

**The Experience of Music Therapists Working With Clients
With Schizophrenia**

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THE EXPERIENCE OF MUSIC THERAPISTS
WORKING WITH CLIENTS WITH SCHIZOPHRENIA

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Abstract

The purpose of this phenomenological study was to explore the lived experience of music therapists who work with clients diagnosed with schizophrenia. The main focus of this study was the music therapists' perceptions of how music therapy impacted these clients. The data was collected through individual, semi-structured interviews that occurred in person and via telephone conversations. The participants were four board-certified music therapists who worked with this population within the last five years. The interviews were coded and analyzed, revealing two overarching categories and four themes. The first category was *The Perceived Impact of Music Therapy on Clients*. This category contained the themes: *Growth Reported by Music Therapists* and *Growth Reported by Clients*. The second category was *Experiences in Music Therapy*. This category contained the themes: *Personal Experiences of Music Therapists* and *Perceptions of Client Experiences*. All four participants reported that their clients have experienced growth as a result of music therapy. These reports were from the perspectives of the participants, as well as the perspectives of their clients. The participants described that their overall experience in working with this population was enjoyable, and that their clients seemed to have positive experiences in music therapy.

Keywords: Music Therapy, Schizophrenia, Phenomenology

The Experience of Music Therapists Working With Clients With Schizophrenia

Schizophrenia is a severe mental illness that has an impact on one's behavior, thoughts, and emotions (National Institute of Mental Health [NIMH], 2016). There are a variety of potential causes for schizophrenia, though scientists are unsure of what exactly causes it to develop. Those diagnosed with schizophrenia can receive treatment in order to reduce the severity of their symptoms, including medication and a variety of therapies (NIMH, 2016).

Music therapy can be an effective treatment option for individuals who experience schizophrenia. A variety of goals can be addressed with this population in music therapy, such as improving socialization, self-expression, and impulse control (Langdon, 2015). There are four music therapy methods that can be used with any client population in order to accomplish therapeutic goals. These methods are receptive (listening to music and responding to it), improvisation, songwriting, and re-creation of preferred music (Bruscia, 2014). The purpose of this literature review is to explore the impact of music therapy on those who experience schizophrenia.

Literature Review

Schizophrenia

According to the National Institute of Mental Health (NIMH; 2016), schizophrenia is defined as “a chronic and severe mental disorder that affects how a person thinks, feels, and behaves” (para. 1). The symptoms experienced by those diagnosed with schizophrenia include positive, negative, and cognitive symptoms. Positive symptoms refer to distortions of thought

and perception (Harvard Health Publishing, 2006). Positive symptoms include hallucinations, delusions, movement disorders, and thought disorders. Negative symptoms are disturbances in regards to behavior and emotion. This includes decreased facial expression, decreased speaking, and decreased enjoyment of life. Cognitive symptoms include alterations in elements of thinking, such as difficulties in focusing and using working memory (NIMH, 2016). The National Alliance on Mental Illness (NAMI; 2020) reported that schizophrenia symptoms typically begin to emerge in late adolescence and early adulthood. Those with schizophrenia may also experience co-morbidity with posttraumatic stress disorder, major depressive disorder, obsessive-compulsive disorder, or substance use disorders (NAMI, 2020).

Scientists are not yet certain what exactly causes schizophrenia (NIMH, 2016). However, there are a variety of factors that could potentially lead to the development of schizophrenia. Schizophrenia can develop as a result of genetics, specific environmental factors, brain chemistry, or substance use. In regards to genetics, schizophrenia can run in families (NIMH, 2016). If one has a close family member with schizophrenia, their likelihood of developing schizophrenia is over six times higher than one who does not have schizophrenia in their family (NAMI, 2020). Scientists believe that a combination of genes can cause the development of schizophrenia, not just a single gene. The interaction of genes with the environment can also lead to the development of schizophrenia. Environmental factors that can contribute to the development of schizophrenia include issues during the birthing process, malnutrition prior to birth, and contact with certain viruses (NIMH, 2016). In regards to brain chemistry, chemical imbalances in the brain and issues during brain development can result in the development of

schizophrenia (NIMH, 2016). Drug use during adolescence and early adulthood can also cause schizophrenia to develop (NAMI, 2020).

There are three different types of treatment that can be provided for those diagnosed with schizophrenia. A person will likely be prescribed antipsychotic medications in order to diminish the symptoms being experienced (NIMH, 2016). After appropriate pharmacological intervention, a person may be referred to participate in psychosocial therapy. Therapy is provided in order to help the client learn coping mechanisms that can be used in response to their symptoms (NIMH, 2016). Another treatment option is coordinated specialty care. Coordinated specialty care includes antipsychotic medications, different types of therapy, case management, education and job settings that are supportive of a person's condition, and family participation (NIMH, 2016). The development of other healthy habits, such as regular meditation and maintaining a healthy diet, can be used to complement treatment. Currently, schizophrenia can not be cured, therefore, treatment is focused on reducing the intensity of symptoms (NAMI, 2020).

According to the American Psychiatric Association (APA; 2013), there are certain criteria that one must meet in order to be diagnosed with schizophrenia. Persons must be experiencing two or more of the following symptoms: delusions, hallucinations, disorganized speech, negative symptoms, and catatonic behavior or gross disorganization (APA, 2013). One of the two symptoms must be either delusions, hallucinations, or disorganized speech. Secondly, one must experience a significant deterioration in ability to function in important areas of life, including occupation and relationships (APA, 2013). Finally, one must be displaying signs of schizophrenia for a minimum of six months.

Experience of the Illness

Bradshaw and Brekke (1999) were interested in the subjective experience of schizophrenia. They observed the impact of a variety of variables on the self-esteem, life satisfaction, and distress of those diagnosed with schizophrenia or schizoaffective disorder. The variables included the intensity of their treatment, psychosocial functioning, milieu, personal traits, and the severity of the mental illness (Bradshaw & Brekke, 1999). There were 103 adult participants in this study who were diagnosed with either schizophrenia or schizoaffective disorder. Those diagnosed with schizoaffective disorder experience the symptoms of schizophrenia and the symptoms of a mood disorder, such as depression or bipolar disorder (U.S. National Library of Medicine, 2020). Each participant was receiving treatment at the time of this study (Bradshaw & Brekke, 1999). The participants were interviewed twice a year over a period of three years. A variety of scales were used to evaluate the participant levels of each variable, including the Brief Psychiatric Rating Scale and the Intrapsychic Foundations portion of the Quality of Life Scale. The authors found that symptom severity had the largest impact on self-esteem, distress, and life satisfaction (Bradshaw & Brekke, 1999).

People diagnosed with mental illnesses typically experience stigma. Dickerson et al. (2002) examined the stigma experienced by outpatients diagnosed with schizophrenia. The participants completed the Consumer Experiences of Stigma Questionnaire. Other variables were observed and considered during the study, such as severity of symptoms, quality of life, integration in the community, socioeconomic status, awareness of mental illness, well-being, and depression. Dickerson et al. (2002) discovered that the majority of participants had personally experienced stigma based on their mental illness. Most participants reported that they feared

being perceived in a negative manner as a result of having schizophrenia. Many of the participants reported that they have not disclosed to others that they have a mental illness due to their fear of stigma. Approximately half of the participants reported that they had heard negative statements about those with mental illnesses, and had seen this population portrayed negatively in the media. Finally, it was found that there was a significant correlation between socioeconomic status and stigma experiences. Specifically, those who felt that they were in poor financial situations reported that they perceived stigma more frequently. However, the participants' income itself did not cause this significant correlation; it was solely caused by the participant's perception of being in a poor financial situation (Dickerson et al., 2002).

Music and Mental Health

Music may be a common part of self-care routines for well adults. Skånland (2013) examined the ways in which adults use digital music devices (i.e., MP3 players) as part of their self-care practices through a qualitative interview study. The majority of the participants stated that they use their MP3 players for the purpose of affect regulation, in that they create a space that is private for them to focus on their mindsets and in turn, alter their moods and emotional states. This affect regulation through the use of digital music occurred, regardless of whether it was a conscious choice or not (Skånland, 2013).

Participation in active music-making can be beneficial for one's mental health as well. Longhofer and Floersch (1993) created a program in which they taught African Dagbama drumming for persons with mental health issues and their case managers. During weekly sessions, the participants learned Dagbama drumming, singing, and dancing, and prepared for

performances (Longhofer & Floersch, 1993). This group music experience had a positive impact on those involved. Staff members reported that they could not determine the mental illnesses of the participants while working in the group. As a result, group members were not treated as if they were mentally ill, they were treated as if they were musicians. It was reported that this group experience improved the social skills and self-esteem of the participants (Longhofer & Floersch, 1993).

Community music and theater programs provide opportunities for many people to participate in the arts. These opportunities may be replicated within the context of mental health treatment. Ørjasæter et al. (2017) studied the effect of participation in a music and theater workshop at a mental health hospital on the identity beliefs of the participants. The participant group included 11 adults with a history of mental health issues. Data was collected through the use of individual interviews. Three themes emerged from the interviews: becoming a whole person, being allowed to hold multiple identities, and exploring diverse perspectives (Ørjasæter et al., 2017, p. 4). Participation in the music and theater group provided the participants with the opportunity to alter and develop individual and collective identities. Participants reported that being mentally ill was a large part of their identity prior to participation. One participant stated that when they were in the music and theater workshop, they were treated as an actor, not as a mentally ill person. This experience provided participants with the opportunity to develop positive, healthy identities that were not tied to being mentally ill (Ørjasæter et al., 2017).

There are a variety of perspectives on the experience of schizophrenia. Lee (2005) described the experience of schizophrenia from a first person perspective. The author experienced auditory and visual hallucinations, as well as a thought disorder. Through the use of

proper medication and cognitive behavioral therapy, the author was able to diminish the experienced symptoms of schizophrenia (Lee, 2005). Cognitive behavioral therapy taught the author how to use intellectual reasoning to cope with the symptoms of schizophrenia. Mental activities were reported to be beneficial as ways of coping as well as ways of preventing mental deterioration. These activities include reading, playing and listening to music, and participation in sports. Lee (2005) explained that participation in music helped to calm emotions and prevent undesirable thoughts from entering the mind. The author reported that they have been able to successfully live and work in society while coping with the symptoms of schizophrenia (Lee, 2005).

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, para. 1). Music therapy can be utilized with a variety of client populations. Music therapists can work with children or adults who are either healthy or are experiencing challenges, such as disabilities or terminal illnesses (Wheeler, 2015).

There are four main methods utilized in music therapy: improvisation, re-creative, composition, and receptive (Bruscia, 2014). When clients engage in improvisation, they are spontaneously creating music vocally, instrumentally, and/or with the use of body percussion. The improvisational method in music therapy can be used to address a variety of clinical goals, such as expression and identification of emotions, or identity formation (Bruscia, 2014). The

re-creative method involves the client reproducing a pre-composed piece of music via singing, playing instruments, and/or performing. Goals addressed through the re-creative method include the development of memory skills and/or sensorimotor skills (Bruscia, 2014). Composition involves the client and therapist writing songs together. These songs can be written in a variety of ways, and can address therapeutic goals such as the development of skills in decision-making, or using the lyrics to explore themes that have been present in therapy (Bruscia, 2014). Receptive music therapy experiences involve the client listening and responding to music that is either live or pre-recorded. Receptive music therapy can target many goals, including relaxation and the development of skills in the auditory and motor realms (Bruscia, 2014).

Music Therapy and Schizophrenia

Music therapy can be designed to address various therapeutic goals for those diagnosed with schizophrenia. Solli and Rolvsjord (2015) explored the lived experience of those with psychosis who participated in music therapy, as well as how they relate their experiences in music therapy to challenges in life and their mental health. Nine participants participated in music therapy, either individually or in weekly group sessions. The sessions consisted of improvisation, songwriting, creating CDs, recreating music from songbooks, playing instruments, listening to music, mixing and recording songs, and uploading those songs onto the internet (Solli & Rolvsjord, 2015, p. 71). As a result, participants reported that they felt free from their psychosis, free from the stigma associated with it, and free from other forms of treatment that focused solely on their psychosis. Participants reported that music therapy was motivating, enjoyable, and satisfying. Music therapy instilled a sense of hope for the future within the participants. The majority of participants reported that they achieved mastery in music therapy

through playing certain instruments or songs. Music therapy provided symptom relief as well. Participants reported that engaging in music therapy reduced, and sometimes eliminated, disturbing voices and thoughts. One participant reported that engagement in music therapy reduced the visual hallucinations experienced. Finally, participants stated that music therapy helped them connect with themselves, their emotions, other people, and gave them a sense of feeling alive (Solli & Rolvsjord, 2015). Overall, participants perceived music therapy as a very positive experience that provided them with support. According to Solli and Rolvsjord (2015), participants reported that they had become more active in life, as well as feeling greater senses of hope and motivation.

Group music therapy can have a positive impact on quality of life for persons with schizophrenia. Grocke et al. (2009) examined the effect of music therapy on social anxiety and quality of life of people with severe mental illness. Twenty-nine participants were split into five music therapy groups. While some participants had other mental health or cognitive diagnoses, the majority of participants were diagnosed with schizophrenia (Grocke et al., 2009). The participants engaged in music therapy once a week for a total of 10 weeks. The sessions consisted of songwriting experiences, improvisation, and singing participant-preferred music. The participants completed questionnaires prior to and at the conclusion of music therapy, and participated in a focus group interview. The data from 12 of the participants was not included due to questionnaires being filled out inappropriately or not filled out at all (Grocke et al., 2009). In the quantitative data, it was found that there were improvements in quality of life, social support, and health. No improvements were found regarding experience of symptoms. The qualitative data showed that participation in the music therapy group gave the participants a

sense of joy, pleasure, relaxation, and belonging. Participants reported feeling creative; they felt a sense of accomplishment from writing songs and producing a CD. However, participants also felt frustrated because the one-hour session did not provide enough time to finish writing a song, and because they could not continue their participation in the music therapy group once the study ended (Grocke et al., 2009). Participation in music therapy had a positive impact on social anxiety and quality of life.

Music therapy can positively influence the overall functioning of those with schizophrenia. Geretsegger et al. (2017) completed a Cochrane Review that examined the impact of music therapy on those with schizophrenia and similar mental disorders. A total of 18 studies were included in which the effects of music therapy and standard care together were compared to the effects of standard care without music therapy (Geretsegger et al., 2017). The results imply that music therapy is capable of positively impacting one's global and mental state, quality of life, and overall functioning (Geretsegger et al., 2017).

Music therapy can provide symptom-relief for those with schizophrenia. Tseng et al. (2016) completed a meta-analysis in order to assess the treatment effect of music therapy for those with schizophrenia. The researchers observed negative and positive symptoms, symptoms of mood, the psychopathology of schizophrenia, and the severity level of schizophrenia (Tseng et al., 2016). The twelve studies included in the meta-analysis consisted of clinical trials, case-controlled trials, and any articles in which there was a comparison between people with schizophrenia who received music therapy and those who did not. It was concluded that music therapy had a significant positive impact on the treatment effect, specifically that those who received music therapy experienced improvements in negative and positive symptoms, as well as

mood symptoms. There were no significant results in terms of the general psychopathology (Tseng et al., 2016).

Ulrich et al. (2007) examined the impact of music therapy on negative symptoms, quality of life, and interpersonal relations. A total of 37 people were randomly assigned to control and experimental groups. The control group received conventional treatment, and the experimental group received music therapy as well as conventional treatment. Surveys were administered to patients and nurses before and after every music therapy session. Pre-tests and post-tests were also administered to the participants before and after the music therapy intervention (Ulrich et al., 2007). The experimental group experienced an average of seven 45-minute music therapy sessions during this study. Overall, it was found that those in the music therapy group experienced improvements in psychosocial orientation and negative symptoms. Quality of life did not seem to improve significantly as a result of music therapy compared to the control group (Ulrich et al., 2007).

Music therapy can be designed to address memory skills for persons with schizophrenia. Ceccato et al. (2006) studied the influence of Sound Training for Attention and Memory (STAM) on the memory, attention, and social skills of those with schizophrenia. STAM is a music therapy protocol that was developed by Enrico Ceccato and Paolo Caneva consisting of a sequence of recorded music sessions and sound tracks that concentrate on selective attention and memory (Ceccato et al., 2006). Sixteen participants diagnosed with schizophrenia were split into a control group and an experimental group. The experimental group received STAM, and the control group received improvisatory music therapy sessions (Ceccato et al., 2006). The participants received weekly 55-minute music therapy sessions for a total of 16 weeks. Before

and after the study, the participants were given a neuropsychological evaluation. The results indicated that both types of music therapy aided in improving social skills, and that the STAM music therapy experience did improve their memory abilities compared to the improvisation-based music therapy group (Ceccato et al., 2006).

Active and passive music therapy can have an impact on schizophrenia symptoms. Mohammadi et al. (2012) observed the influence of active and passive music therapy on the positive and negative symptoms of schizophrenia. Active music therapy referred to improvisation, moving to music, singing, and playing music in groups or individually. Passive music therapy referred to the receptive music therapy method, in this case listening to pre-recorded music. The 96 adult participants with schizophrenia were divided into one control group and two experimental groups. The control group received neuroleptic medication. The experimental groups received neuroleptic medication and either active or passive music therapy (Mohammadi et al., 2012). Both forms of music therapy significantly reduced negative symptoms, and significantly impacted passive/apathetic syndromes, emotional withdrawal, and poor rapport. The results suggest that the passive music therapy experience provided the greatest benefit for the participants (Mohammadi et al., 2012).

Purpose of the Study

Music therapy can provide various benefits for persons with schizophrenia. Benefits reported include symptom relief, freedom from the illness, improved quality of life, improved overall functioning, and improved social skills (Ceccato et al., 2006; Geretsegger et al., 2017; Solli & Rolsvjord, 2015). What was not readily available in the published literature were studies

in which the music therapists working with these individuals provided their perspective on the music therapy process. Thus, this study addresses a gap in the literature regarding the experience of the music therapists who work with this population, and their view on the effectiveness of this work.

The purpose of this study was to explore the experience of music therapists working with people diagnosed with schizophrenia. The research question and sub-question addressed are as follows: What is the lived experience of music therapists who have worked with clients diagnosed with schizophrenia? How do music therapists perceive the impact of music therapy on these clients?

Method

Epoché

I am interested in working with the mental health population as a music therapist. I am specifically interested in working with those diagnosed with schizophrenia. As I learned about the symptoms by those with schizophrenia, I wondered if music therapy could be designed to provide symptom relief. I wondered about the other ways in which music therapy could impact this population. However, I was primarily interested in understanding how those with schizophrenia perceived their music therapy experiences. Would they report that music therapy had an impact on them? If so, what would that impact be? I originally wanted to interview those diagnosed with schizophrenia, but as a student researcher, it is inappropriate for me to conduct research with such a vulnerable population. Therefore, I decided to interview music therapists who have worked with clients diagnosed with schizophrenia in long-term care. I approached this

research with a desire to understand the way in which music therapy sessions were designed to address the needs of this population. In order to address my primary interests, I desired to learn about the music therapists' perceptions of the impact of music therapy on these clients.

Participants

The participants were four board-certified music therapists who have worked with clients diagnosed with schizophrenia in long-term care. Long-term care was defined as a stay of 30 days or more in a psychiatric facility. Participants were required to have at least five years experience as music therapists, and a minimum of two years of experience working in a long-term mental health facility. Participants could have been currently working in this setting, or could have worked in this setting within the past five years. Participants had experience working with the mental health population for a minimum of 20 hours per week. Two participants did not work in a long-term psychiatric facility within the past five years. However, both participants worked in other settings with clients diagnosed with schizophrenia on a long-term basis within the past five years. Therefore, they were still eligible for participation. One participant was my clinical supervisor at the time of writing this study, and I worked with these clients under this supervisor. However, I did not have any relationship with the other participants prior to meeting them for this study. The participants will be referred to as Participant A, Participant B, Participant C, and Participant D.

Recruitment

I retrieved an email list from the Certification Board for Music Therapists of music therapists who have been certified for a minimum of five years (Appendix A). I emailed each

therapist on this list with the details of the study and the requirements for participation (Appendix B). I also posted the details and requirements of the study on the Facebook page, “Music Therapists Working in Mental Health” (Appendix C). Interested persons self-selected for participation in the study. Those who expressed interest received an email with the information sheet for participation, as well as the interview questions (Appendices D, E, F). The individuals agreed to participate by responding to the email and stating their interest.

Methodology

This research was developed as an interpretivist design. According to Wheeler and Bruscia (2016), the purpose of interpretivist research is to explore, analyze, and understand a particular phenomenon. The theoretical foundation of this study is phenomenological. Wheeler and Bruscia (2016) define the phenomenological theoretical foundation as being “concerned with how a person perceives, feels, thinks, and derives meaning from a lived phenomenon” (pp. 5-6). According to Jackson (2016), phenomenological inquiry allows researchers to obtain first-person perspectives and experiences on the topic of a research study. The specific type of phenomenology that influenced my method is empirical phenomenology. Empirical phenomenology aims to “understand the meaning of a lived experience through multiple experiencers’ descriptions of the phenomenon” (Jackson, 2016, p. 445). Each participant provided descriptions of their personal experiences of working with the same population. I analyzed those descriptions in order to gain an understanding of the meaning of their individual lived experiences.

Method

I acquired the data for this phenomenological research study by conducting individual, semi-structured interviews with the participants. One interview took place in person, and the other three took place via phone call. The interviews were audio recorded so they could be reviewed after the initial interview occurred. The objective of this type of interview is to explore and comprehend the lived experience of the person participating in the interview (Keith, 2016). According to Jackson (2016), conducting interviews that are live and open-ended are optimal because they allow the researcher to adjust questions in the moment to gain the best understanding of the participants' lived experiences. The interviews were transcribed, and analyzed for themes and patterns, which were interpreted for meaning and connections (Eyre, 2016). As I interpreted the themes and patterns, I specifically looked for similarities and differences between the participants' experiences. This study was approved by the Human Research Ethics Board at SUNY New Paltz.

Data Analysis

The participants' interviews were audio recorded using *Audacity* as well as the *Voice Memos* iPhone app. The audio recordings were transcribed, then coded for themes. I utilized In Vivo and Descriptive codes during this process. By using both coding methods, I discovered themes based on the direct quotes of the participants, as well as general descriptions of information the participants provided (Saldana, 2016). I utilized interpretive phenomenological analysis as my approach to the data.

Once my interviews were transcribed, I provided the participants with the opportunity to review their individual transcripts. They were invited to add or remove any information as they felt necessary. In some cases, participants were asked to clarify the information provided in the initial interview. This is a process referred to as member checking (Creswell & Creswell, 2018). By engaging in member checking, I was able to ensure that the information provided by the participants was represented accurately. As I was completing the member checking process, I read each interview transcript. This allowed me to comprehend the lived experience of each individual participant. Once this was complete, I began the coding process. I read each transcript multiple times, extracted In Vivo codes, and assigned Descriptive codes. I created a codebook, which was a single document containing all the codes I discovered (Saldana, 2016). As I filled my codebook, I noticed the similarities and differences between participant experiences. I analyzed the codes in regards to the research question and sub-question, and placed them into specific categories. This process was reviewed with my research advisor.

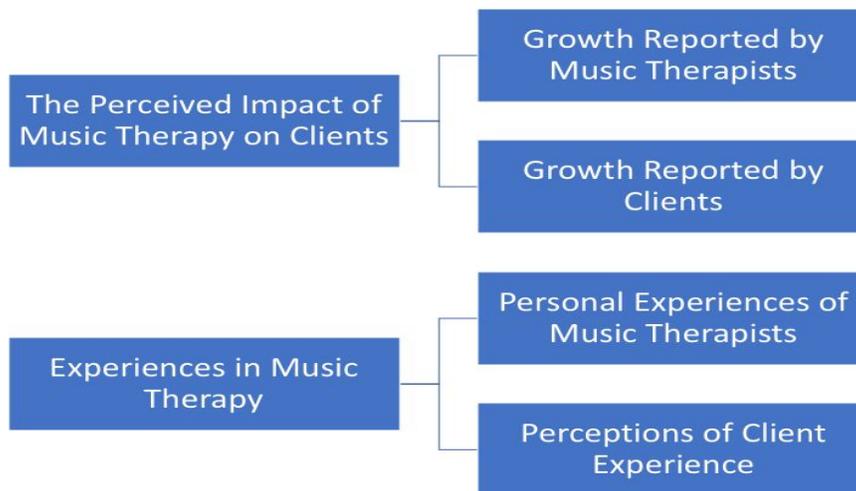
Results

The data analysis resulted in the emergence of two categories and four themes. These categories and themes directly address the research question and sub-question: What is the lived experience of music therapists who have worked with clients diagnosed with schizophrenia? How do music therapists perceive the impact of music therapy on these clients? The two categories are *The Perceived Impact of Music Therapy on Clients* and *Experiences in Music Therapy*. The category *The Perceived Impact of Music Therapy on Clients* contains two themes: *Growth Reported by Music Therapists* and *Growth Reported by Clients*. The category

Experiences in Music Therapy contains two themes as well: *Personal Experiences of Music Therapists* and *Perceptions of Client Experience*. These categories and themes reveal the nature of the phenomenon explored in this study. Figure 1 illustrates the relationship between categories and themes.

Figure 1

Categories and Themes of Interviews



The Perceived Impact of Music Therapy on Clients

Each participant reported that they have perceived growth in their clients that they believe is a result of music therapy. Simultaneously, each participant has also stated that their clients have expressed feeling personal growth as a result of music therapy.

Growth Reported by Music Therapists

The participants reported client growth in various areas of functioning. These areas include confidence, managing stress, focus, reality orientation, self-expression, connection with others, enjoyment, and mood improvements. Each participant provided a description of the general growth they have seen in their own clients (Table 1).

Table 1***Growth Reported by Music Therapists***

Participant	Direct Quotes from the Participants
Participant 1	Improved relationship, relatedness, improved communication, improved sense of individual identity and self-expression, improved length of engagement and quality of engagement, and improved enjoyment or lightheartedness.
Participant 2	Probably the biggest one is when I can get somebody to focus, when I can get somebody to socialize, when I can...you know, I'm not going to cure anybody with schizophrenia, but if I can make them have a more oriented experience, a successful experience, and actually interact in groups with some level of insight, to me that's huge.
Participant 3	Long-term, music therapy could help regain some reality orientation and some feelings of empowerment and agency over their own thoughts.
Participant 4	Yes, patients can show positive interactions with others, maintain attention to tasks, express themselves with simple phrases.

Participants 1, 2, and 4 all stated that they noticed their clients were connecting and interacting with the music therapist, music therapy group members, and/or others more often as a result of music therapy. This is the most common growth area reported by the participants. Other common growth areas include reality orientation, focus, and self-expression. Participants 2 and 3 stated that music therapy could positively influence the reality orientation of their clients. In regards to reality orientation, Participant 3 stated:

By making music, or engaging with music, clients are in the here-and-now [...] Through playing the ocean drum for a moment or exploring the singing bowl, they were immediately orientated to reality; and then, through playing music, entering into the music space. That didn't mean they necessarily were able to stay reality-oriented the whole time, or not have anxiety intrude, but we at least could enter into a space immediately in a healthy manner.

Participants 2 and 4 reported growth in the amount of time that clients could maintain focus and attention to tasks. Participants 1 and 4 both noticed an increase of self-expression as a result of music therapy. In regards to self-expression, Participant 1 reported that one of his clients has been expressing himself more in the music; whereas Participant 4 found that their clients have been more expressive verbally. The growth areas reported the least were an increased sense of identity, enjoyment, and empowerment. Only Participant 1 reported that his clients experienced an improved sense of identity and increased enjoyment. Participant 3 is the only participant who reported an increased level of empowerment in her clients.

Participants 1, 3, and 4 shared clinical examples in their interviews. The example shared by Participant 1 described the importance of treating clients with respect and how that can

impact their functioning. Participant 1 provided an example in which a client wrote an original song and performed it in the community with the music therapist and a group of clients.

Participant 1 reported that:

On the piano, he was not mentally ill. In the music, he was professional and healthy and rose to the occasion and took everyone with him because he could do it, and we all could do it because he was the center of the whole thing.

In regards to this example, Participant 1 stated that the way in which clients are treated can have an impact on their overall functioning. Participant 1 said:

So if I treat people as respected artists, then they're gonna feel like respected artists and in most cases they're going to function like respected artists, in spite of these other things that people see in them that they call pathology.

The example provided by Participant 3 revealed that therapeutic rapport can have an important impact on client growth. Participant 3 described a client's initial response to entering a treatment facility: "When he first got there he didn't want to participate in anything. Didn't want to do anything. He was angry and what I discovered over time was that yelling really overwhelmed his senses, and so he would yell back." Participant 3 was able to build rapport with this client over time. Participant 3 described the impact this rapport had on the client:

So even through our therapeutic rapport, I was able to help him deescalate immediately and manage stress, manage stressors on the unit, and at least adhere, maybe not always or happily, but adhere to what the nurses are telling him.

Participant 3 reported that the combination of therapeutic rapport, receiving affirmation, and medication resulted in the client's participation in groups. The growth displayed by this client

over time resulted in his discharge from the treatment facility. Regarding this, Participant 3 stated:

And when I left he had been at a really great community placement, for at least a year and a half, so again, that stability. And I do attribute his early willingness to participate in his treatment to music therapy.

Participant 4 reported that the use of certain music therapy interventions generated growth in clients. Participant 4 discussed the use of music videos and singing in music therapy sessions: “Music videos and singing help bridge some drastic gaps in culture, race or socioeconomic status.” This participant stated that music videos and singing can reduce the auditory hallucinations experienced by clients, and provide them with a sense of grounding. They stated, “These interventions usually calm down the voices and have them being grounded in the group as they see how other people shared their likes for music”.

Growth Reported by Clients

Each participant stated that their clients have reported having growth experiences as a result of music therapy. These growth experiences include life improvements, enjoyment, education, shifts in mood, and self-esteem. The participants provided a description of the growth their clients have reported (Table 2).

Table 2*Growth Reported by Clients*

Participant	Direct Quotes from the Participants
Participant 1	<p>He has reported that his life is better and he's thinking about life improvements in his outside life. He certainly seems a little lighter when he comes in here. He has reported that this is a positive thing for him, he thinks about it a lot. He comes in here with ideas and he's written songs.</p>
Participant 2	<p>So, first of all we have to do Press Ganey. Press Ganey is a survey form. So we do post-discharge surveys with all of our patients. So, when they roll through [...] the patients rate, you know, how their group experience was, how the meals were, how all the different things. And often, I or another music therapist will get mentioned by name. "Music was really helpful," "Music was really great," "I really liked so-and-so's groups," "I learned this, I learned that" [...] We've had patients that will come back in and say, "I'm really glad I was in your group, it was really helpful."</p>

Participant	Direct Quotes from the Participants
Participant 3	I would end a lot of my sessions with, what I call the “So What?” conversation. You know, we'd have a little bit of processing about our music experience. And I would take it back to them, “What was the point of this?” or “How did this relate to your recovery?” Because we really focused on recovery versus illness. Because again, hope building and affirmation building, strength building, “How did this relate?”, “What part of your personality, or how did your choices today...?” Or you know, “What kind of things...?” That gave them a chance to self-evaluate and that's where they could say, “Oh, by participating in this I feel a lot more hopeful” or “I feel a lot better,” “My mood is improved.” You know, and I'll even note the small things, like, “Hey look, you just drummed for ten minutes, and last week you really didn't want to do it. Wow, that's a big difference!” So they could also go “Hey, look...”[...] but they would start owning some of that too.
Participant 4	Mostly mood changes. They enjoy the opportunity of autonomy by picking songs from a menu and participating in other music therapy interventions.

Each participant stated that their clients have reported enjoying music therapy. This is the most common reported area of growth among the participants. Improvements in mood were reported by Participants 3 and 4, making it the second most common reported growth. The client described by Participant 1 is the only person who reported growth in self-esteem and self-concept. Participant 2 is the only music therapist who stated that clients have reported feeling educated as a result of music therapy. Participant 2 specified that she provided many

psychoeducational groups at her facility. According to Lukens (2015) psychoeducation involves providing a client with information about their illness, providing therapeutic support, and helping the client learn how to cope with their illness. Participant 3 reported that clients felt that music therapy provided a sense of hope. The clients mentioned Participant 4 were the only people who reported that experiencing autonomy was enjoyable for them. This autonomy was experienced by choosing songs in music therapy, as well as choosing to engage in other music therapy interventions.

The client described by Participant 1 disclosed that he has experienced growth in self-concept and self-esteem as a result of music therapy. In regards to this, Participant 1 stated:

One thing he said which I love, he says these beautiful things sometimes [...] I said, "It's great to see you blossoming with your music." And he said, "It's good to be accepted for who you are." Last week he said, "Look at me, a guy with a history of schizophrenia and I'm doing all this stuff. I'm working all these jobs and I'm writing songs." And it's like he was able to have that feeling of self-esteem. [...] And that's a pretty important statement, a shift in self-concept. Because somebody could say, "Well I have these low level jobs," working whatever he's working, but he was seeing it in a different way. Like, he's a person who could be incapacitated and could be doing nothing, could be on complete SSD [social security disability] or something, and is actually out there working hard and earning money and thinking about his future.

This client reported significant growth in self-esteem and self-concept. Based on the information provided by Participant 1, this client seemed to feel a sense of pride regarding his accomplishments and direction of his life. This client also reported that he felt accepted as a

person in music therapy. Therefore, it can be insinuated that this feeling of acceptance had an important impact on the growth experienced by this client.

Participant 3 reported that clients who receive individual music therapy sessions typically report their growth experiences more in-depth than those in group music therapy. Participant 3 mentioned that she works on building hope, affirmation, and strength in her clients. According to Participant 3, individual clients have reported that music therapy helped them to “engage with their health; engage with their strength; do something they love, like our patient band, for example.” Participant 3’s clients described growth in regards to health and strength, and experienced enjoyment as a result of music therapy.

Experiences in Music Therapy

This category encompasses the personal experiences of music therapists working with clients with schizophrenia, as well as the perceived experiences of their clients in music therapy. This includes the feelings of the participants, their experiences working with other mental health populations, and the perceived feelings of their clients in regards to music therapy.

Personal Experiences of Music Therapists

The participants reported their experience of working with this population. This included their overall feelings of working with this population, and how the experience of working with this population compares to the experience of working with other mental health populations. The participants first described their overall experience and what they have learned (Table 3).

Table 3*Personal Experiences of Music Therapists*

Participant	Direct Quotes from the Participants
Participant 1	I like it. I'm interested in it. I treat them like anybody else, just face value. This is how they are, and how can we make music? And if there's something getting in the way of the music, then we work with that. [...] There's an expression you know, that if you've met one person with autism you've met one person with autism, meaning you can't just make a blanket statement as to what it is and how they are. So everybody's an individual. [...] So I just accept them like I accept anybody that I'm considered to be working with as a therapist.
Participant 2	It can be really challenging, but there's a huge need for therapists that are comfortable working with that type of population, with schizophrenia.
Participant 3	Oh I loved it. I absolutely loved it. It's absolutely challenging because sometimes you don't know what kind of symptoms your [...] patients might be dealing with when they come into your sessions. But what I really loved was getting to know them and really seeing how music aided with their recovery.
Participant 4	Mostly pleasant and unpredictable. The patient's mood and cognitive abilities might change from the morning group to the afternoon group. It is important to continuously communicate with the staff and nurses and visit the unit before planning a music therapy group.

The most common report on this experience is that it is enjoyable. Participants 1, 3, and 4 stated that they have had a pleasant experience working with this population. Other commonly reported aspects of this experience are the challenge and unpredictability of this work.

Participants 2 and 3 stated that this work can be challenging. Participants 3 and 4 stated that the challenge of working with this population is due to the unpredictability. According to them, the client's symptoms or cognitive abilities can fluctuate throughout the day. This fluctuation makes it difficult to know how a client may present during sessions.

Participants 1 and 3 stated that part of the experience is getting to know the clients. Participant 1 emphasized that he treats each client as an individual and accepts them for who they are. Participant 3 reported that getting to know the clients for who they are was an enjoyable part of the experience of working with this population. Participant 2 spoke about this as well, stating, "So when people's symptoms start kind of receding [...] it's lovely to see how they contribute to a group and the insights that they have." The majority of participants reported that their overall experience of working with this population was enjoyable. However, the most frequently reported enjoyable aspect of this work was getting to know the clients.

Music Therapy with Other Mental Health Populations. The participants were asked if they have worked with other mental health populations, and if that experience is different than working with the schizophrenia population. Each participant had experience working with other mental health populations and/or working with clients who had dual diagnoses. The participants discussed if the work with clients diagnosed with schizophrenia is different than the work with clients who have other diagnoses (Table 4).

Table 4*The Experience of Working with Other Mental Health Populations*

Participant	Direct Quotes from the Participants
Participant 1	I take everybody as an individual, and I work with them how I can to see if we can have a musical relationship that seems like a healthy musical relationship to me. Where we're both working together, we can understand each other. [...] I just take everybody at face value, you know? I'm not trying to cure schizophrenia or cure autism or cure depression or cure anything. I'm just trying to play music with people, which might sound frivolous in the estimation of some people, but in my understanding of what it can do for people, it's legitimate therapy and that's what I'm able to do so that's what I'm trying to do.
Participant 2	Oh yeah, night and day. And it's how you facilitate a group. It's the depth to which you are going to go. It is the amount of things you are going to squeeze into a 45- minute intervention. It's the topics that we use.
Participant 3	Yes. When I first started offering individual GIM sessions, I got a lot of referrals, most of my referrals were women diagnosed with borderline personality disorder. [...] they typically had more of the bipolar with psychotic features, so again, once their mood was stabilizing, their thoughts were stabilizing. But they also had all the borderline emotional [...]. And so I got some of that.

Participant	Direct Quotes from the Participants
Participant 4	Usually, patients with schizophrenia are happy to participate in music and make some music. The interventions with patients diagnosed with schizophrenia have more active music components and less discussion. The interventions with other patients have more discussion than active music-making.

The majority of participants reported that the experience of working with other mental health populations is different than working with those diagnosed with schizophrenia. It was most frequently reported that music therapy sessions are structured differently depending on the diagnoses of the clients. Participants 2 and 4 primarily reported these findings, and described them in more depth. Participant 2 stated that the way in which groups are facilitated, the depth of the experience, and the topics explored will vary depending on the client's diagnosis. Participant 3 provided examples of this as well:

I have a grief and loss group, and that is absolutely a mood disorder group. I have another grief and loss group that is for our senior patients. So just the way that I would plan one of those groups is very different than if I'm talking about, say, understanding and managing your symptoms, or self-care, or discharge planning. So both the topics and the way that I build the groups are very different depending on the population.

Participant 4 reported that active music-making occurs more frequently than discussion when working with clients diagnosed with schizophrenia. This is the opposite for clients with other mental health diagnoses; their sessions typically contain more discussion than active

music-making. Participant 3 reported that the primary difference between working with the two populations is the symptoms that the clients present.

Participant 1 reported that the experience of working with clients diagnosed with schizophrenia is not different than working with any other population. Participant 1 approaches each client in the same way. He treats the clients as individuals and accepts them for who they are. In doing this, Participant 1 explores different ways in which he and the clients can make music together based on the clients' interests, strengths, and capabilities. Regarding this, Participant 1 stated:

There's no typical musical treatment for a person with schizophrenia. I'm gonna work with them based on what they present, based on what their interest in music is and what their capabilities are, and, you know, how do we make music together? And we go past whatever barriers there are, or work with those barriers, and work with the strengths, and find a way to make music and normalize their experience within that context.

Participant 1 also explained that he focuses on five primary areas with each client. He has outlined these, as well as his overall approach:

My assumption is that if I can normalize the experience within music then we are working on those issues of relationship and self-esteem and length or level of engagement, having a little fun in life instead of suffering all the time, and being understood and expressed for who you are, your unique individuality. Which, I think many people get lost in the health system or the system of diagnosis and programs and et cetera. You know, can lose their individuality or their quality of their individuality as far as how other people are treating them. So those are the five areas that I really feel I'm

focusing on: relationship, length and quality of engagement, unique individual expression, enjoyment, and self-esteem or competence, or what I call self-efficacy, meaning that you can do stuff, you're good at it, which people need to feel that they're competent in some area.

Participant 1 provided a perspective on the treatment of clients that varies from the perspectives of the other participants.

Perceptions of Client Experience

The participants were asked to describe their perceptions of their clients experiences in music therapy. Their perceptions primarily included the way in which clients typically respond to and feel about their music therapy experiences. These were provided by each participant (Table 5).

Table 5

Perceptions of Client Experience

Participant	Direct Quotes from the Participants
Participant 1	I mean, they're gonna do it in their own time and I'm gonna keep finding the way in you know, that I can comprehend that feels like a positive thing for them.

Participant	Direct Quotes from the Participants
Participant 2	<p>Oh they like them. [...] We are very very acute quick turn-around and so we also have a pretty high recidivism rate, a lot of re-admissions. So people know me. And it's, "Aren't you gonna bring your guitar? Aren't we doing music today?" Because I don't do only music groups. I do groups with other topics, groups that I don't bring music into the play of it. So yes, I think they're very well received.</p>
Participant 3	<p>For the most part, they were pretty receptive. [...] I tried to design my groups based on the needs of our patients. So I had groups that were for fun, like karaoke, and I had groups that were a little bit more serious, like I had an addiction group. [...] I was at a place in my career where [...] planning wasn't as labor-intensive as it is when you're a student, so therefore I could be very present and work things on the fly too. And I mean, not from pre-planning, but from responding to what's happening with the clients at the moment. So in that way, I think that made them very receptive to music therapy. I mean it wasn't for everybody, I had some patients that never joined music therapy, and that's fine. But I can think of multiple that I had in groups for ten years. So, you know, that says something about their value, how they value being in music together.</p>

Participant	Direct Quotes from the Participants
Participant 4	Patients usually enjoy the most singing along and dancing. The music video intervention is structured towards discussion or memory recall. Music videos and singing help bridge some drastic gaps in culture, race or socioeconomic status. These interventions usually calm down the voices and have them being grounded in the group as they see how other people shared their likes for music. Patients seem to do better during music groups than any other psychotherapy/art therapy setting.

Participants most frequently reported that their clients find enjoyment in music therapy. Participants 2 and 4 primarily spoke about this. Participant 2 stated that clients would frequently inquire about music therapy sessions, even when Participant 2 was leading a different type of session. Participant 2 provided more detail on this, stating that there were multiple music therapists working at this facility. Therefore, clients were receiving music therapy from various people. In regards to this, Participant 2 stated:

So they're getting it from several different people, a very very different, big variety of education, a big spread in our age, our style. So I think that benefits them. Like, nobody needs to be with me; I don't need to be everybody's music therapy experience. They may absolutely benefit from somebody else or relate to somebody else more than they do to me. But I think the therapy model itself, the type of therapy is very well received.

Participant 4 reported that clients find singing and dancing to be the most enjoyable experiences in music therapy.

Participant 3 reported that clients were receptive to music therapy. The attention given to planning sessions, as well as the ability to respond to clients needs in the moment, are what Participant 3 considers to have positively impacted the receptiveness of the clients to the music therapy experience. Participant 3 mentioned that clients seemed to value being in music therapy together. This is evidenced by the clients' willingness to come to music therapy and stay in music therapy for long periods of time.

Participant 1 reported that clients respond to music therapy in their own time. To demonstrate this, Participant 1 provided an example:

When I was working in the partial hospital program, there were some people who didn't really want to do music, because they all had to come, they were supposed to all come, and some didn't really want to come, and some really did want to come. And usually the ones who really did want to come would be the more extroverted ones and dominate what was happening, and that was okay with me. In a group I don't try and necessarily make everybody equal all the time. If somebody's got more going on at one particular time and I feel like it's a good direction, I'm gonna allow that to happen. But what I found is the people, who had to come twice a week for months, the ones that at first you thought they're never gonna do anything, started doing stuff. So they just needed a little bit more time to get comfortable. So you know, never write anybody off and sometimes those are the more profound experiences because the people that you think are not gonna really get much out of this can get a lot out of it if you just let them have their own pace.

Participant 1 has noticed that some clients need more time to get comfortable in music therapy than others do. Participant 1 emphasized the importance of being patient with clients as they

adjust to music therapy at their own pace. While Participant 1 is being patient with clients, he works on finding different ways to musically connect with them.

Discussion

This study was designed to acquire an understanding of the lived experiences of music therapists who work with clients diagnosed with schizophrenia. The main focus of this study was the music therapists' perceptions of how music therapy impacted these clients. The data was collected through the use of individual, semi-structured interviews. As a result of the data analysis, two primary categories emerged: *The Perceived Impact of Music Therapy on Clients* and *Experiences in Music Therapy*. These results revealed that clients have experienced growth as a result of music therapy, and that music therapists and clients find music therapy to be an enjoyable, positive experience.

The Perceived Impact of Music Therapy on Clients

This category contained two themes: *Growth Reported by Music Therapists* and *Growth Reported by Clients*. All four participants and their clients have reported that music therapy has engendered client growth. The primary areas of growth reported by the participants include an increase in connection and interaction with others, reality orientation, mental focus, and self-expression.

Three participants in this study reported that their clients were connecting and interacting more often with the music therapist, other clients, and/or others in their lives as a result of music therapy. This aligns with the study presented by Mohammadi et al. (2012), in which emotional

withdrawal and poor rapport with others were significantly impacted by music therapy, and negative symptoms were reduced overall. Connection with others was the most common area of growth reported by the participants.

Two participants in the current study reported that music therapy was able to increase reality orientation in their clients. Participant 3 described how playing musical instruments was able to immediately orient her clients to the present moment. Similarly, Ulrich et al. (2007) found that music therapy was able to have a positive impact on psychosocial orientation in participants diagnosed with schizophrenia. Two participants also reported that music therapy was able to increase the amount of time that clients could maintain focus and attention to tasks. However, I was unable to find literature that discussed the impact of music therapy on mental focus for those diagnosed with schizophrenia.

Langdon (2015) stated that music therapy can address self-expression goals for clients diagnosed with schizophrenia. Two participants in this study reported an increase in self-expression as a result of music therapy. Participant 1 noticed that his client was expressing himself in the music. Participant 4 stated that their clients were using simple phrases to express themselves.

The primary growth experiences that clients have reported to their music therapists include enjoyment and improvements in mood. The most common reported area of growth was enjoyment, as each participant stated that their clients have reported enjoying music therapy. This aligns with the results of a study completed by Grocke et al. (2009), in which participants reported that music therapy gave them a sense of joy and pleasure. Participants 3 and 4 stated that their clients experienced improvements in mood as a result of music therapy. According to a

study completed by Tseng et al. (2016) music therapy is able to have a positive impact on mood symptoms in those diagnosed with schizophrenia.

Other areas of growth reported by clients include an increase in self-esteem and self-concept, hope, strength, and psychoeducation. The findings of the current study closely match the findings of the study completed by Solli and Rolvsjord (2015), in which participants experienced a connection with themselves and others, motivation, a sense of hope for their futures, freedom from their psychosis, and overall enjoyment in music therapy.

Experiences in Music Therapy

There were two themes in this category: *Personal Experiences of Music Therapists* and *Perceptions of Client Experience*. All four participants stated that working with the schizophrenia population has been an enjoyable experience for them. The participants found that getting to know the clients was the most enjoyable aspect of this experience. Other common reports described the experience as challenging and unpredictable. These challenges primarily stemmed from the fluctuation of a client's symptoms or cognitive abilities throughout the day.

The participants discussed their experiences in working with clients with other mental health diagnoses as well. Most participants reported that this experience was different than working with clients diagnosed with schizophrenia. These differences stemmed from the approach to sessions, the design of sessions, and the goals addressed in sessions. Mohammadi et al. (2012) studied the impact of different music therapy methods on the symptoms of schizophrenia, and found that participants experienced a reduction in negative symptoms from

all the methods. This aligns with the information shared by the majority of participants: the needs of the specific population determine the goals of music therapy and how they will be addressed.

One participant stated that the work is different based on the individual, not based on the diagnosis. This participant reported that their primary goal is to make meaningful music with the clients they serve. As a result, sessions are approached in the same way with all clients. The music therapy experiences are based on the clients' capabilities, strengths, and interests. This reflects the results of a study completed by Grocke et al. (2009), in which participants with various mental illnesses were provided with music therapy to address the same goals. The results revealed that those participants experienced benefits from this music therapy experience, despite experiencing different diagnoses (Grocke et al., 2009).

Each participant reported that their clients seem to respond positively to music therapy. This statement was based on their personal observations, as well as some verbal and written statements from clients. The participants most frequently reported that their clients find music therapy to be an enjoyable experience. Other reports of client response to music therapy include that they are receptive to music therapy, value being in music together, and that some clients need time to become comfortable engaging in music therapy. The results of the current study are similar to results found by other researchers. Solli and Rolvsjord (2015) and Grocke et al. (2009) both found that those with severe mental illnesses reported music therapy to be an enjoyable experience. Grocke et al. (2009) stated that participants felt a sense of belonging in music therapy.

Related Information

The participants of this study provided extra information regarding their overall experiences of this phenomenon. Collectively, the participants reported using each music therapy method with their clients: re-creative, receptive, improvisation, and composition. Some participants reported that their clients have performed as part of their music therapy experiences.

Additionally, the participants discussed the way in which those with schizophrenia are treated. They provided important information as well as advice for music therapists. While this information does not fit into the categories and themes discovered in the overall data, the information is important for consideration. Table 6 presents related information to help deepen the understanding of the individual music therapist participants' experiences in working with persons with schizophrenia.

Table 6*Additional Information*

Participant	Direct Quotes from the Participants
Participant 1	(On schizophrenia) This is just another way of being a person, it's not a lesser way of being a person.
Participant 2	The mental health population is horribly under served in this country, especially people who are chronically mentally ill. So you're going to see a lot of the same patients again and again, and try to stay creative and do something that's meaningful. It can be really challenging, but there's a huge need for therapists that are comfortable working with that type of population, with schizophrenia.
Participant 3	I feel like it's really important for more research, like you're doing, to be done in the area of mental health [...]. We know that mental health has a stigma in our society and so I certainly on my end have continued to advocate for de-stigmatization [...] in mental health, on the part of therapists and on the part of just greater society.

Participant	Direct Quotes from the Participants
Participant 4	I would like to share some pointers: Do not take anything personally, at times the voices are rude but not the patients. A patient's reality is real. Listen carefully to be able to discourage/encourage the patient. The more you physically visit the unit and interact with patients; they will recognize you more often. The patients will tend to trust you more over the voices the more they know you are real. Patients can become aggressive. Be mindful of your environment at all times. Sometimes, patients don't even remember when they were aggressive and feel upset they put you in danger. Each new day brings new grace. Be careful if someone was aggressive but treat them as usual without bringing up their previous aggressive behavior. Laughter is appropriate when it's part of interactions in groups and context. Please be human and do not laugh at the patient's delusions and hallucinations.

The participants emphasized the importance of respecting those diagnosed with mental illnesses. Each participant is aware of the stigma associated with the mental health population, and they advocated for better treatment of this population in their interviews. Participant 3 specifically emphasized de-stigmatization of this population. Participants 1 and 4 reported that it is important to treat all clients with respect. Participant 2 stated that there is a need for music therapists who are comfortable working with this population. Overall, it is important to treat all clients with respect, despite their diagnoses and the stigma associated with it.

Limitations of the Study

There were two primary limitations of the study conducted. Firstly, there were only four participants involved in this study. I was required to complete this research study within one semester, which reduced the amount of time that I could spend recruiting participants. The involvement of more participants would provide more perspectives and experiences on this research topic. Secondly, all the participants worked and lived in the United States. Music therapists from other cultures may find that the results of this study do not align with their personal experiences. Including participants from other countries and cultures could provide reports from various perspectives.

Recommendations for Future Research

I believe that it would be beneficial to include a larger number of music therapists in future research, and to include participants from various cultures. In doing so, the researcher could compare the results of this research study to their own. Otherwise, I believe it would be optimal to interview clients who are diagnosed with schizophrenia and have received music therapy services. In doing so, the researcher could acquire an understanding of the client's lived experience in music therapy. Researching the client experience could provide music therapists with important feedback regarding client preferences, growth, and general experiences in music therapy.

Conclusion

The categories and themes that emerged from the data suggest that music therapy can be beneficial for those diagnosed with schizophrenia. The results of this study demonstrated that music therapy can promote growth in a variety of areas of functioning. This aligns with the existing literature. Additionally, the results revealed that the participants and clients have found music therapy to be an enjoyable, positive experience. The literature depicts that music therapy is a positive experience for clients, but it does not explore this experience from the perspective of music therapists. I encourage that further research be completed in order to obtain a wider perspective on this phenomenon. A focus on client perspectives in future research can provide music therapists with crucial information regarding clients' lived experience in music therapy.

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Appendix A

Information for the Certification Board for Music Therapists' Email List Order Form

My name is Brittany Earl and I am a music therapy graduate student at SUNY New Paltz. I am currently creating a research study in which I will be exploring the lived experience of music therapists who have worked with clients diagnosed with schizophrenia.

My thesis advisor is Heather Wagner, PhD, MT-BC. She can also be reached at wagnerh@newpaltz.edu if there are any questions or concerns.

Appendix B

Email to the Potential Participants

Subject: Music Therapy and Schizophrenia Research Study

Music Therapists,

My name is Brittany Earl and I am a music therapy graduate student at SUNY New Paltz. I am conducting a research study in which I will be exploring the lived experience of music therapists who work with clients diagnosed with schizophrenia. Specifically, I will be examining the perceived impact of music therapy on clients with schizophrenia.

I am looking for three or four participants for this study. Participants must meet the criteria below:

- Participants must have worked with clients diagnosed with schizophrenia in a long-term care facility (a stay of 30 days or more).
- Participants must have a minimum of five years experience as a music therapist, and a minimum of two years experience working in a long-term mental health facility.
- Participants can be currently working in this setting, or could have worked in this setting within the past five years.
- Participants will work or have worked with the mental health population for a minimum of 20 hours per week.

This study will involve individual interviews in which we will discuss your experience and perceptions in working with this population. Interviews can be conducted face-to-face, via phone, or via web conferences. The interviews will be audio recorded so they can be transcribed

and analyzed. All participants must consent to audio recording and all participants will be kept confidential.

If you meet these criteria and are interested in participating, please reply to this email within ten days.

If you have any questions, please contact me at earlb1@hawkmail.newpaltz.edu.

My thesis advisor is Heather Wagner, PhD, MT-BC. She can be reached at wagnerh@newpaltz.edu if there are any questions or concerns.

Thank you.

Appendix C

Facebook Post

Music Therapy and Schizophrenia Research Study:

My name is Brittany Earl and I am a music therapy graduate student at SUNY New Paltz. I am currently creating a research study in which I will be exploring the lived experience of music therapists who have worked with clients diagnosed with schizophrenia. Specifically, I will be examining the perceived impact of music therapy on clients with schizophrenia.

I am looking for three or four participants for this study. Participants must meet the criteria below:

- Participants must have worked with clients diagnosed with schizophrenia in a long-term care facility (a stay of 30 days or more).
- Participants must have a minimum of five years experience as a music therapist, and a minimum of two years experience working in a long-term mental health facility.
- Participants can be currently working in this setting, or could have worked in this setting within the past five years.
- Participants will work or have worked with the mental health population for a minimum of 20 hours per week.

This study will involve individual interviews in which we will discuss your experience and perceptions in working with this population. Interviews can be conducted face-to-face, via phone, or via web conferences. The interviews will be audio recorded so they can be transcribed

and analyzed. All participants must consent to audio recording and all participants will be kept confidential.

If you meet these criteria and are interested in participating, please email me within ten days. My email address is earlb1@hawkmail.newpaltz.edu. You may email me with any questions as well.

My thesis advisor is Heather Wagner, PhD, MT-BC. She can be reached at wagnerh@newpaltz.edu if there are any questions or concerns.

Thank you.

Appendix D

Email with Information Sheet and Interview Questions

Music Therapists,

Thank you for your interest in participating in this research study. Attached to this email, you will find two documents: the interview questions and the participant information sheet. Please review both documents. If you are still interested in participating in this research study after reviewing the documents, email me within ten days stating that you would like to participate. Once the ten days have passed, I will contact the interested participants in order to set up interview appointments.

Thank you.

-Brittany Earl

Appendix E

Interview Questions

1. How long have you worked with clients who are diagnosed with schizophrenia?
2. How would you describe your experience of working with clients who are diagnosed with schizophrenia?
3. What music experiences do you typically use when working with these clients?
4. How do these clients typically respond to these music experiences?
5. Have you noticed changes within the clients that you believe are a result of music therapy? If so, what are these changes?
6. Have clients reported changes within themselves as a result of music therapy?
7. Do you work with individuals with other mental health diagnoses? If so, is that experience different than working with those diagnosed with schizophrenia?
8. Is there any other information you would like to share regarding this topic?

Appendix F

Information Sheet

Information Sheet for Participation in Research

Title of the Research

The Experience of Music Therapists Working With Clients With Schizophrenia

Researcher Information

Brittany Earl, SUNY New Paltz, Music Therapy Graduate Student, Bachelor of Science

Description of the Research

This study involves research. The purpose of this research is to understand the lived experience of music therapists working with clients diagnosed with schizophrenia. The main focus of this study will be to understand the perceived impact of music therapy on clients with schizophrenia.

Participants

I am looking for three or four participants for this study. Participants must meet the criteria listed below:

- Participants must have worked with clients diagnosed with schizophrenia in a long-term care facility (a stay of 30 days or more).
- Participants must have a minimum of five years experience as a music therapist, and a minimum of two years experience working in a long-term mental health facility.
- Participants can be currently working in this setting, or could have worked in this setting within the past five years.
- Participants will work or have worked with the mental health population for a minimum of 20 hours per week.

Procedures and Data Storage

If you agree to participate in this study, you will be interviewed by the researcher about your experience working with clients who are diagnosed with schizophrenia. These interviews should take one hour maximum to complete. The interview can occur in person, over the phone, or over a web-conference, depending on your preference. The interviews will be audio recorded so the researcher can transcribe and analyze them.

Once I have completed the data analysis, I will invite you to read the transcription of your interview. In doing so, I will ask you to let me know if I have accurately represented the information you provided in the interview and if there is any further information you would like to share.

The audio recordings and transcriptions will be stored in password-protected devices. The researcher is required to keep this data for three years. After three years, it will be destroyed.

Your Participation is Voluntary

Your participation in this project is voluntary. Even after you agree to participate in the research, you may decide to leave the study at any time without penalty. I will retain and analyze the information you have provided up until the point you have left the study unless you request that your data be excluded from any analysis and/or destroyed. You may choose not to answer any questions and may refuse to complete any portions of the research you do not wish to for any reason. Your identity will be kept confidential. However, all the information you provide in the interview can be used in the study unless you request otherwise.

For questions about the research, email the researcher, Brittany Earl, at earlb1@hawkmail.newpaltz.edu.

Questions can also be directed to the researcher's thesis advisor, Heather Wagner, at wagnerh@newpaltz.edu.

For questions about your rights as a research participant, contact the State University of New York at New Paltz Human Research Ethics Board (which is a group of people who review the research to protect your rights) at 845-257-3282. The Human Research Ethics Board of the State University of New York at New Paltz has determined that this research meets the criteria for human subjects according to Federal guidelines.

One copy of this document will be kept together with the research records of this study. Also, you will be required to keep a copy.