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Psychiatric Inpatient and Outpatient Evaluation of Music Therapy and Related Treatments

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PSYCHIATRIC INPATIENT AND OUTPATIENT EVALUATION OF MUSIC THERAPY AND RELATED TREATMENTS

By

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ABSTRACT

Psychiatric inpatients and outpatients (N = 12) were asked to evaluate music therapy services received while admitted in treatment. Each subject was given an anonymous survey with rating, multiple choice, and ranking questions. Music therapy ranked high in the enjoyment category, average result 1.58, and most patients agreed that music therapy helped them progress towards their treatment goals, average 1.67. Relaxation was chosen as the area where music therapy was most helpful, followed by increased social skills. Music therapy was ranked above recreation therapy and occupational therapy as being most helpful, but below one to one therapy. This study will need to be continued with a larger sample size to make the results generalizable and valid.
INTRODUCTION

Music therapy has been used for many years in psychiatric hospitals, with inpatients and outpatients. The National Association of Music Therapy defined music therapy as “The use of music in the accomplishment of therapeutic aims, the restoration, maintenance and improvement of mental and physical health” (Wheeler, 1983). According to this definition, music therapy is a valid practice in the area of mental health. Common music therapy interventions in psychiatric work include songwriting (Schmidt, 1983), lyric analysis, drumming, rhythm activities, and improvisation, (Silverman, 2003; MacIntosh, 2003). These music therapy interventions are frequently used in group music therapy, but songwriting (Silverman, 2003), lyric analysis, and music lessons, guitar, piano, or voice (Tyson, 1982), are often used in individual music therapy sessions as well as group sessions. Music therapy groups are structured around the needs of the patient (Morgenstern, 1982; Hanser, 1984), therefore justifying the need for various interventions. Another music therapy technique, Receptive Music Therapy, or RMT, has been shown to be effective in use with depressed patients to help integrate values (Smeijsters, et al., 1995).

Herd explains that music therapy is a valid method of treatment in behavioral healthcare facilities, according to the standards of care established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (Herd, 1986). Healthcare facilities must follow the standards established by JCAHO in order to maintain accreditation opening the door for music therapy to fulfill the requirement of activity therapy. Although music therapists can fill a role of an activity therapist, music therapists must still work hard to be considered valuable to the total treatment of psychiatric patients (Hanser, 1984).

One big hindrance to music therapy being seen as a vital part of psychiatric care is the lack of research in this area (Körlin, et al., 2000). Less than 5% of articles in the Journal of Music Therapy over a twenty-year span between 1975 and 1995 were about psychiatric music therapy (Choi, 1997). There is a need for more quantitative research in psychiatric music therapy, and this research can help establish music therapy more firmly in the professional psychiatric community. There also needs to be more research on how psychiatric patients themselves perceive music therapy.
LITERATURE REVIEW

There are research studies that seek to discover if current psychiatric treatment programs are effective. The evaluation of patient satisfaction is where much of the research begins. Some studies have globally looked at patient satisfaction, but many of the research looks to discover specifically which factors contribute to positive and negative perceptions of treatment. Type of therapy, diagnosis, and success in reaching treatment goals are shown to be important areas to study when researching psychiatric patient satisfaction.

Tyson found that many times when verbal therapies were no longer effective in helping certain psychiatric patients progress in treatment, those patients were referred for music therapy (Tyson, 1984). In a study that compared treatment outcomes of psychiatric patients receiving primarily verbal therapy and psychiatric patients receiving primarily activity therapy, results showed some differences in outcome (Klyczek, et al., 1986). Patients who received more activity therapy showed four times more symptom reduction than the patients in the verbal therapy group (p.609). When patients are actively involved in therapy groups they are given the opportunity to focus on the task they are given, resulting in a decrease in symptoms at the time of the activity. The patients in the activity therapy group also showed more active involvement in their treatment (p.609).

In a study by Goldberg, McNeil, and Binder, which used patient report to evaluate specifically music therapy and verbal therapy, no statistically significant differences were found in how patients perceived the benefits of music therapy versus verbal therapy (Goldberg, et al., 1988). Patients regarded both forms of therapy as equally helpful in specific areas listed on a questionnaire (p.153). Other areas where activity therapies have been shown to be effective include an increase in communication skills, and an increase in self-perception in contrast with verbal therapy groups (DeCarlo & Mann, 1985).

A study by Cassity and Cassity showed that the main use of music therapy with adult populations was as insight therapy with reeducative goals, based on self-report of clinical training directors (Cassity & Cassity, 1994). Music therapy groups help provide a safe place where the total person can be explored, resulting in greater insight and change in the patient (Tyson, 1984; Bednarz & Nikkel, 1992; MacIntosh, 2003). Group music therapy in psychiatric facilities is probably the most common practice. Research has shown that music is helpful in creating positive group dynamics, group cohesion, and increased communication between patients and staff (Bednarz & Nikkel, 1992). As stated previously, music therapy interventions in psychiatric groups are structured around the needs of the patients (Morgenstern, 1982; Wheeler, 1981), thus music therapy groups are beneficial in dealing with many of treatment goals common to psychiatric patients. Many of the goals include dealing with emotions, social skills, communication, and behavior. Music therapy program goals vary among facilities based on the bias of the facility and how they view the role of music therapy.

Music therapy can be very useful in the area of emotional expression (Dvorkin, 1982; MacIntosh, 2003). It is common for psychiatric patients to have trouble expressing their emotions, or expressing their emotions in a constructive way (Shultis, 1999). Korlin effectively summarized a benefit that creative arts therapies may have over traditional verbal therapy in emotional expression:
“the techniques help access, give form to, and integrate experiences, memories, and emotions that cannot be directly verbalized” (Körlin, et al., 2000).

Music is effective in creating a structured setting where emotional reactions can be revealed and processed (Shultis, 1999, Goldberg, 1989, Dvorkin, 1982).

Music also helps facilitate interpersonal communication between the therapist and the patient, and between the patients themselves (Morgenstern, 1982). Music therapy can play a vital role in the development of social skills, if the patient learns to transfer the communication skills used in music therapy to other situations outside the group (Langdon, et al., 1989).

When working with acutely psychotic patients, the music therapy goal may simply be to connect the patient with reality and to keep them there as long as possible (Shultis, 1999). That connection to reality may enable the patient to demonstrate more organized thinking as evidenced by engagement in the group activity and with peers and staff. Other times the goal may be to change behavior. In a study by Silverman, it was found that music therapy was helpful in increasing positive behaviors of a schizophrenic patient who was very hostile and had poor relationships with the hospital staff (Silverman, 2003). A positive rapport with the music therapist, positive reinforcement of appropriate behaviors, and an emphasis on transferring the new behaviors outside of the music therapy session helped the patient integrate the positive outcome of the individual session (p.33).

Measuring patient satisfaction has become increasingly important lately, due to consumerism in areas where services or products are provided, including healthcare (Morrison, et al., 1996, Hayashi, et al., 2001). Patient satisfaction is important for maintaining demand for services, which can equal more funding for those services. Measuring satisfaction is also important for research into how to provide the best care and services to the consumer (Glass, 1995; Holcomb, et al., 1998, JCAHO, 1995; Rosencheck, et al., 1997).

In general, the purpose of distributing an evaluation survey is to see what works and what does not work (Lambert, 2001). Allowing clients and patients who receive music therapy services to evaluate those services can be helpful to music therapists in the same way that satisfaction data is helpful in improving services in many other fields.

Goloff used a survey to measure patient perceived helpfulness of music therapy while in the hospital (Goloff, 1981). Medical patients who participated in group music therapy were given a survey intended to measure the effects of music therapy on their physical, affective, and emotional states after receiving music therapy. Patients were also asked to rate music therapy in comparison with other activities offered at the hospital. Music therapy was found to be the activity most helpful in making the hospital stay more positive (p.55). Patient evaluation of music therapy is important in bringing awareness about which music therapy interventions are the most effective, or helpful, and which interventions are the least effective, according to patient perception. This information allows music therapists to design treatment plans and music therapy sessions that will best meet the needs of the patient or client (Heaney, 1992, Gordon, et al., 1979).

Previously psychiatric patient views were not always considered when designing programs and evaluating care in the mental health field (Morrison, 1996). Mental health professionals tended to evaluate patient care based on their own views rather than the views of the patient (Perreault, et al., 1996; Gordon, et al., 1979; Lester, 1999). Sadow, Ryder, and Webster found that unfortunately those who work in the mental health profession are not exempt from stigmatizing attitudes, and many times do not view those with mental illnesses as equals.
Given this information it is not surprising that past evaluations of mental health care have not expressed the opinions of those who receive the services.

The misconception that psychiatric patients do not have the capacity to evaluate services (Gordon, et al., 1979; Morrison, et al., 1996) has also been a barrier to research in the area of patient satisfaction. Research has shown that psychiatric patients have the capacity to give their opinions of services, and those opinions can be very reliable and valid (Babiker & Thorne, 1993; Holcomb, et al., 1998, Choi, 1997, Meadows, et al., 2000). Choi found that the results of a survey given to psychiatric patients to evaluate “13 music therapy treatment goals” were very reliable (Choi, 1994). Some of the goals included increases in self-esteem, social skills, and concentration (p.285). It appears that psychiatric patients are capable of recognizing improvements in themselves. In a study that measured satisfaction and self-reported treatment outcomes the results show “significant relationships between patient satisfaction, psychiatric diagnosis, and other outcome measures, and argues for the validity and utility of patient satisfaction measures in assessing the efficacy of inpatient care” (Holcomb, et al. 1998). Research findings have been consistent in proving the validity of the patients’ self-report.

The question whether or not psychiatric patients can consent to research is an ongoing one (Meslin, 1999, Moser, et al., 2002). In 1998 the NBAC published the report Research Involving Persons with Mental Disorders That May Affect Decision Making Capacity that gave recommendations for conducting research with the mentally ill (Meslin, 1999). These recommendations were for federal bodies as well as local IRBs. This report addressed ethical concerns that arise when including psychiatric patients in research studies (p.1011). The main purpose of the report was to help protect the mentally ill from research that could potentially be harmful, and to ensure that the patient is able to give full consent to the study. It is expected that consent to participate is obtained before any research is done, and that a qualified expert, independent of the research, assess each patient’s capacity (p.1012; Capron, 1999).

In a study that tested schizophrenic patient capacity to consent, 80% of those tested were shown to have capacity to consent to a drug trial (Moser, et al., 2002). This study also showed that main factors that affected capacity and understanding were cognitive functioning and negative symptoms (p.1205). Psychotic symptoms were not the main determinant, as some would believe. (p.1205-1206). Mental illness alone has not been shown to be a predictor of capacity to consent, therefore it is argued that one must assume that all have the capacity to consent to participate in any research, unless otherwise determined (Berghmans, 2001).

There is evidence of a positive correlation between psychiatric patient functioning levels and the level of satisfaction with mental health services (Berghofer, et al., 2001; Holcomb, et al., 1998). Patients also report higher satisfaction when they have met more of their goals and objectives (Babiker & Thorne, 1993; Holcomb, et al., 1998; Gigantesco, et al., 2003), as a result of complying with treatment (Hayashi, et al., 2001, Lester, 1999). Music therapists have an important job in reinforcing and supporting the treatment goals and objectives of patients involved in psychiatric treatment, therefore it is important to also measure patient satisfaction with music therapy. If patients are satisfied with music therapy services, music therapists are better able to help the patients transfer issues addressed in music therapy groups to other areas of their total treatment. Satisfied patients may also be more likely to actively participate in music therapy groups and activities (Lester, 1999), which could result in a more positive treatment outcome.

Research has shown that psychiatric patients are generally satisfied with services and demographic factors, such as age, race, and sex, generally have no correlation with satisfaction
levels (Babiker & Thorne, 1993; Cook & Jonkas, 1996; Perreault, et al., 1996, Holcomb, et al., 1998; Gordon, et al., 1979; Svensson & Hansson, 1994; Leavey, et al., 1996; Urquhart, et al., 1986). Patients new to psychiatric care were interviewed in a study by Gordon, Alexander, and Dietzan. 85% of the patients polled in felt that their personal, physical, and emotional needs were met by the psychiatric facility and staff (p.118). Leavey, King, Cole, Hoar, and Sabine also studied patients involved in their first psychiatric hospitalization and found that 88% were satisfied with their hospitalization (Leavey, et al., 1996). Overall treatment by staff was rated highly, but only 19% of those interviewed were pleased with the activities on the unit (p.54). The study also showed that general questions may receive more positive ratings, but specific questions show more variance in satisfaction ratings (p.55). Patient insight has also been shown to be positively correlated with treatment satisfaction (Hayashi, et al., 2001). Schizophrenic patients with poor insight were generally less satisfied and did not believe their therapist was reliable (p.591). It was concluded that patient attitude plays an important role in perceived treatment success and satisfaction (p.592).

Patients diagnosed with depression on two units, a psychobiological research unit, and a standard clinical unit, were given satisfaction surveys to evaluate psychiatric treatment received (Kalman, et al., 1982) and both groups reported high levels of satisfaction (p.345). Patients on both units showed improvement on the Hamilton Rating Scale for Depression, but those on the research unit were more satisfied (p.345). Svensson and Hansson conducted a study that evaluated satisfaction based on personality traits and diagnosis (Svensson & Hansson, 1994). The results showed that 88% of patients were satisfied with treatment design and 84% were satisfied with the treatment program (p.383). Patients with aggressive personality traits and diagnosed personality disorders were less satisfied (p.383).

Urquhart, Bulow, Sweeney, Shear, and Frances were able to isolate certain factors that contributed to patient satisfaction through the use of a questionnaire (Urquhart, et al., 1986). Same sex matching of patient and therapist, individual therapy, therapy with a social worker versus therapy with a medical resident, and longer treatment were positively correlated with satisfaction (p.132,133). In a study conducted by Babiker and Thorne psychiatric patients, referrers, and consultants were asked to list objectives that were important while admitted in the hospital (Babiker & Thorne 1993). Treatment was cited as the most important objective by patients, referrers, and consultants (p.29). There was not always agreement on which other objectives were also important, but accomplishment of patient and consultant objectives was positively correlated with overall satisfaction (p.29). Holcomb, Parker, Leong, Thiele, and Higdon also found that self-reported improvement by psychiatric patients was also related to satisfaction (Holcomb, et al., 1998). Psychiatric inpatients at a veteran’s hospital were given the Treatment Outcome Profile to evaluate their treatment and the perceived outcomes. Higher scores on the Treatment Outcome Profile equaled higher reported overall satisfaction (p.933). The Client Satisfaction Questionnaire (CSQ) was used by Perreault, Rogers, Leichner, and Sabourin to compare satisfaction levels of outpatient psychiatric patients based on diagnosis (Perreault, et al., 1996). The study showed that patient union with the therapist and diagnosis was a greater predictor of satisfaction, than patient demographic features (p.291). Patients who agreed with their therapist about treatment, and those who did not have schizophrenia or other psychotic disorders, were most satisfied with treatment.

Although demographic factors have little to do with satisfaction, diagnosis has been shown to be a better predictor. Psychotic patients tend to report lower levels of satisfaction than patients with affective disorders, such as major depression (Babiker & Thorne, 1993; Perreault,
et al., 1996; Kalman, et al., 1982; Svensson & Hansson, 1994; Leavey, et al., 1996; Hayashi, et al., 2001). Patients who are suicidal, and patients who are drug abusers also tend to have lower reported levels of satisfaction with psychiatric services (Holcomb, et al., 1998; Svensson & Hansson, 1994).

Using a survey as an evaluation tool is probably one of the most basic ways of gathering information, for example, the Client Satisfaction Questionnaire (CSQ) is a widely used, valid, standardized survey used in the mental health field (Babiker & Thorne, 1993, Perreault, et al., 1996). The process of developing a proper and effective tool may take many steps. An effective survey tool can be developed through focus groups, to create questions (Glass, 1995; Gigantesco, et al., 2003), interview (Perschel, 2001), and by launching a pilot study, allowing the tool to be tested (Goloff, 1981; JCAHO, 1995; Perschel, 2001; Sierles, 2003). Surveys can also be evaluated by peers for suggestions and comments (Sierles, 2003). The data gained from a pilot study can answer questions of whether the subject comprehends the questions (Eisen, et al., 2001) and are there additional questions that can be added or questions that can be eliminated. In a study that measured patient satisfaction with day-care facilities two versions of the questionnaire were distributed to test the reliability of the tool itself (Gigantesco, et al., 2003).

Eisen, et al., (2001) point out the "need for standardized instruments" to measure consumer satisfaction. Sierles (2003) calls questionnaires "fundamental research instruments" and also gives some basic guidelines and things to consider when developing a survey tool:

"the research question should be interesting to peers and scientifically answerable" (p.105)
"are conclusions generalizable to population?" (p.105)
subjects should be able to finish in "5-10 minutes" (p.106)
"anonymous surveys increase response" (p.106)
questions should be "closed ended, clear, succinct" (p.108)
questions should be "responsive to education and vocabulary of subject" (p.108)
allowing space for "comments can be valuable" (p.108)

These suggestions were taken into consideration when developing the questionnaire for this research. The purpose of this study is to evaluate psychiatric patients' opinions of their experience with music therapy.
METHOD

Subjects

Subjects (N=12) (Table 1) were recruited from the psychiatric research unit and the partial hospitalization program at a major US city university hospital. The ages ranged from 18-59 years old. Eight females and four males participated. Five of the subjects were outpatients, and seven were inpatients. The inpatients were admitted on the psychiatric research unit and outpatients were members of the partial hospitalization program. Inpatients remained on the unit from one month to three months. Outpatients could remain in their program for up to six months. The average stay of all the subjects was 2.18 months.

<table>
<thead>
<tr>
<th></th>
<th>Status</th>
<th>Sex</th>
<th>Race</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Time in Treatment (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>O</td>
<td>M</td>
<td>C</td>
<td>25</td>
<td>BP</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>I</td>
<td>F</td>
<td>AA</td>
<td>45</td>
<td>MD</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>O</td>
<td>F</td>
<td>AA</td>
<td>22</td>
<td>BP</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>I</td>
<td>M</td>
<td>C</td>
<td>56</td>
<td>BP</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>O</td>
<td>F</td>
<td>H</td>
<td>43</td>
<td>S</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>I</td>
<td>F</td>
<td>H</td>
<td>35</td>
<td>MD</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>O</td>
<td>F</td>
<td>AA</td>
<td>47</td>
<td>SA</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>I</td>
<td>M</td>
<td>AA</td>
<td>19</td>
<td>S</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>O</td>
<td>F</td>
<td>AA</td>
<td>59</td>
<td>BP</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>I</td>
<td>F</td>
<td>AA</td>
<td>39</td>
<td>MD</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>I</td>
<td>M</td>
<td>C</td>
<td>33</td>
<td>BP</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>I</td>
<td>F</td>
<td>AA</td>
<td>37</td>
<td>SA</td>
<td>1</td>
</tr>
</tbody>
</table>

O = Outpatient  I= Inpatient  M= Male  F= Female  C= Caucasian  AA= African American  H= Hispanic  BP= Bi-Polar  MD= Major Depression  S= Schizophrenia  SA= Schizoaffective
Design

The design of this study was a post treatment only survey of patient satisfaction.

Procedure

A two page survey was developed with evaluation questions that addressed the relationship with the music therapist, music therapy interventions, and areas of helpfulness of music therapy and other treatment modalities. The survey contained one rank order question, 5 multiple choice, and 8 rating questions. The rating scale had a five point range from “strongly agree” to “strongly disagree”. Subjects were recruited after participating in at least four process oriented music therapy groups. The qualifying music therapy groups did not include music listening group, music relaxation group, or exercise to music, although these groups were offered on the inpatient unit and led by the music therapist and music therapy interns. Before being approached, potential subjects were previously assessed to have the capacity to consent to research. Patients who agreed to participate in the research were required to sign a consent form. Each subject that was approached agreed to participate, and all surveys were returned.

A pilot study was initially performed to test the survey. 13 patients participated in the pilot study, six females and seven males. The pilot survey contained 15 questions and an optional comments section. Some survey questions were revised, omitted, and added. The pilot study did not originally contain “no opinion” on the rating questions. A question that asked for diagnosis was omitted since that information was obtained when gathering demographic data. Some questions that were intended to provide reliability were omitted to reduce redundancy. A question about discussion during music therapy was added as well as a comparison of music therapy with other treatment groups.

Subjects were given a two-page, 14 question survey to be filled out anonymously when music therapy groups were not taking place or during groups that allowed them to leave for a few minutes. Each subject provided the researcher with basic demographic information such as age, sex, race, and diagnosis. A code was assigned to each patient to identify their responses as those of inpatients or outpatients, and to keep track of the number of subjects enrolled in the survey. Completed surveys were placed and sealed in a coded envelope and returned to the researcher.
RESULTS

Responses to the rating scale questions were compiled and were all in a positive direction for music therapy (Table 2). Using a likert scale scale of 1-5 with 1 being “strongly agree” music therapy was reported to be enjoyable (1.58), with most responding with “strongly agree” to “agree”, leaning towards “agree”. Responses to questions regarding relationship with the music therapist were also positive. Subjects reported a therapeutic relationship with the music therapist (1.5), and concern from the music therapist (1.42), with both averages heavy on the positive end of the scale. Respondents disagreed that the music therapist did not respect them (4.67), with an average close to “strongly disagree.” Patients generally agreed that music therapy had a positive effect on their treatment (1.58), and that it helped with their treatment goals (1.67).

Table 2: Rating Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 MT Enjoyment</td>
<td>1.58</td>
</tr>
<tr>
<td>Q2 MT helped treatment goals</td>
<td>1.67</td>
</tr>
<tr>
<td>Q3 Therapeutic relation with MT</td>
<td>1.5</td>
</tr>
<tr>
<td>Q4 MT did not respect me</td>
<td>4.67</td>
</tr>
<tr>
<td>Q5 MT had positive effect</td>
<td>1.58</td>
</tr>
<tr>
<td>Q6 MT was concerned</td>
<td>1.42</td>
</tr>
<tr>
<td>Q7 Discussion helped</td>
<td>1.5</td>
</tr>
<tr>
<td>Q8 Would not want MT in future</td>
<td>4.17</td>
</tr>
</tbody>
</table>

Table 3 shows the order of issues respondents felt were most helped by music therapy. The most common area where music therapy was reported helpful (Table 3) was relaxation followed by increased social skills. Music therapy had positive effects on concentration, stress, boredom, self-esteem, and depression. Five subjects found that music therapy helped increase focus and decrease mania. Four respondents reported distraction from audio hallucinations, and one reported distraction from visual hallucinations. Music therapy distracted from or decreased medication side effects in three of the 12 patients, and decreased tremors in two patients. One participant did not find music therapy helpful in any areas. Four subjects found that music therapy was helpful in other ways not listed on the survey. Patient comments in the “other” category were: “good to be part of a group”, “communication with staff and patients”, “felt overall better”, and “it is enjoyable.” Most agreed that discussion after the music therapy activity was helpful.
Table 3: MT Helpfulness

<table>
<thead>
<tr>
<th>MT Helped With</th>
<th>% Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relaxation</td>
<td>.83</td>
</tr>
<tr>
<td>Increase social skills</td>
<td>.75</td>
</tr>
<tr>
<td>Increase concentration</td>
<td>.67</td>
</tr>
<tr>
<td>Reduce stress</td>
<td>.67</td>
</tr>
<tr>
<td>Decrease depression</td>
<td>.67</td>
</tr>
<tr>
<td>Decrease boredom</td>
<td>.67</td>
</tr>
<tr>
<td>Increase self-esteem</td>
<td>.67</td>
</tr>
<tr>
<td>Increase focus</td>
<td>.42</td>
</tr>
<tr>
<td>Decrease mania</td>
<td>.42</td>
</tr>
<tr>
<td>Distract from voices</td>
<td>.33</td>
</tr>
<tr>
<td>Other</td>
<td>.33</td>
</tr>
<tr>
<td>Distract/Decrease medication side effects</td>
<td>.25</td>
</tr>
<tr>
<td>Decrease tremors</td>
<td>.17</td>
</tr>
<tr>
<td>Distract visual hallucinations</td>
<td>.08</td>
</tr>
<tr>
<td>MT was not helpful</td>
<td>.08</td>
</tr>
</tbody>
</table>

Table 4 shows respondents' opinions about enjoyment of music therapy. Music listening was the most enjoyed activity, and the least enjoyed was singing. Playing instruments was rated high with six responses, while songwriting ranked as the least enjoyed. Songwriting also received two responses as the least enjoyed music therapy intervention. Movement to music ranked third in the most enjoyable category, followed by music games, discussion and singing. The choice of "other" received one response, but the subjects did not write in what they enjoyed.

There were not as many responses for the least enjoyed activity. Singing and movement tied as the least enjoyed, followed by songwriting, music games, and discussion. Playing instruments, music listening, and "other" did not receive any responses in the least enjoyed category.

Table 4: MT Interventions

<table>
<thead>
<tr>
<th>Intervention Most Enjoyed</th>
<th>% Responses</th>
<th>Intervention Least Enjoyed</th>
<th>% Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Music listening</td>
<td>.83</td>
<td>Singing</td>
<td>.25</td>
</tr>
<tr>
<td>Playing instruments</td>
<td>.5</td>
<td>Movement</td>
<td>.25</td>
</tr>
<tr>
<td>Movement</td>
<td>.42</td>
<td>Songwriting</td>
<td>.17</td>
</tr>
<tr>
<td>Music games</td>
<td>.33</td>
<td>Music games</td>
<td>.17</td>
</tr>
<tr>
<td>Discussion</td>
<td>.25</td>
<td>Discussion</td>
<td>.08</td>
</tr>
<tr>
<td>Singing</td>
<td>.25</td>
<td>Playing instruments</td>
<td>-</td>
</tr>
<tr>
<td>Songwriting</td>
<td>.08</td>
<td>Music listening</td>
<td>-</td>
</tr>
</tbody>
</table>
Not all patients responded to the last question of rank ordering therapies according to helpfulness. Of those that responded, “one to one” therapy with primary therapist ranked highest. Music therapy was second followed by small talking group and community meeting, a bi-weekly meeting with patients and staff created to discuss any issues the patients or staff feel are important to the unit and the unit milieu. Recreation therapy and occupational therapy ranked lowest of perceived helpfulness. Four participants wrote additional comments. One patient reported that “some of the activities did not seem age-appropriate”, but the group was generally enjoyable and the music therapists were “among the most caring of the staff.” Another patient found individual guitar lessons to be helpful for focus during manic states. This patient also enjoyed having CDs to listen to on the unit that the activity therapy department made available for the patients. An outpatient commented that music therapy was “enjoyable” and “creative.”

### Table 4: MT Interventions (cont)

<table>
<thead>
<tr>
<th>Intervention Most Enjoyed</th>
<th>% Responses</th>
<th>Intervention Least Enjoyed</th>
<th>% Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>.08</td>
<td>Other</td>
<td>-</td>
</tr>
</tbody>
</table>

### Table 5: Therapies Ranked According to Helpfulness

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Average Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTO</td>
<td>1.3</td>
</tr>
<tr>
<td>MT</td>
<td>2.7</td>
</tr>
<tr>
<td>STG</td>
<td>3</td>
</tr>
<tr>
<td>CM</td>
<td>3.6</td>
</tr>
<tr>
<td>RT</td>
<td>4.5</td>
</tr>
<tr>
<td>OT</td>
<td>5</td>
</tr>
</tbody>
</table>

OTO= One to one therapy  MT= Music Therapy  STG= Small talking group  CM= Community meeting RT= Recreation Therapy  OT= Occupational Therapy
DISCUSSION

These data may not be considered reliable or valid, because of the small number of subjects (Rosencheck, et al. 1997), which was due to time limitations and low census on the units. Once all of the approvals were granted for the research, there were approximately seven weeks to collect data. Patients had to have participated in four music therapy groups to qualify, therefore, not all patients who were admitted could qualify. Some patients could not be approached, due to diminished capacity to consent, as a result of medication changes or relapses. At the time of this study, the research unit was downsized from 15 to 10 beds, with the remaining five beds used for clinical patients, who would not qualify for the study. Research beds were also used to board overflow patients from the clinical unit, as a result of low research census.

If this study were replicated, some of the questions would need to be reworded or explained more clearly. An instruction to choose one intervention that was most enjoyable and one intervention that was least enjoyable would help define which activities are useful with psychiatric patients. Some research subjects checked one intervention for each question, while others checked multiple interventions. Some patients did not check anything for least enjoyed. The questions could also be reframed as rank order questions.

Inpatients attended a music listening group once a week, which could account for the high number citing this as the most enjoyable activity. It is possible that the patients were thinking of that group when they answered the question, which was not the intent of the question, since music listening is also used sometimes in the process oriented group. Subjects would need to know specifically which group they are evaluating. This would not be a problem with the outpatients since they only had music therapy once a week.

Examples could also be listed next to the groups that the patients were asked to rank. It is possible that some patients are not aware which groups use which type of therapy, because a group may be called "games group" and not "recreation therapy." Patients attended craft shop, and may not consider it recreation therapy or occupational therapy. In future research, these relationships could be specified.

It was not too surprising to see the areas where music therapy was helpful. These choices were included on the survey as a result of comments patients have made during discussion after an activity. Relaxation is reported very often, as well as stress reduction. Although decrease/distraction from medication side effects was ranked low, it is possible that data collection using a different design with observable measures could show higher numbers.

In general the subjects enjoy music therapy and rated it very highly. It is conceivable that the questions are biased towards music therapy, since the survey tool was developed by music therapists. Making surveys anonymous and allowing the subjects to seal them in an envelope hopefully resulted in true opinions. It is possible that the participants did not feel the survey was truly anonymous, since demographic data needed to be collected and the therapist who administered the survey knew which patients took the survey.
CONCLUSION

Data collected from a survey, such as this, could be important in proving to other disciplines the importance of psychiatric music therapy. Music therapy reportedly helped in a lot of areas that are often included in treatment goals of other disciplines. The patients also ranked music therapy as one of the most helpful groups that they attended. Patient report can provide quantitative data to be used in continuing to establish the validity of psychiatric music therapy as a treatment option for hospitals and psychiatric facilities.

This study does not yet have enough subjects to identify where changes are needed in psychiatric music therapy, but it is a good place to start in developing a tool for future use. Using this study as a pilot showed psychiatric patients were able to comprehend survey questions, and each patient could provide consistent, reliable responses. This study will need to be continued over a longer period of time to have a good source of reliable data for use in the future.
APPENDIX A

EVALUATION TOOL

Psychiatric Patient Evaluation of Music Therapy

1. How long have you been involved in your current course of treatment?
   - One month
   - Two months
   - Three months
   - Other______________________________

2. Was this your first experience with music therapy?
   - No
   - Yes

3. I enjoyed music therapy.
   - Strongly agree
   - Agree
   - No opinion
   - Disagree
   - Strongly disagree

4. Music therapy helped me progress in my treatment goals.
   - Strongly agree
   - Agree
   - No opinion
   - Disagree
   - Strongly disagree

5. I had a therapeutic relationship with the music therapists.
   - Strongly agree
   - Agree
   - No opinion
   - Disagree
   - Strongly disagree

6. The music therapists did not treat me with respect.
   - Strongly agree
   - Agree
   - No opinion
   - Disagree
   - Strongly disagree
7. Music therapy had a positive effect on my total treatment.
   - Strongly agree
   - Agree
   - No opinion
   - Disagree
   - Strongly disagree

8. The music therapists treated me with concern.
   - Strongly agree
   - Agree
   - No opinion
   - Disagree
   - Strongly disagree

9. Discussion during and after the Music Therapy activity was helpful.
   - Strongly agree
   - Agree
   - No opinion
   - Disagree
   - Strongly disagree

10. I would not want music therapy as part of any psychiatric treatment I may receive in the future.
    - Strongly agree
    - Agree
    - No opinion
    - Disagree
    - Strongly disagree

11. In which areas do you feel music therapy was helpful?
    (Check all that apply)
    - Increase concentration
    - Increase focus
    - Increase in relaxation
    - Positive stress management
    - Decrease in depression
    - Decrease in mania
    - Decrease in boredom
    - Distract from voices
    - Distract from visual hallucinations
    - Distract from or decrease medication side effects
    - Decrease tremors
    - Improve social skills
    - Improve self esteem
    - Other ______________________________________
    - Music therapy was not helpful in any areas
12. Which part of music therapy did you enjoy the most?
   - Singing
   - Playing instruments
   - Music listening
   - Music games
   - Movement to music
   - Discussion
   - Song writing
   - Other___________________

13. Which part of music therapy did you enjoy the least?
   - Singing
   - Playing instruments
   - Music listening
   - Music games
   - Movement to music
   - Discussion
   - Songwriting
   - Other_____________________________

14. Rank order these therapies according to greatest treatment benefits for you personally. Put a 1 by the one you consider most helpful, a 2 by the one you consider next most helpful, etc. Put “NA” next to any groups you did not participate in.

   ____ Community Meeting
   ____ One to one with primary therapist
   ____ Music Therapy
   ____ Occupational Therapy
   ____ Recreation Therapy
   ____ Small talking group

Additional comments:
APPENDIX B

FLORIDA STATE HUMAN SUBJECTS RESEARCH APPROVAL

Florida State University
Office of the Vice President for Research
Tallahassee, Florida 32306-2763 (850)644-5260 • FAX (850) 644-4392

APPROVAL MEMORANDUM

from the Human Subjects Committee

Date: September 4, 2003

From: David Quadagno, Chair

To: Kira Travis
911 Garden Lane
Homewood, IL 60430

Dept: Music
Re: Use of Human subjects in Research
Project entitled: Psychiatric Inpatient and Outpatient Evaluation of Music Therapy and Related Treatments

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on August 13, 2003. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by August 12, 2004, you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.
APPENDIX C

FLORIDA STATE UNIVERSITY INFORMED CONSENT

Florida State University
Consent for Participation in Research
Psychiatric Inpatient and Outpatient Evaluation of Music Therapy and Related Treatments

Why am I being asked?
You are being asked to be a subject in a research study about patient satisfaction with music therapy conducted by Ellen Rayfield of the Department of Psychiatry at the University of Illinois at Chicago and Kira Travis of Florida State University. You have been asked to participate in the research because you are receiving psychiatric treatment, and you have attended at least four music therapy groups and may be eligible to participate. We ask that you read this form and ask any questions you may have before agreeing to be in the research.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future treatment or relations with the University of Illinois or Florida State University. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

Why is this research being done?
The findings of the research are expected to help music therapists provide the best treatment and better understand how persons with mental illnesses perceive music therapy treatments.

What is the purpose of this research?
The purpose of this research is to evaluate psychiatric patients' opinions of their experience with music therapy.

What procedures are involved?
If you agree to be in this research, we would ask you to do the following things:

- Give basic information such as gender, race, age, and the diagnosis you were given by your treatment team
- You will fill out a two page survey.
  - The survey has multiple choice questions, and rating questions.
  - There is also an optional section at the end for any of your personal comments about music therapy
- This will be a one time survey.
  - The total amount of time for the survey should be no more than 15 minutes.
  - The survey will be filled out in the room where music therapy takes place, or in a private office.

Approximately 40 subjects may be involved in this research at the University of Illinois at Chicago and with Florida State University.

What are the potential risks and discomforts?
The research has minimal risk. There is a possibility that some people may experience stress or a negative emotional reaction due to the questions asked in the survey. If this occurs during your participation, you will be able to discuss your concerns with the investigator giving the survey.

Are there benefits to taking part in the research?
There is no direct benefit to taking part in this research. Subjects participating in this research will be contributing to the greater knowledge of the professional realm of music therapy, and enabling the profession to provide more effective treatment in the future.

What about privacy and confidentiality?
The only people who will know that you are a research subject are members of the research team. No information about you, or provided by you during the research, will be disclosed to others without your written permission, except

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if necessary to protect your rights or welfare (for example, if you are injured and need emergency care or when the UIC or FSU Institutional Review Board monitors the research or consent process), or if required by law.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

All surveys will remain anonymous, and all data collected will be stored in a locked cabinet. The researchers will be the only ones with access to the data. The only information gathered from the chart will be in order to find out the number of music therapy groups attended by the subjects. All data collected will be stored for no longer than one year.

**What are the costs for participating in this research?**

There is no cost for participating in this research.

**Will I be reimbursed for any of my expenses or paid for my participation in this research?**

You will not be paid for your participation in this research.

**Can I withdraw or be removed from the study?**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don’t want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

**Who should I contact if I have questions?**

The researchers conducting this study are Ellen Rayfield and Kira Travis. You may ask any questions you have now. If you have questions later, you may contact the researchers at: (312)355-1851.

**What are my rights as a research subject?**

If you have any questions about your rights as a research subject, you may call the Office for Protection of Research Subjects at (312)996-1711 and at (850)644-8673.

**Remember:** Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current treatment or future relations with the University of Illinois or Florida State University. If you decide to participate, you are free to withdraw at any time without affecting your treatment or that relationship. You will be given a copy of this form for your information and to keep for your records.

**Signature of Subject**

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I have been given a copy of this form.

Signature_________________________________ Date _____________________________

Printed Name____________________________
APPENDIX D

UNIVERSITY OF ILLINOIS HUMAN SUBJECTS RESEARCH APPROVAL

UNIVERSITY OF ILLINOIS
AT CHICAGO

Approval Notice
Amendment to Research Protocol and/or Consent Document - Expedited Review
UIC Amendment #1

September 18, 2003

Ellen Rayfield, Music Ed, MT-BC
Psychiatry
1601 w Taylor Street
M/C 912
Chicago, IL 60612
Phone: (312)355-1851

RE: Protocol # 2003-0263
"Psychiatric Inpatient and Outpatient Evaluation of Music Therapy and Related Treatments"

Dear Dr. Rayfield:

Members of Institutional Review Board (IRB) #3 reviewed the amendment to your research and/or consent form on September 16, 2003 under expedited procedures for minor changes to previously approved research allowed by Federal regulations [45 CFR 46.110(b)(2)]. The amendment to your research was determined to be acceptable and may now be implemented.

Please note the following information about your approved amendment:

- Amendment Approval period: September 16, 2003 - June 1, 2004
- Amendment: UIC Amendment #1 dated July 21, 2003 consists of the addition of Florida State University as a cooperating institution and changes in the research tool.
- Performance Sites: UIC, Florida State University

Please note the Review History of this submission:

<table>
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<tr>
<th>Receipt Date</th>
<th>Submission Type</th>
<th>Review Process</th>
<th>Review Date</th>
<th>Review Action</th>
</tr>
</thead>
</table>


Please be sure to:

→ Use only the IRB-approved and stamped consent document(s) enclosed with this letter when enrolling new subjects.

→ Use your research protocol number (2003-0263) on any documents or correspondence with the IRB concerning your research protocol.

→ Review and comply with all requirements of the,
"UIC Investigator Responsibilities, Protection of Human Research Subjects"

Please note that the UIC IRB has the right to ask further questions, seek additional information, or monitor the conduct of your research and the consent process.

We wish you the best as you conduct your research. If you have any questions or need further assistance, please contact me at (312) 355-1609 or the OPRR office at (312) 996-1714. Please send any correspondence about this protocol to OPRR at 263 AOB, M/C 672.

Sincerely,

Suzanne French, OPRR
IRB Coordinator, IRB #8
Office for the Protection of Research Subjects

Enclosure(s):  (1) UIC Investigator Responsibilities, Protection of Human Research Subjects
(2) Consent Documents - UIC Consent, "Patient Satisfaction Music Therapy,”
Version 3, July 21, 2003

cc: Joseph Fishery, M.D., Head, Dept. of Psychiatry, M/C 912
Why am I being asked?

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  The survey has multiple choice questions, and rating questions.
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**What about privacy and confidentiality?**

The only people who will know that you are a research subject are members of the research team. No information about you, or provided by you during the research, will be disclosed to others without your written permission, except:

- if necessary to protect your rights or welfare (for example, if you are injured and need emergency care or when the UIC Institutional Review Board monitors the research or consent process), or
- if required by law.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

All surveys will remain anonymous, and all data collected will be stored in a locked cabinet. The researchers will be the only ones with access to the data. The only information gathered from the chart will be in order to find out the number of music therapy groups attended by the subjects.

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Can I withdraw or be removed from the study?

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don’t want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

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Signature of Subject

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I have been given a copy of this form.

Signature ___________________________ Date __________

Printed Name _______________________________

Signature of Researcher ______________________ Date (must be same as subject’s)
REFERENCES


Kira Travis was born in Highland Park, Illinois on July 18, 1975. Her early education took place in Illinois, Puerto Rico, and Florida. Kira graduated from Lyman High School in Longwood, Florida in June 1993. She graduated summa cum laude with a Bachelor of Music Arts degree from Oral Roberts University in May 1997. Kira began working on a Master’s degree in Music Therapy in August 2001 at Florida State University. As part of the fulfillment of the degree, Kira completed a music therapy clinical internship at the University of Illinois at Chicago Psychiatric Institute in July 2003. A Master of Music degree was awarded to Kira in December 2003.