The Effect of Music Therapy and Psychoeducation versus Psychoeducation for Mainstreaming Mental Health Patients into Society

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School Of Music

The Effect of Music Therapy and Psychoeducation Versus Psychoeducation for Mainstreaming Mental Health Patients into Society

By

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The Office of Graduate Studies has verified and approved the above named committee members.
This thesis is dedicated to my parents and family that have attributed to my success and those of the past James W. Pierce II and Midge Hickman.

Also to my rottweilers Gracie and Mark.

Special Thanks is extended to Dr. Standley
and the spectacular Florida State University Faculty
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This study examined the effects of music therapy with a psychoeducation curriculum with 40 heterogeneously diagnosed adult psychiatric patients. This study used two pre/posttests, Life Skills Attitude Questionnaire (LSA) and Community Living Competencies evaluation (CLC) and subjects’ perceptions of sessions as indicated by the Session Evaluation and Response Sheet (SERS). Scores on the LSA and CLC were found to be significant between groups using a Mann-Whitney U statistic test. Future research implications are discussed.
INTRODUCTION

According to the American Music Therapy Sourcebook, 21% of the populations served by music therapists are in mental health settings. The benefit of providing music therapy in aiding treatment of psychiatric populations has been on the rise in recent years. Also in recent years a paradigmatic shift in treatment facilities has been transpiring. The once highly occupied cost effective state institutions or hospitals are declining. The reasons for the decline can be attributed to a cornucopia of reasons stemming from rising cost for effective and efficient health care, expensive costs associated with accreditation and certifications standards and political intervention (Bellus, et al 2003). These state hospitals, sometimes given the name asylums, are being replaced because the facilities were having difficulty meeting the demands of a rising populations. These facilities were experiencing difficulties with providing enough staff for long-term populations. The stigma attached to long-term state hospitals also contributed to the decline due to political influence of state funding. The shift for treating and rehabilitating mental health patients has been passed to the hands of community-based health care facilities (Bachrach, 1992; Serling & Johnson 1990; Smith, Hull, MacKain & Wallace 1996). These facilities are sometimes able to obtain additional funding from previously closed off sources and provide more community-based programs targeted to reintroducing mental health patients into society.

Mental health patients’ rehabilitation requires an array of mental health services independent from each other and sometimes forming symbiotic relationships. Once mental illness individuals seek assistance one of the first steps is to see a professional for assessment of medication and therapy (Baker, 2000). At this point the professional will make many beneficial decisions regarding adjustment issues changing medications. The reentry to the community for the patient is as equally important as any other step in the path to recovery and just as difficult. Reentry can be a litmus test that is the final step to being a functional part of society. The patient has to be able to reenter society and establish him or herself as much as functionally possible (Bellus et al., 2003). Mental health patients must be able to be rehabilitated physically, emotionally and socially while in the care of health professionals. The author suggests that mental health patients can strive to obtain vast improvements while under the care of professionals but sometimes cannot make the transition back into the community. Blair and
Ramones (1997) stated, “Arguably education can be seen as a useful intervention” and discussed the benefits because “clients ability to monitor their illness, decreases stress and symptomology”

There are many articles citing the benefits of music therapy and implementation of music with treating the adult mental health population. Adult and adolescent psychiatric patients have benefited from music therapy interventions (Bednarz & Nikkel, 1992; Bohnert, 1999; Brooks, 1989; de l’Etoile, 2002; Tang, Yao & Zheng, 1994). Recently a meta-analysis by Silverman (2003) revealed that of the 19 research studies conducted all “proved to be significantly effective for suppressing and combating symptoms of psychosis”. Another study by de l’Etoile (2002) investigated if music therapy could change psychiatric symptomatology, if subjects would report a change in the presence of curative factors and if there was difference in their attitudes towards mental health professionals in the field. The study included eight subjects who attended a day treatment program who received 1 hour of music therapy per week for 6 weeks. Using three different self-report measurement tools the study showed a decrease in symptoms of anxiety, including obsessive-compulsive, interpersonal sensitivity and phobic anxiety. Music therapy was able to increase 8 of the 10 curative factors with the largest increase begin cohesion. The attitudes of subjects did not change due to music therapy sessions.

Many studies in the medical research community have been conducted using some form of music therapy in psychiatry and psychotherapy. A study by Courtright, Johnson, Baumgartner, Jordan & Webster (1990) using an ABAB group of adult male psychiatric patients under music and no music conditions, and found that music decreased incidents of disruptive behavior with an inverse effect during the no music condition. An observational study by Meschede, Bender & Pfeiffer (1983), with adult male and female psychiatric patients reported increased motivation, elevated mood and positive feelings of responsibility after engaging in active music making. Schmuttermayer (1983) conducted a study with 10 adult schizophrenic females to investigate 4 types of music therapy (listening, singing, dancing and ensemble playing). This study used a behavioral observation with a scored questionnaire to find that music intervention increased patients’ communication and music functioned as an anxiolytic towards symptoms of anxiety. Pfeidffer, Wunderlich, Bender, Elz & Horn (1987) found that the use of instrumental music improved communication and enhanced activity level. Reinhandt & Ficker (1983) conducted an observational study with clinically diagnosed-depressed adults who after receiving receptive music increased emotion expression and understanding. In comparison of 15
schizophrenics, 15 depressives and 15 clinically normal controls music improvisation of therapist to group revealed significant differences in each of the groups capacity for musical contact Pavlicevic & Trevarthen (1989). This same study found that schizophrenics were unable to establish a musical contact with the therapist spending 12% of the session in a no contact state. The depressed group however did reflect that these individuals do have the capacity to for organized musical functioning spending less than 2% in a no contact state. A study conducted in China by Tang, Yao & Zheng (1994) with 76 in-patients diagnosed with residual subtype of schizophrenia were randomly assigned to either the control group or the music therapy treatment group. The treatment group had subjects listen to music individually with headphones or collectively as a group four out of five days a week for 1 month. One day a week the treatment group would be engaged in sing along, individually or as groups and the subjects had the ability to use a variety of rhythm instruments. Beginning of each session subjects would discuss with music therapist what they wanted to listen to and preferred activity for the day. After the 19 music therapy sessions using four coders who were blind to the study scored behaviors using the Scale for the Assessment of Negative Symptoms and the unpublished translation of the in-patients version of the Disability Assessment Scale. The SANS score and subscores showed significant results for all subjects receiving music therapy and no change was found in the control group. In comparison of the groups the DAS results found that the treatment group had significantly increased in conversation ability, decrease level of social withdrawal and increased interest in external events. The usefulness of music therapy with this population is on the rise and with an ever increasing research base music therapy is emerging as a valid successful treatment.

Heaney (1992), found between music, art and recreational therapies, music was rated highest on the pleasurable and pain scale among patients. This same study found patients also did not view the music, art or recreational therapies as significantly less important than any other aspect of care. The author considers patients’ attendance and participation not enough for improvement; these individuals need to also believe in the treatment method of the group. When the patient believes in the treatment he/she is mentally able to make the commitment to change their behavior. Bene-Kociemba, Cotton and Fortgang (1982), conducted open-ended interviews with 22 former state hospital patients. Of these former patients, 68% preferred help with either concrete tasks or some psychotherapeutic aspect of treatment. Bene-Kociemba, Cotton and
Fortgang (1982) also found that the satisfaction of the psychotherapeutic relationship was not based on the amount of time spent with the patients but in fact that they “felt understood by the aftercare worker”.

Group psychotherapy was found to be a time and cost effective treatment that yielded many benefits for clients (Leszcz, Yalom & Norden, 1985). Bryant (1987) states that using his cognitive model that offers an adaptive, behavioral framework to assist in dealing with present and future disturbances, a music therapist could aid the client with defining, discriminating, debating and refuting self-defeating irrational beliefs. Patients view group music therapy as more pleasurable than individual sessions due to the socialization and interaction of other patients (Heaney, 1992). If patients view the group music therapy as pleasurable attendance should positively correlate. Heaney (1992), according to the pleasurable and painful scale patients found that music therapy and other activity therapies received such high ratings due to the “increased socialization and group cohesion, provision of safe, expressive outlets for emotions, and the learning of new skills or the rekindling of previous interests which foster positive self-esteem”. Music therapy is able to succeed in reaching even the less cooperative mental health patient.

Covington (2001), found that “Many patients with psychiatric disorders struggle with poor skills in coping and problem solving, communication, socialization, and self-expression”. These deficiencies can predispose this population to experiencing higher stress and anxiety levels causing maladaptive behaviors, inappropriate emotional outburst/expressions, and cognitive misperceptions, ultimately experiencing a relapse. Change in stress levels can be one of the common triggers of relapse for this population (McCann McKeown & Porter 1996; O’Conner, 1994). These relapses usually occur as the patient is attempting to reenter the community and therefore preventive measures are recommended to counteract such an outcome.

The effectiveness of psychoeducation with mental health patients has been well established in the literature. The effectiveness of providing psychoeducation for patients and/or families to assist in reentry to the community or rehabilitation has been found to be successful (Collins, Mowbray & Bybee 1999; Crist, 1986; Eaton, 2002; Klingberg, Wiedemann & Buchkremer 2001; Maio et al. 2000; Miller, Eisner & Apport 1994; O’Conner 1994). Reddon, Pope, Dorais and Pullan (1996), found that psychiatric patients after a 16-week life skills education program had significant improvements in depression symptomology, social
symptomology and patients rated having overall satisfaction with the program. In an extended program that provides extended institutional care Lehman, et al. 1986-87 states the usefulness of educating through his life skills program, which is a comprehensive rehabilitation program that helps patients “development of skills necessary for effectively negotiating the demands of everyday living.” The educating support system of schizophrenic families was found to be effective in helping the member adjust to into society (Zhang, Yan, Yao & Ye, 1993). Prema and Kodandaram (1998), and McCann, KeKeown and Porter (1996), found that psychoeducation of families of chronic mentally ill patients and including them in the rehabilitative process decreased stress levels of the family members and patient. Asher-Svanum, Lafuze, Barrickman, Van Dusen and Fompaloy (1997), found that surveyed relatives stated that beside the relatives being included in the rehabilitative process, they felt that mentally ill patients themselves should understand their own illness and need to be taught better coping skill with their illness.

Despite the success of psychoeducation, patients are still unable to grasp concepts about their condition. Gibbons, Hogan and McGauran (1999), found with 22 schizophrenic subjects only 25% of the subjects could correctly explain their diagnosis. In terms of pharmacotherapy, 58% could name all their current medications and 25% could name just one medication. This same study was conducted with 23 patients with bipolar disorder and found that 56% reported having insufficient information about their illness. Gibbons, Hogan and McGauran (1999), concluded that “despite the prolonged length of time for which the patients in this study had been attending the psychiatric services, they were shown to have a limited knowledge of their own diagnosis and drug treatment regimen, this being especially marked in patients with schizophrenia”.

Psychoeducation with mental health patients has been found successful in the hospital or facility but research suggests that the longevity of this newly acquired knowledge out of the health care facilities is short lived. A study by Markar and Mander (1989) found that in a two-year follow up, as many as 90% of bipolar patients were rehospitalized and there was no significant difference between the treated and untreated patients. Dewees, Pulice and McCormick (1996) tracked 46-discharged mental health patients four years later, fifty percent had to be rehospitalized. Of these, 23% had to be rehospitalized up to a year in duration and the other 17% stayed a year or more. It appears that patients are able to improve enough to become discharged but are unable to adapt back into society.
The use of psychoeducation has been included in an array of other rehabilitation strategies such as the psychosocial model (Bachrach, 1992), (Baker, 2000). The psychosocial model provides a variety of rehabilitation services such as medication, cognitive-behavioral therapy, coping strategy enhancement and education. The use of psychoeducation is found in the cognitive-behavioral model as found in Blair and Romones (1997) and Romana. Ford-Martin (2002) stated, “Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy.” Psychoeducation adapts well into many rehabilitative services and intervention models. Psychoeducation material focuses on specifically targeted objectives enhancing the effect of structured music therapy sessions. Blair and Ramones (1997) stated that the use of psychoeducation should follow a cognitive-behavioral model.

The purpose of this study was to show the effectiveness of psychoeducation material delivered to adult psychiatric patients through music therapy sessions. The hypothesis is that the music therapy experimental group will yield significantly higher scores on the pre/posttest measurements than the control group. The information and material covered are topics found in many psychoeducation objectives and goals. The objective of this study was to reflect the enhanced understanding of patients’ medication and mental health condition, to increase basic living skills, to increase communication, to increase ways to cope with illnesses, to increase individual involvement and to help clients take responsibility for their lives. Sessions in this study followed the familiar cognitive-behavioral model. Sessions were structured to help mainstream mental health patients by changing the cognitive internal/external thoughts as well as the belief structure and their self-image all-necessary to then effect behavior. This change was achieved by teaching through a music therapy format of psychoeducation to patients for the purpose of learning/relearning new cognitive strategies, understanding and deal with their specific mental illnesses and assist in living in the community as independently as possible within their means. The behavioral change that takes place should initiate an increase in self-esteem and patients would intrinsically be motivated to stay in the community. This study unearthed a new combination of psychoeducation and music therapy.

For many patients receiving inpatient services, the long awaited goal is to achieve discharge status. Considerable amount of research exists to universally define the behaviors or type of incidences that delay such a status. Some examples of typical behavior that prevents discharge of an individual are being danger to themselves or others in their environment, having
a tendency to set fires, publically abusing legal and illegal substances, emitting a higher rate of violence and being noncompliant with staff (Dewees, Pulice & McCormick 1996; Lehman et. al 1986-87; Seling & Johnson 1990; Gannon, Meagher & Watters 1997). This study assisted the served mental health population with the necessary resources to obtain discharge status by targeting many of these behaviors in the psychoeducation sessions. Some sessions were structured to assist patients with anger management and improved decision-making. Communication skills and emotional expressions issues were addressed to aid in controlling outbursts and displaying appropriate nonverbal and verbal behaviors.

The session topics were chosen to touch on every aspect of living in the community. The most basic skills were addressed such as transportation, communication, basic living skills and appropriate emotion expression. Sessions were structured to assist even more advanced patients by addressing more complex issues concerning specifics about medications and mental health issues. The purpose of covering such a vast range of information during this short intervention was to encompass every aspect of community integration.

The experimenter designed the dependent variables: Session Evaluation and Response Sheet, Community Living Competencies (CLC) and Living Skills Attitude (LSA). The LSA includes general questions that the patients can answer based upon general situations or scenarios. The questions on the CLC are more specific than the LSA with questions based on scenarios to be judged. LSA was based on the Educational Needs Questionnaire (ENQ) a 45-item self-rated instrument found in Gibbons, Hogan & McGauran (1999). The ENQ used a 5-point Likert scale to determine what information a person suffering from a mental illness or a relative would like to know more about. The ENQ was successful in pinpointing gaps of knowledge of mental health patients. The ENQ needed to be modified because the purpose of this study was create a behavioral checklist of skills required to be a functional part of society.
METHOD

Facilities

Subjects were drawn from two different mental health facilities in the local area. Site I was a day treatment facility that provided morning and afternoon groups for clients. Site I groups included arts and crafts, life skills, current events, basic living skills and music therapy. Local certified teachers in the county taught these groups. These groups were mandatory for clients; however, they were free to choose which group to attend. During this study, site I had a preexisting token economy in place with all their clients. Clients could earn tickets for attending groups. These tickets could in return be exchanged for a variety of snacks, drinks or other privileges. Clients were responsible for their own tickets and exchanged them at their leisure. To ensure attendance during the study both the control and experimental groups received an extra five points to each of their tickets per day. To minimize confounding variables, individuals who currently attended music therapy groups or had a history of attending were divided up equally between the two groups. A board certified music therapist conducted music therapy sessions in the early afternoon. The experimenter conducted the study during the clients’ normal group time in the morning.

Site II of this study was conducted at the Behavioral Health Center building of a local area hospital. This 60-bed facility accommodates adults and adolescents but for the purpose of this study only the adults were included. Site II is a residential facility that utilizes a Multi-Disciplinary Treatment Program, which includes: psychiatrist, psychiatric nurse, social worker, psychologist, mental health associate, music therapist, recreational therapist and teacher. Daily patients receive an array of therapeutic services including one of the following; psychotherapy group, community group and an expressive therapy group (recreational or music therapies) conducted by board-certified therapists. The psychotherapy group gives information about their condition and ways to deal with their current living arrangement and the community group assists the patients in daily short-term and long-term goals. The length of stay for every patient on the units varies in length due to diagnosis and other health reasons; therefore, history of exposure to music therapy was not adjusted for this study. At site II, Unit I was the control group and Unit III was the experimental group. The research group was conducted at the normal time for Unit I, but a special time was arranged for Unit III.

Subjects
This study included 40 subjects, twenty-seven subjects from Site I and thirteen subjects from Site II. All subjects had been diagnosed by a health care professional and/or referred by primary care physicians, counselors and other health professionals, as well as by self-referrals. Both sites had preestablished groups so the experimenter randomly assigned each of the preexisting groups to a condition by the flip of a coin. Subjects from each site were placed in both groups. The experimental group received psychoeducation with music therapy and the control group received psychoeducation only. To be considered in this study each subject had to attend a minimum of three out of the five sessions. These sessions could be attended sequentially or intermittently; meaning once the subject attended three sessions they met the standard to be included in this study.

Both experimental and control groups consisted of twenty subjects. The control group consisted of 55% male and 45% female with an age range of 18-81 yrs and a mean age of 46 yrs. Eighty-five percent of the subjects were African-American and 15% Caucasian. The experimental group consisted of 30% male and 70% female with an age range of 18-87 yrs with an average of 47 yrs. Fifty percent of both groups had a marital status of single. Each Global Assessment of Functioning Scale (GAF) of the Diagnostic and Statistical Manual-IV-TR (2000) was recorded for each patient. The range of GAF for the control group was 25-65 and 20-50 for the experimental group. Control and experimental groups had contrasting Axis I diagnoses. For group demographics and heterogeneous composition of diagnoses refer to Tables 1 and 2.
Table 1: Demographics of Control Group

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Design

The design of this study was experimental and control groups with pre/posttest. The dependent variables were the experimenter designed Session Evaluation and Response Sheet (SERS) (Appendix A), Community Living Competencies evaluation (Appendix B), Experimenter designed Life Skills Attitude Questionnaire (LSA) (Appendix C). The SERS used a 5-point Likert scale, 1 meaning strongly disagree and 5 meaning strongly agree for posttest evaluation of a session. The LSA and CLC, with 14 and 44 questions, respectively, that required dichotomous answers.

Data Procedure

At Site I the subjects were recruited two weekdays prior to the study. During the course of the day the experimenter individually interviewed each subject. The experimenter explained the consent form and allowed time for questions. When the subject signed and dated the consent form, then the experimenter prepared the subject to answer study’s yes or no questions. The experimenter prepared subjects by explaining that there were no wrong or right answers and that answers were based on individual opinion. Every subject signed consent form first then answered the questions from the LSA followed by the CLC. Questions were read as they appear on all measurement instruments. The experimenter began interview with the LSA followed by the CLC. Interviews lasted approximately 10-5 minutes and, upon conclusion, the experimenter would thank the subject and remind him/her of the following week first session time and day. Site II followed the identical protocol, except due to the high turn-over rate, the experimenter conducted interviews in the morning of the first session day. Interviews continued for the first three days of the study.

Session Procedure

Detailed session plans are provided in Appendix 1-5 for the control group and 6-10 for the experimental group. Each experimental session began with live music performed by the experimenter playing the guitar and singing client preferred music. The experimenter encouraged a sing along and asked for requests. The purpose of providing introductory music was to familiarize and orient the group to live music, assist in socialization of subjects, establish
rapport, and assist adjustment to a new therapist. In contrast, the control group began with a daily greeting.

Control and experimental group sessions incorporated identical material with the difference being the format of delivery. For example, the control group sessions were requested to participate via worksheets and pencil tasks followed by group discussions. Except for the asterisked sheets/handout, which are noted in session appendixes 1-10, the experimenter generated all other materials. The experimental group sessions would discuss the information found on the worksheets and paper and pencil tasks would be replaced by a variety of common music therapy techniques specified in appendices 1-10. Both the control and experimental groups sessions were 50-60 minutes in length. The last ten minutes was reserved for each subject to fill out the daily Session Evaluation and Response Sheet. The experimenter would instruct the subjects to fill out the sheets and not to put their names on them. Each of the five days experimenter explained that these sheets were their own opinions and anonymous. When the task was completed subjects put sheets in an envelope placed in the room. The contents of the envelope were sealed and not read while on the facility premises. This activity concluded all 5-day sessions.
RESULTS

Table 3: Mean Scores on Measurement Tools

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Table 3 shows the means scores from each of the measurement tools. The control and experimental groups were found to have higher scores from both pretests. The Mann-Whitney U was used to statically analyze difference between groups on the LSA. A one-tailed test with $\alpha = .05$ showed no significant difference in the pretest. The obtained $U = 254$ for the control group and $U = 145$ for the experimental group with the critical $U$ value of 138. There was a significant difference between groups on the posttest with the obtained $U = 366$ for the control group and $U = 34$ for the experimental group with the critical $U$ value of 138.

The Mann-Whitney U was used to statically analyze difference between groups on the CLC. A two-tailed test with $\alpha = .05$ showed no significant difference in the pretest. The obtained $U = 262$ for the control group and $U = 138$ for the experimental group with the critical $U$ value of 127. There was a significant difference between groups on the posttest with the obtained $U = 392$ for the control group and $U = 9$ for the experimental group with the critical $U$ value of 127.
Graph 1: Mean Results of Group Self-Report Perceptions of Sessions

Graph 1 illustrates the mean pre/post session difference in scores on the Self-Evaluation and Response Sheets as indicated by subjects across all five sessions. The lowest scores were found to be Day 1 for both the control group (63%) and experimental group (89%). The highest scores for both groups were on Day 5 with the control group at 88% and the experimental group at 96%. Both groups increased from Day 1 though to Day 5. The largest difference in scores was found Day 3 with the control group at 69% and the experimental group at 92%. The experimental group initially started higher (89%) and increased slightly across time. The control group consistently increased across time, almost matching the experimental group on the last day.
Providing therapeutic music therapy services with psychoeducation curriculum is found desirable by the mental health patients and a vital tool in defense of rehospitalization. Since both groups benefited from the study one can conclude that the usefulness of psychoeducation has been proven to be valid material that should be included in many, if not all-rehabilitative services. Psychoeducation material combined with music therapy prepares this population with the appropriate resources necessary for reentering and remaining in the community. Music therapy has an appeal in addressing the psychoeducation material due to the significant difference between the groups. Although it is unclear to the severity of those effects of music according to graph I due to the large difference between the two groups at the beginning of the study, it is apparent that the psychoeducation curriculum was perceived as beneficial by all clients as indicated from the SERS. The control subjects’ poor perceptions of the sessions could have been a result of the significantly lower scores on the pre/post test. Day five there is a spike in the data for the control group in graph I. This is attributed to the subjects’ value for the topics that day. For site II, the topics could have been found to be especially important as many were waiting to be discharged. At site I, this topic could have been useful to help ensure success after the day treatment program. It is assumed that subjects in the experimental group rated their sessions much higher than did the control group as a direct result of the music because the material between all sessions was identical. The effect of subjects’ higher ranking of music therapy sessions could be attributed to the diverse use and effectiveness of music therapy techniques at achieving common rehabilitative goals.

The LSA and CLC found significant differences between groups due to the addition of music therapy. Although identical material was discussed between groups, the experimental group yielded significantly higher scores on the posttest than the control group. The Psychoeducation curriculum was learned more in the experimental group as indicated by scores between pre and posttests. Both measurements were successful in reporting the patients’ increase of knowledge on understanding of medication and mental health condition, increased basic living skills, increased communication, increased ways to cope with illnesses, and increased individual involvement.
There could have been unexpected confounding variables that influenced the results of this study. The subjects’ willingness to please the experimenter could have altered the results. Subjects’ in either group could have reported higher acceptance in the SERS or given inflated answers to the posttests in hopes of pleasing the experimenter despite the efforts to minimize such effects. This could be the reason for both groups benefitting. Future research is needed to future explore this conclusion.

Future research with psychiatric mental health patients needs to be investigated to help establish the effectiveness of music therapy and psychoeducation. Research with music therapy and psychoeducation need to include longer intervention period as mentioned by the research by de l’Etoile (2002). The increased treatment period could yield a wealth of knowledge regarding effective teaching strategies specifically implemented during music therapy sessions. Blair and Ramones (1997), state that adult mental illness education is learner focused utilizing the relationship between the teacher and learner. Future research should be done to further explore the relationship between a music therapist and a mentally ill learner. Being able to track subjects as they reenter the community after psychoeducation and music therapy intervention is also needed. This study will hopefully be a springboard for future research into a very expanding and successful treatment method. This study further reflects the great effectiveness of music therapy with adult psychiatric populations.
APPENDIX A

SESSION PLANS
Session Plan #1 Control

Topic: Daily Activities Session

Procedure

Experimenter will give patients the Eating & Sleeping Well handout. Experimenter will allow 10-15 minutes for each individual to fill out sheets. Then experimenter will engage patients in a group discussion about handouts. List of good habits will be brainstormed and then the Tips for Health handout will be given. Food Pyramid will be given out and explained. Experimenter will give out the Transportation handout. Subjects will engage in a group discussion and then allow 5 minutes to fill out the handout. After the group has discussed the answers experimenter will ask for questions to conclude session.

Summary
Eating & Sleeping handout followed by group discussion
Tips for Health and *Food Pyramid handouts followed by group discussion
Transportation handout followed by group discussion

Materials
Copies of the following: Eating & Sleeping Well Handouts, Tips on Health Handouts, Food Guide Pyramid, Transportation Handouts and Pencils

* denotes citation in reference section
Session Plan #1 Experimental

Introduction  Experimenter will play 2-3 songs on guitar to start session

Topic   Daily Activities Session

Procedure

Experimenter will discuss the information from the Eating & Sleeping Well handout. Experimenter will engage subjects in a group discussion about the information. List of good habits will be brainstormed and then the Tips for Health handout will be given followed by the Food Pyramid. Both handouts will be discussed and explained. Experimenter will engage the group in a song rewriting activity using the Food Pyramid and Tips on Health handouts. Subjects will be asked to incorporate the knowledge from handouts into the song “My Girl” by the Temptations. Experimenter will lead the group together in the exercise. Subjects will sing along with the group example and experimenter will ask if any volunteers want to create and sing their own. The next task for subjects will be a listening/rhythm activity, which covers the material from the Transportation handout, which will not be distributed. Experimenter will pass out rhythm instruments and have subjects listen to a story that include those sounds. As experimenter reads, the story will cue subjects to play their instruments. This activity will be followed by a group discussion about transportation. The information will cover the material from the handout. The group discussion will conclude session.

Summary
Discuss the information from Eating & Sleeping handout but will not be handed out Tips for Health and *Food Pyramid handouts followed by group discussion Song rewrites using information from handouts, My Health Rewrite sheet distributed upon request Listening/Rhythm activity based on a story called Just a Normal Day Group discussion about transportation
Materials
Copies of the following: Eating & Sleeping Well Handouts, Tips on Health Handouts, Food Guide Pyramid, Transportation Handouts, My Health Rewrite sheets, Pencils, Rhythm Instruments and Guitar

* denotes citation in reference section
Food Guide Pyramid
A Guide to Daily Food Choices

KEY
1. Fat (naturally occurring and added)
2. Sugars (added)

These symbols show that fat and added sugars come mostly from fats, oils, and sweets, but can be part of or added to foods from the other food groups as well.

Fats, Oils, & Sweets
Use Sparingly

Milk, Yogurt,
& Cheese Group
2–3 Servings

Vegetable
Group
3–5 Servings

Meat, Poultry, Fish,
Dry Beans, Eggs,
& Nuts Group
2–3 Servings

Fruit Group
2–4 Servings

Broad, Cereal,
Rice, & Pasta
Group
6–11 Servings

SOURCE: U.S. Department of Agriculture/U.S. Department of Health and Human Services
Eating & Sleeping WELL

I eat ____ meals a day and get on average ____ hours of sleep daily.

Put a check for each item that is the cause of your lack of sleep:

<table>
<thead>
<tr>
<th>Not enough time</th>
<th>Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of alcohol</td>
<td>Lighting</td>
</tr>
<tr>
<td>Too much caffeine</td>
<td>Changing sleep times</td>
</tr>
<tr>
<td>Medication</td>
<td>Lack of exercise</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>Temperature</td>
</tr>
<tr>
<td>Temperature</td>
<td>Noise level</td>
</tr>
<tr>
<td>Eating habits</td>
<td>Other-</td>
</tr>
</tbody>
</table>

Put a check for each item that prevents you from eating healthier:

<table>
<thead>
<tr>
<th>Unable to plan meals</th>
<th>Too much stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enough time</td>
<td>Can't follow recipes</td>
</tr>
<tr>
<td>Can't go to grocery store</td>
<td>Do not know any recipes</td>
</tr>
<tr>
<td>Can't cook</td>
<td>Not enough money</td>
</tr>
<tr>
<td>Indecision about menu with others</td>
<td>Other-</td>
</tr>
</tbody>
</table>

Solutions for sleeping:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Solutions for eating:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Bill is married and has two kids. His wife Bernice says “Remember today is Thursday and I have dance class so you’ll have to pick up the kids in an hour” (female subject reads this part). Bill (read by male subject) “Sure no problem”. Bill decides that he still has 45 minutes before he has to leave. He does some household chores like take out the trash (cue) finishes the deck by hammering some nails (cue) into the deck and tidies up the house. Bill then takes the dog (cue) for his routine walk (cue) around the neighborhood. Bill sees his friend Ed. Bill waves as Ed says (read by male subject) “Beautiful day for a walk”. Bill replies smiling “Yep”. Bill says to himself ‘it’s a beautiful day for a walk..yeah everyday the dog and I go for a walk. Today is Thursday and tomorrow is Friday so just one…’ just then he realized he had to go so Bill and his dog go for a run back to the house (cue). Bill is not late but just on time. Gets in his car and hears (cues). Bill car won’t start. What does he do?

<table>
<thead>
<tr>
<th>Male subject</th>
<th>Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male subject</td>
<td>Ed</td>
</tr>
<tr>
<td>Female subject</td>
<td>Bernice</td>
</tr>
<tr>
<td>Anyone</td>
<td>Paper (trash) cue</td>
</tr>
<tr>
<td>Anyone</td>
<td>Hammer and nails</td>
</tr>
<tr>
<td>Anyone</td>
<td>Dog collar sound</td>
</tr>
<tr>
<td>Anyone</td>
<td>Drum sound for Bills foot steps</td>
</tr>
<tr>
<td>Everyone</td>
<td>Sound of the bad car</td>
</tr>
</tbody>
</table>
MY HEALTH
Based on My Girl by Temptations

*We will work this first one together:*

_____________________________  (I want to get ___ hours of sleep)

_____________________________,  (how often? every week day etc…)

_____________________________  (I want to eat ________ kinds of healthy foods)

_____________________________,  (how often _______ times a day or week)

I guess you say, what can make me feel this way?

My health, my health, my health, talking ‘bout my health

*Do this one on your own.*

_____________________________

_____________________________

_____________________________,

_____________________________

_____________________________,

_____________________________
Tips on Health

Sleeping:

Sleep at the same time every night
Try to get the adequate quantity sleep
Try to darken the room
Find a quiet place in house/apartment
Try to get quality sleep

Eating:

Make good food choices (see figure 1)
Do not over eat
Eat in a schedule, not one big meal

What are some that you know:

__________________________________________________________________________
__________________________________________________________________________

Things not to do:

Self-medicate
Use other substances alcohol etc.
Ignore symptoms
Name some places you have to go in one week:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Check how you get to these places?

- Bus
- Your car
- Friend drives you
- Family drives you
- Plane
- Boat

What would you do if one of those did not work? How would you get around?
________________________________________________________________________

In order list your choices of transportation:
1. __________________   3.   __________________
2. __________________   4.   __________________

How could you save gas?
________________________________________________________________________
Session Plan #2 Control

Topic Emotions Management

Procedure

Experimenter will give out the Emotions handout and have subjects mark their most frequently expressed emotions. Experimenter will engage group into a discussion about emotions. Experimenter will pass out the Take Off Your Cool handout. Experimenter will facilitate a group discussion by reviewing answers from handout. Experimenter will pass out and discuss the Managing Emotions handout.

Summary
*Emotions handout followed by discussion
Take Off Your Cool handout followed by discussion
Managing Emotions handout

Materials
Copies of the following: Emotions handout, Take Off Your Cool handout and Managing Emotions handout and Pencils
* denotes citation in reference section
Session Plan #2 Experimental

Introduction  Experimenter will play 2-3 songs on guitar to start session

Topic  Emotions Management

Procedure

Experimenter will have subjects play the emotion charade game using rhythm instruments. Individual subjects will have to nonverbally display a particular emotion using various musical instruments. Experimenter will give out the Emotions handout and the other subjects will have to guess what emotions are being expressed. Then subjects will engage in a song analysis to “Take of your cool” by Outkast. Subjects will listen to recorded music and engage in a group discussion about the song and emotions. Experimenter will pass out the Take Off Your Cool handout and then ask questions such as: What do you think “cool” represents in the song, What does “cool” mean to you and What does the line “Baby take off your cool” mean. Questions are to facilitate and help orientate subjects to task. Experimenter will end the session with the Managing Emotions handout.

Summary

Emotional charades with rhythm instruments, followed by discussion
Take Off Your Cool handout
Song analysis and group discussion
Managing Emotions handout

Materials

Copies of the following: Emotions handout, Take Off Your Cool handout and Managing Emotions handout, Pencil Rhythm Instruments, and Guitar

* denotes citation in reference section
Managing Emotions

“You always complain that I don’t know how to show my emotions, so I made these signs.”

Strategies

Better express yourself
Communicate clearly
Change environment
Avoid particular person(s)
Do pleasurable healthy activities
Manage stress
Understand & identify triggers (internal & external)
Manage time & money

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1. If you feel ______________, how do you deal with it?

____________________________________________________________________________________

2. How do you express yourself appropriately? ______________________________________________

________________________________________

3. What are appropriate ways to express frustration, anger, happiness, and sadness?

____________________________________________________________________________________

4. Is this important when meeting new people?    YES     or       NO

5. When talking to new people what are thinking to yourself?

____________________________________________________________________________________

6. What are some things you need to have for yourself before you can meet new people?

____________________________________________________________________________________
Take Off Your Cool
By Outkast featuring Norah Jones

Hey Yaa…Ba-doo-baaaa-ba-doo-baaaa
Baby, take off your cool
I wanna see you, I wanna see you
Baby, don’t be so cool
I wanna see you, I wanna see you

Baby take off your cool
I want to get to know you (Take off your cool)

1. If you feel ____________, how do you deal with it?
   ____________________________________________________________________________________

2. How do you express yourself appropriately? ________________________________________________

3. What are appropriate ways to express frustration, anger, happiness, and sadness?
   ____________________________________________________________________________________

4. Is this important when meeting new people?      YES      or      NO

5. When talking to new people what are thinking to yourself?
   ____________________________________________________________________________________

6. What are some things you need to have for yourself before you can meet new people?
   ____________________________________________________________________________________
<table>
<thead>
<tr>
<th>Emotion</th>
<th>Emotion</th>
<th>Emotion</th>
<th>Emotion</th>
<th>Emotion</th>
<th>Emotion</th>
<th>Emotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>aggressive</td>
<td>alienated</td>
<td>angry</td>
<td>annoyed</td>
<td>anxious</td>
<td>apathetic</td>
<td>basaltful</td>
</tr>
<tr>
<td>bored</td>
<td>cautious</td>
<td>confident</td>
<td>confused</td>
<td>curious</td>
<td>depressed</td>
<td>determined</td>
</tr>
<tr>
<td>disappointed</td>
<td>discouraged</td>
<td>disgusted</td>
<td>embarrassed</td>
<td>enthusiastic</td>
<td>envious</td>
<td>ecstatic</td>
</tr>
<tr>
<td>excited</td>
<td>exhausted</td>
<td>fearful</td>
<td>frightened</td>
<td>frustrated</td>
<td>guilty</td>
<td>happy</td>
</tr>
<tr>
<td>helpless</td>
<td>hopeful</td>
<td>hostile</td>
<td>humiliated</td>
<td>hurt</td>
<td>hysterical</td>
<td>innocent</td>
</tr>
<tr>
<td>interested</td>
<td>jealous</td>
<td>lonely</td>
<td>loved</td>
<td>lovestruck</td>
<td>mischievous</td>
<td>miserable</td>
</tr>
<tr>
<td>negative</td>
<td>optimistic</td>
<td>paired</td>
<td>paranoid</td>
<td>peaceful</td>
<td>proud</td>
<td>puzzled</td>
</tr>
<tr>
<td>regretful</td>
<td>relieved</td>
<td>sad</td>
<td>satisfied</td>
<td>shocked</td>
<td>shy</td>
<td>sorry</td>
</tr>
<tr>
<td>stubborn</td>
<td>sure</td>
<td>surprised</td>
<td>suspicious</td>
<td>thoughtful</td>
<td>undecided</td>
<td>withdrawn</td>
</tr>
</tbody>
</table>
Session Plan #3 Control

Topic Time and Money Management

Procedure

Subjects will fill out the Money Management handout and then discuss with experimenter. Experimenter will pass out the Saving $$$ handout and discuss effective money saving strategies. Experimenter will orient subjects to new topic of time management by having group brainstorm about frequent things/activities people procrastinate. Then experimenter will have subjects fill out the Procrastination handout and then briefly discuss. Subjects will receive the My Goal handout and fill out the contract portion to conclude the session.

Summary
*M Money Management handout
Saving $$$ handout followed by discussion
*Procrastination handout
My Goal handout

Materials
Copies of the following: Money Management handout, Saving $$$ handout and Procrastination handout My Goal handout and Pencils
* denotes citation in reference section
Session Plan #3 Experimental

Introduction  Experimenter will play 2-3 songs on guitar to start session

Topic  Time and Money Management

Procedure

Experimenter will discuss but not distribute Money Management handout and the Saving
handout. Experimenter will engage subjects in a group discussion about effective money saving
strategies and patterns of behaviors that could be triggers to impulse buying/spending.
Experimenter will orient subjects to new topic of time management by having group brainstorm
about frequent things/activities people procrastinate. Effective strategies will be discussed to
reduce or eliminate procrastination behavior and tendency. Subjects will receive the My Goal
handout and fill out the contract portion. The contract portion of the My Goal handout will be
used in a song writing session based on 12 bars blues progression. The Blues Rewrite sheet will
be written on the board and only requested person(s) will receive sheet. Then either subjects
individually or experimenter will sing the blues rewrites. The blues rewrites will conclude
session.

Summary
Saving $$$ handout, *Money Management handout and *Procrastination handout will be
discussed but not distributed
My Goal handout
Sing blues rewrites

Materials
Copies of the following: Money Management handout, Saving $$$ handout and Procrastination
handout My Goal handout Blues Rewrite sheet, Pencils and guitar
* denotes citation in reference section
MY GOAL

CONTRACT FOR MYSELF
1. Write one goal that you are or going to accomplish.

_____________________________________________________________

2. Write the steps to accomplish this goal.

_________________________
_________________________
_________________________
_________________________
_________________________
_________________________

3. Sign and date

_________________________  Date ___________________
HOW CAN I SAVE MONEY? – We all have monthly expenses that take big bites out of our financial resources. Can we reduce these expenses, thereby using our money more wisely?

Under each expense below, list strategies that we could use to reduce these amounts.

<table>
<thead>
<tr>
<th>RENT</th>
<th>Write in your own c &amp; d</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>get a roommate</td>
</tr>
<tr>
<td>b.</td>
<td>live on second floor</td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UTILITIES</th>
<th>Write in your own c &amp; d</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Turn off lights when not in use</td>
</tr>
<tr>
<td>b.</td>
<td>set thermostat lower at night</td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLOTHING</th>
<th>Write in your own c &amp; d</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>go to thrift store</td>
</tr>
<tr>
<td>b.</td>
<td>buy items &quot;on sale&quot;</td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOOD</th>
<th>Write in your own c &amp; d</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>use coupons</td>
</tr>
<tr>
<td>b.</td>
<td>buy generic brands</td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSPORTATION</th>
<th>Write in your own c &amp; d</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>use bus</td>
</tr>
<tr>
<td>b.</td>
<td>walk</td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RECREATION</th>
<th>Write in your own c &amp; d</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>go/attend free activities</td>
</tr>
<tr>
<td>b.</td>
<td>attend movie matinees</td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
</tbody>
</table>
Evaluate your spending habits by circling a or b:

1. a. I buy something when I feel like it.
   b. I buy things only after much consideration.
2. a. I seldom spend money on leisure or entertainment.
   b. I prioritize leisure and spend money on it.
3. a. I put money in savings.
   b. I scrounge money weekly with nothing left over for savings.
4. a. If I buy a major item, I go to a store and buy it, saving time by not comparing prices.
   b. If I buy a major item, I compare prices, read up on the best product, and then buy.
5. a. I plan credit card purchases and pay the full balance when it's due.
   b. I overextend on credit cards, paying only part of the full balance each month.
6. a. I can control cash in my hand/wallet, or I make sure I never have cash "on hand".
   b. Cash is a "trigger" for me to spend.
7. a. I never spend money on myself.
   b. I choose to spend some money on myself.
8. a. I confront my financial situation, evaluating and updating as time passes.
   b. My money has a mind of its own; I allow my money to run itself.
9. a. I manage my money independently — not asking for others' help.
   b. I ask for help from those who can manage money better than I.
10. a. I know my income, expenses and budget, and plan accordingly.
    b. I don't know my financial situation, so I don't plan.

Which one of the above ten issues are you willing to address?

How can you make changes in this area?
<table>
<thead>
<tr>
<th>Things put off doing</th>
<th>Feelings as a result</th>
<th>Is it really a Priority?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

"Time offers us possibilities to create opportunities."
To make your own blues just fill in the information

I’ve got the (answer to #1) ____________________________ blues

I’ve got the (answer to #1) ____________________________ blues

I’ve got the (answer to #1) ____________________________ blues

But I’m goin’ to beat the blues by:

List you items from #2

________________________

________________________

________________________

________________________

________________________
Session Plan #4 Control

Topic Communication

Procedure

Experimenter will pass out the Conversation Skills and Listening Skills handouts. Experimenter will allow time for subjects to complete handouts. Experimenter will facilitate a group discussion by requesting volunteers share and demonstrate their answers. Experimenter and subjects will role-play examples of communication styles. Examples communication styles are open vs. closed, interpreting nonverbal communication and many others. Experimenter will pass out and discuss the Tips for Conversation handout. Experimenter will ask questions such as the following: How is communication important in here (meaning their respective facilities), Does communication affect your report with doctors, social workers, and staff? How about relatives, friends? Experimenter will answer any questions and end session.

Summary
*Conversation handout
*Listening handout
Group discussion and role-play exercises
Tips for Conversation handout

Materials
Copies of the following: Conversation Skills handout, Listening handout and Tips for Conversation handout and Pencils
* denotes citation in reference section
Session Plan #4 Experimental

Introduction  Experimenter will play 2-3 songs on guitar to start session

Topic  Communication

Procedure

Instead of distributing the Conversation Skills handout and Listening Skills handout subjects will cover the same material by participating in a drum/improv ensembles. Experimenter will pass out each subject a rhythm instrument and give very brief explanation on how to play, if necessary. Experimenter will pair up individuals to create three small ensembles. Each group will choose a percussion instrument and be given a color/shape that will represent their group. Each group will play four bars of a standard blues progression according to the chart or cue by experimenter. Only the cued group is allowed to play the other ensembles have to refrain from playing and listen. Once subjects understand the fundamentals of activity then prerecorded music of Bb Blues Jamey Aebersold will be played on a CD player while experimenter directs group using a color/shape chart. The 12 bar blues will be divided up into three four bar phrases. Each group will read the chart and follow the experimenter. For example, bars 1-4 are the blue ensembles and then the green ensemble for bars 5-8 etc.. The final task is all groups’ play without assistance and trade 12 bar phrases with experimenter performing on an instrument. Following activity a group discussion will begin about communication. Then experimenter will pass out and discuss the Tips for Conversation handout. Experimenter will conclude session by transferring knowledge into everyday settings. Experimenter will ask questions such as the following: How is communication important in here (meaning their respective facilities), Does communication affect your report with doctors, social workers, and staff? How about relatives, friends? Experimenter will answer any questions and end session.

Summary

Drum circle and improv ensembles

Tips for Conversation handout followed by group discussion
Materials

Copies of Tips for Conversation handout. Other materials include: Rhythm Instruments, Experimenter’s Performing Instrument, Color/Shape Chart and Guitar.

* denotes citation in reference section
Conversation

Look directly at the person speaking and make eye contact
Look interested by focusing on the individual speaking
Ask follow up questions
Avoid tightening facial muscles, look relaxed and comfortable
Demonstrate open body posture
Try to have smooth muscles movements when speaking/listening
Try to speak at a comfortable volume
If appropriate shake hands
Don’t look distracted (focusing on TV, looking at paper etc.)
Smile

Tip: I realize you’re used to talking to me on the chat line, but would you mind not moving your fingers like you’re typing everytime you say something?"
**CONVERSATION SKILLS**

IS  
WHERE  
IT'S  
AT!

Sometimes, when we first meet people, it's difficult to start up a good conversation. What to talk about? What not to talk about? How often do you...

<table>
<thead>
<tr>
<th>ALWAYS</th>
<th>SOMETIMES</th>
<th>NEVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face and look directly into the eyes of the person you are talking to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid overusing &quot;I&quot;. (Sometimes people talk a lot about themselves because they're nervous.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure you focus and listen when the person responds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try bringing up something that's neutral – weather, recent movies or TV shows, current events, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try to be honest, but not too honest. (Honesty is a good quality in relationships, but it can be overdone.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give sincere compliments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept compliments by saying &quot;Thank You&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid touchy subjects, like religion, politics or overly personal information from your past.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End a conversation with a pleasant phrase - &quot;Nice meeting you&quot;, &quot;Hope to see you again&quot;, &quot;It's been nice talking to you&quot;, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Looking at the marks above, which do you do best in conversations? ____________

Which area do you feel you need to work on the most? ____________

Conversation skills, like all skills, take time and practice. GIVE IT A TRY!
LISTENING SKILLS

LISTENING IS WHERE IT'S AT!

Listening is a major part of a healthy communication process and an important skill. How would you rate your listening skills? How often do you...

- Put aside what you're doing.
- Focus your eyes on the speaker.
- Think about what the speaker is really saying.
- Avoid 'stepping on the other person's words'.
- Show interest with facial & body gestures.
- Respond with a non-judgmental attitude.
- Ask interested questions, remembering points for next discussion.
- Try not to overdo when bringing your own experiences into the discussion.

Looking at the marks above, which do you do best as a listener? __________________________

Which area do you feel you need to work on the most? __________________________

Listening skills, like all skills, take time and practice. GIVE IT A TRY!
Session Plan #5 Control

Topic: Living and Coping with Mental Illness

Procedure

Experimenter will pass out the Talking About Illness handout. Experimenter will read the handout and answer any ensuing questions. Experimenter will pass out the Do You Know Your Meds handout and request subjects to fill in their answers. For any question(s) that is not filled out or subjects does not know the information experimenter will instruct these individuals to ask staff to fill them in for them afterwards. Then the Med List handout will be distributed and experimenter will lead the group in filling out the first line together. Experimenter will request subjects fill in the rest later and seek help from staff if needed. Experimenter will hand out but not go over the Fact Sheet at the end of the session. Experimenter will request they read this later and seek help from staff if needed.

Summary

* Talking About Illness handout
* Do You Know Your Meds handout
* Med List handout
* Fact Sheet

Materials

Copies of the following: Talking About Illness handout, Do You Know Your Meds handout, Med List handout Fact Sheet and Pencils

* denotes citation in reference section
Session Plan #5 Experimental

Introduction  Experimenter will play 2-3 songs on guitar to start session

Topic  Living and Coping with Mental Illness

Procedure

Experimenter will engage subjects in a song analysis regarding self-awareness issues. Experimenter will pass out the lyrics to the song “Man in the Mirror” and use prerecorded music for subjects to follow along. Then experimenter will facilitate a group discussion about making a change and how knowing what to change is the first step. Today’s change will be increased self-awareness about you mental health condition and ways to cope with issues related to having and living with a mental illness.

Experimenter will not distribute but will discuss the material on the Talking About Illness handout. Experimenter will read the handout and answer any ensuing questions. Experimenter will pass out the Do You Know Your Meds handout and request subjects to fill in their answers. For any question(s) that is not filled out or subjects does not know the information experimenter will instruct these individuals to ask staff to fill them in for them afterwards. Then the Med List handout will be distributed and experimenter will lead the group in filling out the first line together. Experimenter will request subjects fill in the rest later and seek help from staff if needed. Experimenter will handout but not go over the Fact Sheet at the end of the session. Experimenter will request they read this later and seek help from staff if needed.

Summary

Song Analysis followed by a group discussion
Discussion about *Talking About Illness handout, not distributed
*Do You Know Your Meds handout
*Med List handout
*Fact Sheet will be discussed but not distributed
Materials
Copies of the following: Talking About Illness handout, Do You Know Your Meds handout, Med List handout Fact Sheet, “Man in the Mirror” lyric sheets, CD player with CD, Pencils and Guitar.
* denotes citation in reference section
TALKING about illness

Talking about your mental health difficulties to friends, family, peers, or neighbors can be challenging. Should you? Shouldn't you? How can you feel okay about discussing it? Or not discussing it? How much do you say? How about those awkward or nosy questions you sometimes get, when you're least expecting it? It's wise to give it some thought . . .


WITH whom are you comfortable being completely open and honest?
WITH whom or in what situations do you want to be more discreet, giving less information?
WITH whom do you want to completely keep your privacy?
Then, give yourself permission to respect these decisions.

WHAT TO SAY - WHAT TO SAY - WHAT TO SAY - WHAT TO SAY

☐ THINK, it may be helpful to think what to say before situations arise, so you're not caught off guard. Rehearse your response if you'd like. And remember . . . there's no right or wrong . . . find your own ways of talking about it.

☐ HELP others to understand by using language that is medically correct, for example, 'depression' rather than 'nervous breakdown.' Refer to information pamphlets or fact sheets to help explain.

☐ DESCRIBE your symptoms in clear terms. Poor concentration, 'confused thoughts' or 'difficulty sleeping' will help others understand, since these difficulties/concepts are easy enough for most people to grasp.

☐ AVOID or eliminate mysterious, frightening or derogatory words such as 'psycho,' 'crazy' or 'looney.' These words do not portray an accurate picture of mental illness; in fact they are likely to perpetuate a stigma!

☐ EMPHASIZE the positive aspects of what you are doing, e.g., "I'm getting a lot of help." "The program I'm in is teaching me a lot."

DO NOT WANT TO TALK ABOUT - DO NOT WANT TO TALK ABOUT

If you don't want to disclose anything, you have this right. Indicate the subject is off limits, in a pleasant but firm voice. Try something like, "I'm just not comfortable talking about it right now."

The term 'personal problems' covers a lot but without actually disclosing much, and avoids the problem of outright lying. Similarly, 'internal problems' might be a way of suggesting an illness too delicate for further discussion.

Acknowledge others' concern with "thanks for caring" or "I appreciate your concern." Practice quickly changing the subject, "How are you?" people might actually prefer talking about themselves anyway.

DO YOU KNOW YOUR MEDS?

Everything you always wanted to know about medications...

What medications do you take now?

Can you answer each of these questions about your meds?

1. The name of one of my meds is...

2. How does this medication help me?

3. What is the medication for?

4. What kind of medication is it?

5. How often should I take it?

6. How long should I take it?

7. How should I take it? (before or after meals, with water, etc.)

8. What times of the day should I take it?

9. What are the side effects?

10. What can I do to reduce the side effects?

11. How does it mix with other medications?

12. Are there certain foods to avoid?

13. Do I need a blood test?

14. Is the medication addictive?

15. Does it mix with alcohol?

16. What should I do if I miss a dose?

17. How will this medication affect my lifestyle?

When you are prescribed medication, the questions above are the ones to ask!

If you didn’t have all of the answers about your meds, where can you go to find the answers?

Who can or should you share this information with?

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FACT SHEET

Facts about over-the-counter medications (OTC)

1. Non-prescription medications are intended to relieve symptoms of minor ailments. If conditions persist, see your doctor.
2. Some over-the-counter medications should NOT be taken with others. It may interfere with effectiveness.
3. There is information on the labels that warns people who have special health problems.
4. If in doubt about purchasing an OTC medication, ask your pharmacist. This can help prevent problems.
5. Check with your pharmacist before taking any OTC medication with your prescription.

Playing it safe... (the no-no's or never's)

1. Never discontinue medications on your own.
2. Never take someone else's medications.
3. Never give your medication to someone else.
4. Never take the labels off your medication containers.
5. Never leave medication within the reach of children.
6. Never combine a medication from its original bottle to another.
7. Never keep prescriptions you are no longer taking.
8. Never go far from home without a list of medications.

Just in case you didn't know!!!

1. Store medications in a cool, dry place. This most likely is NOT your medicine cabinet!
2. Some medications may cause drowsiness and can make operating a car or machinery hazardous.
4. It takes time for some medication to produce a noticeable effect.
5. Prescription medication for mental illness does not take the place of therapy or counseling.
6. It may take time for a doctor to find the right medication and dosage for you. Every person is affected differently by medications. Be patient!

NOTES:

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53
Man In The Mirror

Michael Jackson

I'm gonna make a change, for once in my life
It's gonna feel real good, gonna make a difference
Gonna make it right...

As I, turn up the collar on my favorite winter coat

This wind is blowing my mind
I see the kids in the streets, with not enough to eat
Who am I to be blind?
Pretending not to see their needs

A summer disregard, a broken bottle top
And a one man soul
They follow each other on the wind ya' know
'Cause they got nowhere to go
That's why I want you to know

CHORUS
I'm starting with the man in the mirror
I'm asking him to change his ways

Used in Experimental Group

And no message could have been any clearer
If you wanna make the world a better place
Take a look at yourself, and then make a change
(Na na na, na na na, na na, na nah)
I've been a victim of a selfish kind of love
It's time that I realize
That there are some with no home, not a nickel to loan
Could it be really me, pretending that they're not alone?

A willow deeply scarred, somebody's broken heart
And a washed-out dream
They follow the pattern of the wind ya' see
'Cause they got no place to be
That's why I'm starting with me

Chorus
I'm starting with the man in the mirror
I'm asking him to change his ways

And no message could have been any clearer
If you wanna make the world a better place
Take a look at yourself, and then make that...
CHANGE!
APPENDIX B

SESSION EVALUATION AND RESPONSE SHEET
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I could follow today’s session</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I physically and mentally felt good today</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I found today’s session useful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I learned something new from today’s session</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The session was fun</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The activity encouraged me to participate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>This session will help me right now</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I felt eager to participate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I enjoyed working with others in the group</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>More of these sessions would be helpful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Today’s session will help me in the future</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel more confident in myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I could identify with today’s session</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I was eager to attend today’s session</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

# Last question to be added on last session

All five sessions have been helpful                                      | 1                 | 2        | 3       | 4     | 5              |
APPENDIX C
COMMUNITY LIVING COMPETENCIES
<table>
<thead>
<tr>
<th>Statement</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I feel sad and/or gloomy I express this emotion to others appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can wake up in the morning at the time I desire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to pick out an outfit appropriate for that day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I feel happy and/or excited I express this emotion to others appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to do all my hygiene duties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can make breakfast or ask someone to help me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel confident with my abilities to help myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can make myself look appropriate for the day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can set my alarm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I feel angry I express this emotion to others appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to pick out nutritional foods at a store</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel energetic when I wake up in the morning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to get transportation (bus, friend etc) to where I need to go</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I attempt to make a good impression when meeting people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to arrive to appointments on time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have courage when facing new problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I handle stress with ease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I am at work, school, attending sessions or any other activity I am always on task</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have many friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to tackle problems without delay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I eat nutritional foods and exercise regularly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can and will depend on others if needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know it is okay to ask and seek out help when needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to spend my money appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I have a lot of things to do I manage my time well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no problems I can’t handle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have many hobbies to occupy my spare time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am compliant with all mental health workers in my treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take my medication on time everyday consistently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not feel uncomfortable when talking to new people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I am hearing voices or seeing hallucinations I tell only the appropriate people (ie. Doctor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have ways to help me cope with my mental health condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand my mental health condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could explain in a rational way to others about my mental health condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have effective ways of dealing with feelings of anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I express myself to others appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can communicate to others my wants and desires</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get the proper amount of sleep daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I live a good happy life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can keep a meaningful relationship, hold a steady job I like and have a good life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know why I don’t feel good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a bright future</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel like any other average person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have effective ways of dealing with feelings of frustration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Subject #/Group/Facility
APPENDIX D
LIFE SKILLS ATTITUDES
<table>
<thead>
<tr>
<th>Life Skills Attitude (LSA)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am responsible for myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am aware of side effects from medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can adhere to a schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have the ability to keep a job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand my own limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can have a mental illness and have good/meaningful relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I use all help resources when I feel necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can cope with the side effects of my medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel independent and able</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can make good financial decisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have leisure and recreational activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can appropriately express all my emotions to others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I effectively communicate with others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take care of myself</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Subject/Group/Facility
APPENDIX E
FSU HUMAN SUBJECT COMMITTEE APPROVAL
Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2783
(850) 644-3833 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 4/25/2004

To:
James Pierce
1872 Narcia Avenue
Tallahassee FL 32310

Dept: MUSIC THERAPY

From: John Tomkowiski, Chair

Re: Use of Human Subjects in Research
The effects of Music Therapy and Psychoeducation Versus Psychoeducation for
Mainstreaming Mental Health Patients into Society

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
4/14/2004. 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 4/13/2005 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 ensure 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.

cc: Jayne Standley
HSC No. 2004.270
Consent Form

This research is being conducted by Jim Pierce, who is a graduate student under the study of Dr. Jayne Standley in the School of Music at Florida State University. I understand that the purpose of this study is to compare the effects of music therapy on increasing self-awareness and understanding of mental health issues.

My participation will involve attending five sessions consecutively during the week for 45-60 minutes in duration. My participation may involve group discussions, paper and pencil exercises and activities related to the topic of mental health or the same activities but within a music therapy format that includes prerecorded and/or live music.

I understand that my participation is totally voluntary, and I may stop participation at any time. My name will not appear on any of the results. I understand that my demographic/recorded information will be paired with a number that will reside with experimenters. The facility is the only holder of my subject name and number. I understand that all information about this study will be kept for a maximum of two years. Information obtained during the course of this study will remain confidential to the extent allowed by law. There are no foreseeable risks or discomforts if I agree to participate in this study.

I understand that everyone participating in this study could gain an enhanced understanding about mental health issues and learn effective coping skills strategies. I understand that the study will help increase the knowledge about mental health issues and ways to better serve them.

I understand that this consent may be withdrawn at any time without prejudice, penalty or loss of benefits to which I am otherwise entitled. I have been given the right to ask and have answered any inquiry concerning the study. Questions, if any, have been answered to my satisfaction.

I understand that I may contact Dr. Jayne Standley, Florida State University, and School of Music. (850) 644-4565, for answers to questions about this research or my rights. Group results will be sent to me upon request.

I understand that if I have any questions about my rights as a participant in this research, or if I feel I have been placed at risk, I can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633.

I have read and understand this consent form.

(Subject’s Name Printed)

(Subject’s Signature)

(Date)
REFERENCES

AMTA Member Sourcebook (2003), Silver Springs, MD: American Music Therapy Association.


<table>
<thead>
<tr>
<th><strong>BIOGRAPHICAL SKETCH</strong></th>
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| **Name:** James W. Pierce IV  
**Date of Birth:** 19th December 1976  
**Place of Birth:** Morgantown, West Virginia |
| **Education:** Bachelor of Psychology  
Bachelor of Visual and Performing Arts  
West Virginia University  
Morgantown, West Virginia |
| **Major:** Music  
Psychology  
Master of Music in Music Therapy  
August 2004  
Florida State University  
Tallahassee, Florida |
| **Affiliations:** 2002-2004 served as Music Representative on FSU Congress of Graduates Students  
2004 Pi Kappa Lambda  
2001 Member of American Music Therapy Association  
2000-2001 Psi Chi President  
1999 Psi Chi Member |