History	
Recent Life experience (housing, living with, resources, employment, etc.)	
General Education History	
Health Concerns	
Life Story	
Goals	
Strengths/ Interest	
Music listened to or created during session	
Follow-up needed?	

Appendix F*Music Therapy Exit Assessment*

Date	
Name of Patient	
Assessment of Anxiety	
Assessment of Depression	
What was learned	
What musical memories will the patient take with them	
Favorite musical experiences	
What did the patient not enjoy?	
Where is the patient going upon discharge	

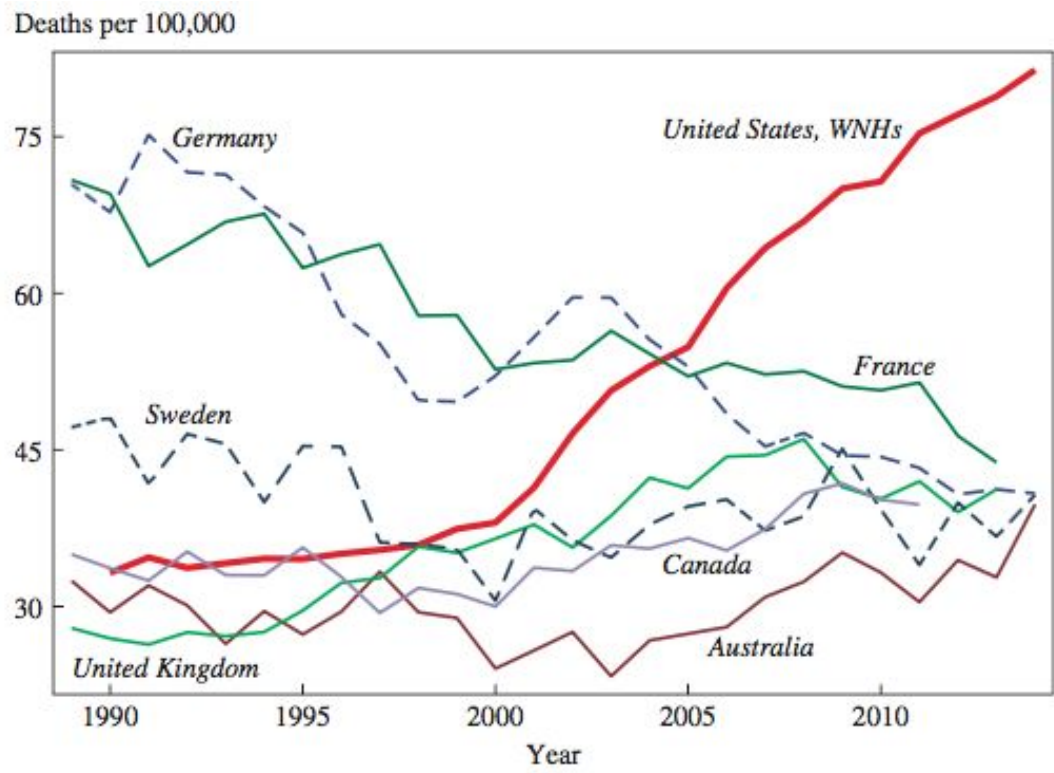
Appendix G

Fact Sheet

for
Addiction and Music Therapy
April 2020

Presenting the Need for Music Therapy:

Deaths of Despair (from drugs, alcohol, and suicide)



From: Case & Deaton (2017).

Did you Know?

Addiction is not due to a moral failing

(Hari, 2015; Lewis, 2015; Matano and Wanat, 2000)

Humans have a fundamental need to connect on deeper levels, beyond words

(Punkanen, 2011; Scheiby, 1999; Geller and Porges, 2014)

Music Therapy is a field where music and human connection meet

(Scheiby, 1999, Dickerson, 2012; Baker, Gleadhill and Dingle, 2007; Albornoz, 2011; Punkanen, 2006;)

Music activates the same part of the brain that addictive substances activate

(Loewy, 2017; Fachner, 2017;)

Music Therapy has been proven to lower levels of anxiety and depression, ie. despair

(Cevasco et al., 2005; Gardstrom, Klemm & Murphy, 2017, Winkelman, 2003; Fachner, 2013; Heiderscheit, 2009)

Participating in musical experiences creates a sense of connection and belonging, reducing the sense of despair and isolation

(Liebowitz, Tucker, Frontz and Mulholland, 2015; Horesh, 2006; Hill, 2017; Smith, 2017)

Music Therapy is working with science to move forward the understanding of the therapeutic work needed to reduce the use of addictive substances

(Heiderscheit, 2017; Loewy, 2017; Fachner, 2017)

Harm reduction policies meet the clients where they are, and work with them to improve their lives. The goal is to build a healthier life, with the intention of reducing the need for emotion and pain avoidance

(Smith, 2017; Ghetti, 2004)

Music Therapy is used in groups and individually to address specific issues related to addiction

(Punkanen, 2006; Hill, 2017; Gallagher and Steele, 2002; Albornoz, 2011; Liebowitz et al., 2015)

Music Therapy uses multiple ways of connecting with music: by listening and interacting with music, writing and improvising music, and playing and/or performing music, often combined with verbal processing

(Punkanen, 2011; Albornoz, 2011; Dickerson et al., 2012; Silverman, 2010, Smith, 2017)

Music therapy is the drug-free alternative to replacing one drug with another

(Silverman, 2010, 2012, 2015, 2016; Punkanen, 2006, 2011; McFerran, 2011; Hammer, 1996; Scheiby, 1999; Heiderscheit, 2017; Gallagher and Steele, 2002)

Addiction arises from abuse, negative environmental pressures, and avoidance of pain

(van der Kolk, 2015, Valentish, 2020; Ghetti, 2004; Heiderscheit, 2017; Hari, 2015; Borling, 1992; Felitti, 1998)

Music therapy arises from creativity, relationship, and scientific research
(AMTA, 2015)

More research is needed to explore the long-term effects of consistent, rigorous applications of **music therapy in the treatment of those with a substance use disorder**

(Murphy, 2015; Silverman, 2003)

Appendix H

Resume

SARAH HITCHCOCK

845-596-2854

sallyhitchcockbell@gmail.com

CURRENT ADDRESS

26 Old Route 299
New Paltz, New York 12561

EDUCATION

College of Wooster, Wooster, Ohio
Bachelor of Arts in French, Minor in Art and Music
Universite de Nantes, Nantes, France
French history, French culture
Ecole Normale de Musique, Paris, France
Piano, Music Theory
University of Notre Dame, Notre Dame, Indiana
Masters of Art in Music History
Nyack College, Nyack, New York
Permanent Teaching Certificate in the Art of Teaching Music, K-12
State University of New York at New Paltz
Masters of Science in Music Therapy

WORK EXPERIENCE

Northeast Center, Lake Katrine, New York
Music therapy intern
Nordoff-Robbins Center, New York University, New York
Music therapy intern
Benedictine Hospital, First Step inpatient addiction treatment program,
Kingston, New York
Music therapy intern

CURRENT

Benedictine Hospital, First Step inpatient addiction treatment program
Music therapist
Bridge Back, Outpatient addiction treatment program
Recreational therapist
Rhinebeck Reformed Church, Rhinebeck, New York
Organist, choral director, liturgical planning, funerals, weddings

TEACHING
EXPERIENCE

South Orangetown Public School District, Orangetown, New York

Staff accompanist, choral assistant

Freelance musician

NYSSMA Coach, coach/accompanist for professionals

Private piano teacher

Beginner to advanced

Pearl River Public Schools

Music teacher, Courses taught: Fundamentals of music, Chorus

Nyack College Music Department

Vocal coach, opera accompanist/performer, solo concert accompanist

Choral tour in France: choral member and French translator

Rockland County Choral Society

Rehearsal accompanist, assistant choral director

Norwalk Community College

Muse professor, courses taught: Music History, History of Opera,

The Creative Voice, Chorus, Founder and creative director of the Music

Theater Department

Created and conducted 8 seasonal concerts and four musicals

CHURCH
MUSIC

St. Stephens Episcopal Church, Pearl River, New York

Organist, choral director of adults and children,

Liturgical planning, funerals, weddings

West Nyack Reformed Church, West Nyack, New York

Organist, choral director, liturgical planning, funerals, weddings

Pearl River Methodist Church, Pearl River, New York

Organist, funerals, weddings

St. Matthew's Episcopal Church, Bedford, New York

Professional choral section leader: alto

St. Peter's Catholic Church, Haverstraw, New York

Organist, funerals, weddings, assistant cantor

Trinity Episcopal Church, Fishkill, New York

Organist, Choral director, liturgical planning

First Presbyterian Church, Beacon, New York

Organist, pianist, choral director, liturgical planning,

coordinator of music, funerals, weddings

West Point Military Academy, West Point, New York

Supply organist

Goodwill Presbyterian Church, Montgomery, New York

Pianist for traditional service

OTHER
EXPERIENCES

Lived abroad for five years: France, Scotland

Renovated four houses

Raised four children

Hudson Valley Singers, semi-professional chorus, NYC

Soprano, rehearsal accompanist

Choral tours in Hungary, France and Costa Rica
Participated in seven **triathlons** and training for an eighth
French speaker, reading knowledge of German and Latin

CERTIFICATIONS **Music Therapist Board Certified (MT-BC):** February, 2018
New York State Teaching Certification: June, 2006

MEMBERSHIPS **American Guild of Organists (AGO)**
American Music Therapy Association (AMTA)

VOLUNTEER
EXPERIENCES **Rehabilitation Through the Arts,** 2015-present
Woodbourne Prison, Greenhaven Prison
Teaching artist: piano, choral, concert coordinator
Oratamin Swim Club, West Nyack, New York
President, 2009-2012
Nyack Public Schools, K-12 1989-2005
Classroom volunteer, choral and orchestra accompanist
Curriculum Planning

REFERENCES Available upon request

Appendix I

Annotated Bibliography

Albornoz, Y. (2011). The effect of group improvisational music therapy on depression in adolescents and adults with substance abuse: A Randomized controlled trial. *Nordic Journal of Music Therapy*, 20(3), 208-224.

This study examined the effect of improvisational music therapy on 24 Spanish-speaking patients who were being treated for substance abuse at a treatment facility. Each of the participants completed the Beck Depression Inventory and the Hamilton Rating Scale for Depression. The 24 men were divided into two groups: one group taking part in 12 group sessions making improvisatory music over three months plus the standard treatment for addiction. The other group received standard treatment for addiction. After three months the group members who took part in the improvisational music-making were found to be significantly less depressed than the control group. Improvisational music therapy had a clinically significant impact.

Austin, D. (2015). Revisiting Grace Street: A retrospective account of an arts-based research study of alcoholics anonymous. *Music Therapy Perspectives*. 34(1), 1-12.

The author of this study created an arts-based research project exploring the possibility of the connection between additions, Alcoholics Anonymous, humanity and music. She showed how art interfaces with pain and human connection. She attended AA groups starting in 1991, identifying with the

members and their stories. Over the course of her study she created many forms of art, poems, stories, journal entries and ultimately a short musical which she wrote entirely herself and produced at SUNY New Paltz. The musical includes the relational aspect of experiencing AA and the ongoing issues that permeate the field like pain, High Power, self-loathing and darkness.

Baker, J., Gleadhill, L., & Dingle, G. (2007). Music therapy and emotional exploration:

Exposing substance abuse clients to the experiences of non-drug-induced emotions. *The Arts in Psychotherapy, 34*(4), 321-330.

The authors of this study explored the efficacy of music therapy as a means to reducing the emotional response of patients being treated for substance use disorder when facing emotions or experiences which tend to drive them to use their substance. The authors used cognitive behavioral music therapy to modify patient's responses to process difficult emotional states without using their substance. The study involved 24 patients who were involved in a three week long detoxification-rehabilitation program. The authors used pre- and post-test questionnaires to explore the response of the patients to the music therapy session offered, incorporating song analysis, song parody, song singing/listening, and instrumental improvisation. The result of the study was that the patients experienced strong emotions during the music therapy sessions without needing to resort to using a substance, a learning experience for the patients.

Borling, J. (2017). Stage two recovery for substance use disorder: Considerations and strategies for music therapists. *Music and Medicine, 9*(1), 59-63.

In this article, the author discussed the first stage of recovery (physical recovery and abstinence) and the second stage of recovery which includes the mental, emotional, and spiritual aspects of recovery. This second stage includes addressing relationship problems, and self-defeating behaviors. There is the ever-present possibility of relapse. At some point during this stage there appears a true desire to stop the cycle of using, and to begin building a new life and new self. The search for core “meta-needs”, wholeness, justice, simplicity, beauty, playfulness and autonomy come into play. These values are built on the process of making amends, prayer, and meditation. Music, and the relationships which can ensue can be an important part of this personal development. Musical rituals, therapeutic singing, drumming, clinical improvisation, song discussion, composition and movement are all ways in which an integration of the whole person can occur for emotional affective growth. The author concluded that music imagery can help in healing trauma and in leading a patient to long-term recovery.

Borling, J. (2011). Music therapy and addiction: Addressing essential components in the recovery process. In A. Meadows (Ed.), *Developments in music therapy practice: Case study perspectives* (pp. 334-349). Barcelona Publishers.

The author offers an introduction to terminology related to addiction and recovery and an explanation of the 12-step principles which include the concepts of surrender, honesty, accountability, and stability. He outlines the three stages of music therapy in this field as, bio-physical, psycho-emotional, and psycho-spiritual. The author has a strong belief that the “answers to recovery must

come from within the client.” During the first stage the author uses stress management, physical movement and drumming to deal with the discomfort of withdrawal symptoms. During the second stage of recovery, the author often uses lyric discussion, song writing, and structured imagery work which he combines with phrases from the 12-step literature. The third phase focuses on spiritual recovery, finding one’s Higher Power. He believes that spiritual recovery is essential for a secure, long-term recovery and a deep sense of well-being.

Cevasco, M., Kennedy, R., & Generally, N. (2005). Comparison of movement-to-music, rhythm activities, and competitive games on depression, stress, anxiety, and anger of females in substance abuse rehabilitation. *Journal of Music Therapy, 42*(1), 64-80.

This study based its work on the premise that females enter into a habit of substance abuse for reasons which differ from males. The authors studied the effect of music therapy on four emotions: depression, stress, anxiety, and anger. The study involved three different interventions: movement-to-music, rhythm activities, and competitive games. The group of ten women in an outpatient substance abuse rehabilitation program participated in a six-week long music therapy program which used the three interventions and measured the state-trait anxiety and anger after each of the 12 sessions. At the end of the study there was no significant improvement in the repeated-measures ANOVA over time, but immediately after each session there was a significant lowering of depression, stress, anger, and anxiety in the patients.

Dingle, G., Gleadhill, L. & Baker, F. (2008). Can music therapy engage patients in group cognitive behavioral therapy for substance abuse treatment? *Drug and Alcohol Review*, 27(2), 190-196.

The issue of retaining patients once they have entered treatment is an ongoing matter of concern. This study used surveys to explore the satisfaction rates of patients in a substance abuse treatment music therapy program. Twenty-four surveys were analyzed, completed by 10 men and 14 women, aged 17 to 52 years, who were part of a rehabilitation. The process included seven, 90-minute sessions with a music therapist and psychologist, and used cognitive behavioral music therapy techniques. The therapist found that patients often drop out of programs because they are too controlling, with no freedom of expression. Techniques included lyric analysis, song-writing, improvisation and singing. The sessions were educational and individually focused. The authors determined that the study supported use of music therapy in substance abuse programs as it provides an enjoyable approach to learning and includes the needs of both young and older patients.

Fachner, J. (2017). Retraining of drug reward, music cues and state-dependent recall in music therapy. *Music and Medicine*. 9(1) 8-14.

Music processing is located in the same part of the brain as the experience of euphoric drugs. This study explores the possibility that patients may be able to retrain their connection between certain types of music and their habitual response of using illegal drugs. The music may be employed as an addition to or a

substitute for mental health drugs already in use, thereby reducing the need for such medications. The author discusses the scientific and chemical links between the euphoria experienced by certain music to that of drugs and the reduced effect over time of the use of the drug. The hope is that music used in therapy may help to reframe the emotions of the drug's effect by the patient, supplanting the drug with music.

Gallagher, L. & Steele, A. (2002). Music therapy with offenders in a substance abuse/mental illness treatment program. *Music Therapy Perspectives*, 20(2), 117-122.

In collaboration with Recovery Resources, the Cleveland Music School Settlement developed a music therapy program which is used in a program for substance abuse/mental illness. Most of the patients were dual-diagnosed with substance use disorder as well as schizophrenia, schizoaffective disorder, and other thought disorders. Each cycle of the program lasted around nine months. Each session was 45 minutes long with a mean group size of nine participants. The patient learned about the effectiveness of music therapy in addressing recovery issues and to identify their daily state of being. Activities included playing instruments, engaging in relaxation techniques, and verbal participation. At the end of the program cycle, patients were found to process an increased number of tools to deal with their recovery at home. The patients acquired coping skills for stress management, recovery, mental health stability and relapse prevention.

Gardstrom, S., Klemm, A. & Murphy, K. (2017). Women's perceptions of the usefulness of group music therapy in addictions recovery. *Nordic Journal of Music Therapy*, 26(4), 338-358.

The authors conducted research pursuing the hypothesis that the voices of the women in recovery need to be heard. Data was collected from written and spoken responses of the women in an inpatient residential program. The participants varied week to week due to the revolving roster of women at the facility. The researchers used re-creation, receptive, and improvisational music therapy methods. The session format was flexible. The researchers tabulated seven therapeutic factors which are: universality, altruism, instillation of hope, group cohesiveness, existential factors, catharsis, self-understanding, and understanding. They also tabulated seven intrapersonal processes which include altering feelings/mood in a desired direction, impacts present energy level, aids in strengthening sense of self, offers pause/diversion, produces enjoyment and fosters musical connections. and discussed each factor in the body of their work. The study found that music therapy is a useful treatment modality, including the music techniques employed and the intrapersonal aspects of the work.

Ghetti, C. (2004). Incorporating music therapy into the harm reduction approach to managing substance use problems. *Music Therapy Perspectives*, 22(2), 84-90.

This article discusses what harm reduction is in substance use treatment, and explores how music therapy can be an important component in the harm reduction work. The author states that the goal of harm reduction is to reduce the negative

consequences of substance use instead of the traditional goal of complete abstinence. Clinicians have found the harm reduction approach to be more effective when coupled with traditional psychoanalytic and cognitive-behavioral approaches. Music therapy works well within the context of harm reduction. It can help clients in their step-by step process of stages of change coupled with respect, accessibility and adaptability and self-reflection. The clinician can effectively work with groups to modify responses, group dynamics and music preferences. Music therapy can facilitate working with emotional content, and damaged self-esteem, teach new ways to cope, and increase motivation. Lyric analysis, improvisation, and musical group work can aid in rebuilding social skills, and self-discipline, support relaxation and modify stress responses.

Heiderscheit, A. (2017). The effects of the Bonny Method of Guided Imagery and Music (GIM) on interpersonal problems, sense of coherence, and salivary Immunoglobulin A of adults in chemical dependency treatment, *Music and Medicine*, 9(1), 24-36.

This author pursued a study with 19 men and women in an inpatient facility over four to eight weeks. The author's study tested the effectiveness of GIM on interpersonal problems, a sense of coherence, and salivary Immunoglobulin A. After taking part in several assessments, the patients in the experimental group received a GIM session once a week for up to seven weeks. The control group received the usual inpatient treatment without GIM sessions. The author administered post-tests before each patient left the unit. She found that GIM helps

patients to feel better about managing, and finding meaning and understanding in their lives, as seen in the test results.

Hohmann, L., Bradt, J., Stegemann, T. & Koelsch, S. (2017). Effects of music therapy and music-based interventions in the treatment of substance use disorders: A systematic review. *Plos One*, 12(11): e0187363.

The authors of this study conducted a systematic search to determine the positive effects of music therapy and music-based interventions. Thirty-four quantitative and six qualitative studies were included in their review, some were randomized controlled trials. The details between studies were inconsistent so that it was difficult to determine the effectiveness of music therapy in many cases. Four themes were found within the qualitative studies: emotional expression, group interaction, development of skills, and improvement of quality of life. The authors determined that more research is required in order to be able to conclude that music therapy is, or is not, an effective therapy with substance use disorders.

Horesh, T. (2006). Dangerous music: Working with the destructive and healing powers of popular music in the treatment of substance abuse. In Aldridge, D., & Fachner, J. (Ed.). *Music and Altered States: Consciousness, transcendence, therapy and addictions* (pp. 125-139). Jessica Kingsley Publishers.

In this study, the author looked at the impact that music can have on a person in the recovery process and the relationship that exists between various addictions and musical choices. The author outlined the relationship between using music and using drugs to sooth, stimulate, give context to, and to forget parts of their

lives. The patients were struggling to move from the culture of addiction to the culture of recovery, which can be more difficult than the initial phase of substance withdrawal. The author found through verbal processing, after various music therapy experiences, that the patients were able to integrate their experience and move on to a greater understanding of their vulnerabilities and the process of change.

McFerran, K., (2011). Moving out of your comfort zone: Group music therapy with adolescents who have misused drugs. In A. Meadows (Ed.), *Developments in Music Therapy Practice: Case Study Perspectives* (pp. 248-265). Barcelona Publishers.

In this book chapter, McFerran discussed her experience as a music therapist working with seven teenagers working to recover from a life of addiction and living on the streets. The power of musicking is integral to this author's work. This study progressed over 10 weeks within a residential housing program. She used instrumental improvisation, vocal improvisation, recording, and songwriting in her work with the youth. There was considerable discussion of group dynamics, taking chances, growth, loss, identity, and the ways that they were positively worked out through the music and individually.

Megranahan, K. & Lynskey, M. (2018). Do creative arts therapies reduce substance misuse?: A systematic review. *The Arts in Psychotherapy*, 57, 50-58.

This systematic review of the literature asked if creative arts therapies reduce substance misuse. The author found five randomized control trials which fit her criteria and were designed and executed by the same researcher. The author

observed that individuals who are caught in the world of addiction find that their life options and expressive language become limited. The author studied the impact of creative therapies on reducing substance misuse and motivation for readiness. Items studied in the trials included contemplation, action, helpfulness, treatment readiness and total motivation. They showed a meaningful improvement (effect size greater than 0.5). In each study, the intervention was limited to a single session. These music therapy interventions were concluded to have produced moderate to strong effect sizes for treatment readiness and motivation. More research in this field is needed.

Miller, S. (2017). Music therapy and mindfulness: Treating women with addiction in a therapeutic community. *Music and Medicine*. 9(1), 50-58.

The author led a study of the use of mindfulness coupled with music therapy in a group of women over a period of 12 weeks. She chose a single sex group to explore how the openness of such a group differed from a mixed gender grouping. Music has been found to help individuals process “emotions, decrease negative affect, decrease stress and anxiety, and improve mood”. Additionally the music experiences affords the group an opportunity to create a supportive community. The author used mindfulness techniques and philosophy to connect with the AA principle of “one day at a time”.

Murphy, K.M. (2013). Adults with substance use disorders. In L. Eyre (Ed.), *Guidelines for Music Therapy Practice in Mental Health* (pp. 449-501). Barcelona.

This detailed discussion of music therapy methods and procedures is a resource for the music therapist working with patients with substance abuse disorders. The author addressed the work of a music therapist in assessment and referral procedures, and guidelines for music therapy in substance abuse treatment. The main body of this chapter attends to the methods and procedures that a music therapist can use in this work. Receptive music therapy is the most commonly used method of music therapy delivery in recovery work. Within each section of each method the author discusses overview, preparation, what to observe, procedures, and adaptations.

Murphy, K., (2015). Music therapy in addictions treatment. In B. Wheeler (Ed.), *Music therapy handbook* (pp. 354-366). Guilford Press.

The author outlined the goals and methods of music therapy in addiction recovery, and addresses treatment that focuses on the biophysical, psycho-emotional, and psychospiritual aspects of recovery. The biophysical issues are the main topic of the detoxification which include withdrawal and initial emotional symptoms accompanied by pain, insomnia, and uncomfortability. The psycho-emotional elements come to the fore in the early part of rehabilitation, including topics like depression, anxiety, anger, sense of loss, and an awareness of their state of being, faulty thinking, denial, self-esteem issues, change, acceptance and forgiveness. Spiritual recovery is a factor in the recovery journey. The author outlines the parts of a typical session for her practice: check-in, a choice of activity between two choices, verbal processing and closure. She addressed the

possibility of working with other disciplines to collaborate on the work of a specific topic or shared therapeutic goal. Music therapy affords patients the opportunity to connect with their bodies, minds and spirits.

Murphy, K. (2017). Music therapy in addictions treatment: A systematic review of the literature and recommendations for future research. *Music and Medicine*, 9(1), 15-23.

This author compiled the literature of music therapy in inpatient detoxification units. She used numerous refining criteria to winnow the many articles down to 12. The study sorted the articles by the music therapy method used, music and imagery, lyric analysis, songwriting, and comparing two, three, and four methods versus a control group, and a dependent variable (interpersonal problems, sense of coherence, depression, and others), outcome measures, and the result of each experiment.

Punkanen, M. & Ala-Ruona, E. (2011). Making my body a safe place to stay: A psycho-therapeutically oriented approach to vibroacoustic therapy in drug rehabilitation. In A. Meadows (Ed.), *Developments in music therapy practice: Case study perspectives* (pp. 350-367). Barcelona Publishers.

The authors of this chapter address the process that they followed to help a 23-year-old woman with a substance use disorder learn to cope with her difficult emotions. The process was divided into three phases. The first phase included music therapy sessions twice a day for one week. During the second phase, the sessions were held twice a week and during the third phase which lasted four months, the sessions were weekly. Each session lasted about one hour. They

started with dialogue, then the physioacoustic treatment followed, ending with a verbal discussion of her experience. The physioacoustic treatment consisted of low frequency sound vibration and music listening as well as verbal processing, working with physiological and psychological experiences at the same time. The client in this study found that the therapy had created a safe place for herself within her body, integrating her past with her present, making sense of her experiences.

Punkanen, M. (2006). On a Journey to Somatic memory: Theoretical and clinical approaches for the treatment of traumatic memories in music therapy-based drug rehabilitation. In D., Aldridge & J. Fachner (Eds.). *Music and altered states: Consciousness, transcendence, therapy and addictions* (pp. 140-154). Jessica Kingsley Publishers.

This author writes about the complex inner work that a client can manage with a trained therapist, dealing with felt trauma, safety, frozen emotions and potential long-term recovery. He presents two patients and shows how a therapist can carefully work with their individual states to bring them to greater self awareness and health. His method of treatment is three-fold: using the physioacoustic method combined with listening to music. The sound events are followed by therapeutic discussion. In order to work carefully with patients, he prepared the patients, by amassing a supply of anchors to connect with when the work became too painful to tolerate. The author sees the four phases of the addictive spiral as, 1. withdrawing from our bodies, 2. trying to control situations and experiences through denial, 3. reject all negative feelings, and eventually, 4. using drugs.

Silverman, M. (2009). A descriptive analysis of music therapists working with consumers in substance abuse rehabilitation: Current clinical practice to guide future research. *The Arts in Psychotherapy, 36*(3), 123-130.

The purpose of this study was to survey music therapists working in the field of substance abuse. The author found that the most common music therapy interventions were lyric analysis and music assisted relaxation and the most common treatment approaches were twelve-step, and cognitive-behavioral. The most common clinical objectives were communication, coping skills, emotional expression, decision making, and self-esteem.

Silverman, M. (2010). The effect of a lyric analysis intervention on withdrawal symptoms and locus of control in patients on a detoxification unit: A randomized effectiveness study. *The Arts in Psychotherapy, 37*(3), 197-201.

The author worked with 118 patients on a detoxification unit. He assigned the patients to a music therapy group participating in a lyric analysis, or to a control group which took part in a verbal psychotherapy session. The music therapy group was found to have a slightly higher sense of locus of control than the control group and had more mild withdrawal symptoms than the control group. The music therapy participants made more positive comments in their post-test assessments than those in the control group, and expressed that the session that they took part in was the best experience that they had at the hospital.

Silverman, M. (2012). Effects of group songwriting on motivation and readiness for treatment on patients in detoxification: A randomized wait-list effectiveness study. *Journal of Music Therapy, 49*(4), 414-429.

This article explored the impact of group songwriting with groups of men and women in a detoxification unit of a hospital, who participated in a single music therapy session. Fifty-one women and forty-eight men who stayed in the unit for three to five days took part. Each group wrote a collective set of words to a twelve-bar blues progression. This quantitative research involved notating the content of the lyrics and deriving meaning from the lyrics written by each group. The author determined that the single session of group songwriting improved motivation and readiness for treatment on the part of the patients in the study.

Silverman, M. (2015). Effects of lyric analysis interventions on treatment motivation in patients on a detoxification unit: A randomized effectiveness study. *Journal of Music Therapy, 52*(1), 117-134.

This article focuses on the possibility of lyric analysis motivating patients on a detoxification unit to remain in their program and to remain committed to their treatment. The author worked with 104 patients who were divided into groups exploring different songs. He measured treatment motivation such as problem recognition, desire for help, treatment readiness, pressures for treatment, and total motivation. The results showed that a single session of group-based music therapy lyric analysis made a statistical difference in enhancing treatment motivation in the patients.

Silverman, M. (2003). Music therapy and clients who are chemically dependent: A review of literature and pilot study. *The Arts In Psychotherapy, 30(5)*, 273-281.

This article includes an extensive review of literature on the topic of substance use disorders, including the medical, financial, societal and personal costs of the disorder. The author discussed the attributes of music therapy which make it an ideal therapy for this disorder, as it is less intrusive and less threatening than traditional therapies. This article presents a study with a group of women aged 19-65 in a residential treatment center for chemical dependence. Nine to twelve participants took part in the first phase of the study, over eight weeks. Music therapy interventions included: music games, relaxation training, lyric analysis, and songwriting. The second phase of the study researched the effectiveness of music therapy against 19 other groups offered at the center. The results show that music therapy was seen by the patients as a particularly effective means of delivering recovery therapy.

Smith, J. (2017). Creating a “Circle of Song” within Canada’s poorest postal code. *Canadian Journal of Music Therapy, 13(2)*, 103-114.

The Circle of Song was a community based program developed by two music therapists and community members to create a space for individuals who were the most “at risk” for deepening health concerns, due to high-risk lifestyles. The participants had a high incident rate of drug use, homelessness, HIV diagnosis, social marginalization and experienced governmental policies which added to the harm experienced by this population. The program took place in various

locations in the community, reaching out to those in need rather than waiting for individuals to come to them. The program focused on songwriting, jam sessions, and empowerment through peer leadership and community involvement.

Vega, V. (2017). Music therapy with addiction and co-occurring disorders. *Music and Medicine*, 9(1), 45-49.

In this article, the author reviewed seven research articles covering the interrelated subjects of music therapy, substance use disorder and co-occurring disorders. The most common music therapy interventions were songwriting and improvisation. The second tier of interventions were music performance, competitive games, and music listening, using a variety of techniques in various settings. The third tier of approaches were music instruction, movement to music and music for relaxation. The author shared several interventions that she has used: musical murals, which connect to the clients stated music preference, mask making which helps clients to identify and express feelings and the masks that we hide behind. The author noted the important ways in which women and men respond differently to substances and their underlying causes, which drives this author to request for more programs which work with single sex groups and for more research on the topic of music therapy, substance use disorders and their co-occurring disorders.

Winkelman, M. (2003). Complementary therapy for addiction: Drumming out drugs. *American Journal of Public Health*, 93(4), 647-651.

In this peer-reviewed article about the use of drumming in recovery facilities and community programs, the author outlined the many uses of drumming and the

techniques involved. He gave a detailed account of how four male individuals used drumming to work with people with substance use disorders who have not been helped by traditional recovery methods. The drumming circles and shamanic spheres incorporated into their work provided healing in numerous cases.

Drumming has been found to “induce relaxation, brain synchronization, pleasurable experiences, awareness of pre-conscious dynamics, release of emotional trauma and reintegration of self”. Drumming has also been found to reconnect individuals with their healthy self and others, creating community.