

Women with Addictions' Experience in Music Therapy

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Amy L. Dunlap

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This thesis titled
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by
AMY L. DUNLAP

has been approved for
the School of Music
and the College of Fine Arts by

Laura S. Brown
Assistant Professor of Music Therapy

Elizabeth Sayrs
Interim Dean, College of Fine Arts

Abstract

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Women with Addictions' Experience in Music Therapy

Director of Thesis: Laura S. Brown

This phenomenological inquiry examined the experience of group music therapy for women recovering from addictions. Nine, twice-weekly 60- to 90-minute music therapy sessions were provided for 16 women at an all-female inpatient treatment facility with an average three-month treatment length located in rural Ohio. The women were Caucasian, mothers, and ranged in age from 18 to mid-40s. Heroin and methamphetamines were the most commonly cited drugs of abuse among group members. Following the treatment sequence, 11 women participated in voluntary semi-structured interviews about the music therapy experience and three interviews were chosen for phenomenological microanalysis. The analysis yielded four primary themes: music forms connections, desirable intrapersonal shifts, beneficial qualities of music therapy sessions, and music therapy's impact on treatment and recovery. The outcomes from this study align with suggestions for successful addictions treatment for women and indicate that music therapy may be a beneficial treatment across the span of the recovery journey.

Dedication

This work is dedicated to the women who so graciously shared their stories and music. Thank you for being a light so that others may know how to shine.

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Chapter 1: Introduction

The struggles of a woman with addiction are widespread. During active addiction, the woman, her drug(s) of abuse, and their impact on her inner and outer worlds cannot be separated. Weight bears down from all sides from raising children, being in intimate relationships (that may or may not be abusive), living with past traumatic experiences, and trying to earn a living. These factors, coupled with the guilt and shame that often accompany addiction, break down the sense of self, remove the joy from life, and leave the individual with little to no hope. That's the picture the women I worked with in this study painted about life with addiction. After the first music therapy session I conducted with these women, there was a palpable shift in the air, an awakening. Following our first group improvisation, I asked the women how the music felt to them and one woman responded immediately, "It's music for the soul." Further accounts of what these women experienced in group music therapy suggest that hope may be found in the music.

Substance use disorder (SUD, also referred to in this paper as addiction or substance abuse) is a chronic disease of the brain and psyche that is characterized by compulsive use of drugs and/or alcohol and affects physical, emotional, and spiritual health (Borling, 2011; National Institute on Drug Abuse, 2014; NIDA). Recreational use of licit and illicit substances becomes disordered use when an individual develops maladaptive patterns that lead to significant impairments and distress in activities of daily living (American Psychiatric

Association, 2013). Substance abuse often leads to tolerance; individuals with addiction may require larger amounts of a substance to achieve the desired high and experience physical and/or psychological withdrawal symptoms when not using the drug. Individuals dealing with addiction spend a substantial amount of time obtaining and using substances and will likely continue to use drugs and alcohol despite acknowledging a problem exists.

A recent survey by the Substance Abuse and Mental Health Service Administration (SAMHSA; 2014) states that 21.6 million adults, or 8.2% of the population over the age of 12, abused substances in the year leading up to the survey. Alcohol, marijuana, pain relievers, cocaine, and heroin were the most commonly abused substances. Approximately 17.3 million adults abused alcohol and 6.9 million adults abused illicit substances in the year before the survey, with 2.6 million individuals abusing both. Marijuana and cocaine levels maintained or decreased slightly in the last decade, while pain reliever and heroin levels increased over the last ten years. Adult males abused substances at a rate that was almost double the rate for females (11.4% and 5.8% of the population, respectively). However, rates between genders in youth aged 12-17 were essentially the same, with 5.3% of males and 5.2% of females abusing substances. Individuals in metropolitan areas abused substances at a greater rate than those in nonmetropolitan areas (8.6% and 6.6% of adults, respectively), although preferred substances between geographic locations were not discussed.

Substance abuse comes at a tremendous cost to the individual, the family and community (U.S. Department of Health and Human Services, 2016; HHS). Research suggests that substance misuse costs Americans between \$400-700 billion annually in health care, crime, and lost productivity (HHS, 2016; National Institute on Drug Abuse, 2014), not to mention the immeasurable cost of compromised quality of life, child abuse and neglect, and death rates that are climbing as a result of substance misuse (HHS, 2016). Estimates suggest that in 2014, drug and alcohol misuse alone caused 135,055 deaths; 88,000 individuals died from alcohol abuse and, of the 47,055 who died from drug overdose, 28,647 people died from opioids, such as prescription pain killers or heroin – the highest drug-related death rates on record. The Surgeon General calls for an improved comprehensive approach to address substance use problems in the United States and identifies a need for improved access to evidence-based treatment services (HHS, 2016). Evidence suggests that music therapy is a useful treatment for individuals with substance use disorders, Silverman, 2009a). Despite these positive findings, music therapy for the treatment of SUD is still an under-researched area in the literature. The recent reports of unprecedented substance misuse in the United States indicate that this is a critical time for research that examines the full potential of how music therapy can be incorporated into addiction treatment (Mays, Clark & Gordon, 2008; Silverman, 2009a).

Music therapy and addictions research, which varies in design from randomized control trials to qualitative case studies, lacks a consensus regarding the most effective interventions for treating the unique needs of individuals with addictions (Mays, et al., 2008). However, emerging trends indicate that music therapy is effective both in decreasing negative feelings (i.e. depression, stress, anger, anxiety, sadness, guilt) and increasing positive feelings (i.e. acceptance, enjoyment, happiness) for those who are chemically dependent (Albornoz, 2011; Cevalco, Kennedy & Generally, 2005; Gardstrom & Diestelkamp, 2013; Jones, 2005; Silverman, 2011).

A survey by the American Music Therapy Association (AMTA; 2014) found that 20% of music therapists work in mental health, the largest category reporting services. In 2009, approximately 4.6% of AMTA members reported working in the substance abuse setting (Silverman, 2009a) and in 2015, 7.7% of responding music therapists reported working with the substance abuse population (AMTA, 2015). Music therapists treat individuals with addiction in community mental health centers, inpatient treatment centers, state hospitals, and general hospitals (Silverman, 2009a). The results from this survey indicate that an increasing number of music therapists are working with individuals seeking treatment for SUD.

Historically, mixed-gender groups are most prevalent in substance abuse treatment. Silverman's (2009a) survey of music therapists working with individuals recovering from addictions did not differentiate between genders and

settings in which they were served, so it is difficult to say how many music therapists working with substance abuse are providing gender-specific treatment. Single-gender groups have been shown to more effectively address gender-specific problems in substance abuse treatment (Greenfield, Trucco, McHugh, Lincoln, & Gallop, 2007). Women indicate a relationship between gender and substance abuse experiences; therefore, engaging in single-gender treatment is more comfortable than mixed-gender treatment and outcomes may be greater for recovery (Greenfield, Cummings, & Gallop, 2010).

Problem Statement

The rising incidence of addiction in America and its impact on society is a major public health concern. Reports suggest that, as a whole, current mainstream treatment modalities, such as medication and cognitive-behavioral therapy, do not adequately meet the needs of individuals with SUD (HHS, 2016; NIDA, 2014) and a 2016 report by the Surgeon General of the United States identifies a need for more education, resources, policies, and access to proven treatment modalities before SUD may be treated successfully in America (HHS, 2016). Music therapy is a treatment modality that has been used successfully in addiction treatment for years (Silverman, 2003). Research focusing on music therapy with women recovering from addictions indicates that music therapy supports feelings of safety, increases positive mood states, and encourages self-empowerment, self-respect, meaningful connection with others, and allows for emotional expression, all essential outcomes for recovery (Cevasco et al., 2005;

Gardstrom, Klemm, & Murphy, 2016; Silverman, 2003; Yun & Gallant, 2010).

While evidence in this area is increasing, best practices are far from being established. Gardstrom, et al. (2016) argued that women with addictions' needs are best understood through the woman's personal narrative. Only in understanding the women's perspective can music therapists improve service delivery for this relatively untapped subset of individuals in need of services.

Statement of Purpose

Research is needed to understand what women with addictions experience in music therapy treatment so that music therapists may deliver best practice for women with addictions. The purpose of this research is to investigate how music therapy treatment operates within a women's only group. I hope to gain an open-ended client perspective to enlighten music therapists as to what women with addictions experience in music therapy treatment. This research will provide both individual and collective essences of the music therapy phenomenon as the women lived it.

Research Question

The research question for the study is "what is the experience of women with addictions in music therapy?"

Definition of Terms

Recovery – SAMHSA (2015) defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is typically characterized by abstinence from previously abused substances.

Relapse – the reoccurrence of symptoms after a period of recovery. Substance use disorder relapse is typically characterized by reinstated substance abuse (NIDA, 2014). Relapse is not an indication of failed treatment; relapse rates among individuals with SUD are estimated at 40-60%, which is comparable with other chronic illnesses, such as hypertension (50-70%). Relapse is a normal part of substance use disorder that indicates treatment needs to be revisited or adjusted.

Opioids – a family of substances derived from opium poppies known for their painkilling potential and high risk for addiction. Prescription painkillers, such as oxycodone, and illicit, synthetic opioids including heroin and fentanyl are examples opioids that are frequently misused, which can result in serious negative health effects and death due to accidental overdose (SAMHSA, 2016).

Self-efficacy – is defined as an individual's belief that she has the ability to cope effectively with a particularly high-risk situation (Bandura, 1986).

Chapter 2: Literature Review

Individuals may begin to use drugs and alcohol for a number of reasons, but whether or not one's recreational use will develop into an addiction depends on the unique interactions between the substance, the user, and the environment. The potential for addiction differs depending on the substance and the individual; biological predispositions and life experiences may make initial addiction more rewarding for some individuals than for others (Dijkstra & Hakvoort, 2010). Although most substances have the potential for addiction, the method of administration, age of initiation, and unique effects of the chemicals on the brain contribute to differences in addiction rates between substances (NIDA, 2014). Reports suggest that tobacco, heroin, crack/cocaine, and methamphetamines are among the most addictive substances today (NIDA, 2014).

Due to the complexity of the addiction process, a biopsychosocial approach to treatment is suggested, which addresses each of the systems involved (biological, psychological, and social) with equal measure (Masiak, 2013). Considering the variety of factors involved, substance abuse treatment can be intense and complicated and sustained recovery often requires lifelong maintenance (NIDA, 2014). Because of the complex nature of substance abuse treatment, certain approaches or techniques may be more effective than others with particular subsets of the substance abuse population. Music therapy is one

approach used in addiction treatment that has the ability to address biopsychosocial and spiritual needs simultaneously (Borling, 2011).

Addiction Process

Addiction is a disease that affects the brain and in turn, human behavior. The addiction process is complicated, involving biology, genetics, environment, social systems, life choices and experiences. *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) provides a list of criteria distinguishing substance use disorder from recreational substance use. Substance use disorder (SUD) is characterized by maladaptive patterns associated with substances that lead to significant impairment and distress in everyday life. An addicted individual may develop tolerance to the drug of choice and require larger amounts of the substance to achieve the same high, as well as withdrawal symptoms without the drug. Individuals with SUD spend a significant amount of time engaging in activities related to obtaining substances and the resulting substance use may compromise the individual's activities of daily living, including social, occupational, and recreational activities. The *DSM-5*'s final indication of substance use disorder is that the individual continues substance abuse despite knowing a problem exists.

Addiction changes brain structure and how it works (NIDA, 2014). Substance use involves the reward centers in the brain and the neurotransmitter dopamine. Drugs of abuse alter brain processes in the limbic system, which is

the area of the brain responsible for regulating feelings, emotions and motivation. Necessary, life-sustaining activities such as eating, sex, and socializing activate the limbic system and create rewards in the form of dopamine. Dopamine is a neurotransmitter that helps to regulate movement, motivation, emotion, and feelings of pleasure, and it is responsible for the euphoric, rewarding feelings experienced upon taking most drugs of abuse.

Upon entering the brain, drugs of abuse either encourage increased neurotransmitter release or attach to neurotransmitter receptors in place of the intended neurotransmitter and activate brain neurons in different ways, causing the brain to send abnormal messages (NIDA, 2014). Often, these chemical processes create a flood of dopamine to the reward center, causing a euphoric feeling that the brain interprets as a reward for a necessary activity. The reward system aims to keep us healthy by reinforcing behaviors that activate it, and as a result, substance use becomes engrained in our biology very effectively, which can quickly lead to a chemical addiction on the neural level.

Opioid Use in America

The Surgeon General's 2016 report on the state of addiction in America referred to increasing opioid use as a "crisis" (HHS, 2016). Experts suggest that heroin-related deaths increased five-fold between 2001 and 2013 (CDC, 2015) and in the last ten years, heroin use has doubled among Americans between the ages of 18 and 25 (CDC, 2015). Americans are misusing prescription opioids at high rates as and research suggests that individuals who are addicted to

prescription painkillers are 40 times more likely to develop addiction to heroin than those who aren't addicted to prescription opiates (CDC, 2015)

White Americans and women are largely involved in the increasing occurrence of heroin addiction. The CDC (2015) suggests that in the last ten years, the incidence of heroin addiction among women has doubled. Among white Americans, heroin use is up 114% in the last ten years. Heroin use poses a high risk for addiction, substance-related disease, unintentional overdose and death in comparison to other illicit substances (CDC, 2015). In Ohio alone, 3,050 individuals died from unintentional drug overdose in 2015, the highest number on record, and a 20.5% increase from the 2,531 deaths in 2014 (Ohio Department of Health, 2016); of the 3,050 deaths in 2015, heroin accounted for approximately 45% of overdoses, although it is unknown how many of these deaths occurred in women. The increasing rates of addiction among this drug population are concerning due to heroin's devastating impact on the user, the family and society (CDC, 2015).

Women and Addictions

Both men and women experience SUD at increasing rates. Approximately 10.8% of men and 5.8% of women in the United States currently meet the criteria for SUD (SAMHSA, 2014). Differences in addiction rates are one indicator of the different experiences men and women have when addicted to substances.

Literature regards women as a social group independent of men when considering precipitating causes for substance abuse (Watson & Parke, 2011).

Women initiate substance use to cope with negative emotions and pain, while men are more likely to seek positive affective states from substance use (Corcoran & Corcoran, 2001; Langan & Pelissier, 2001). Additionally, women indicate a correlation between addiction onset and a stressful life event, including but not limited to domestic violence or abuse, rape, incest, child abuse, male dominance, lack of support, and motherhood (Miller, 1997).

Apart from stressful or significant events, women cite other themes related to substance abuse including neglect, isolation from support and trust of other women, depression, low self-esteem, guilt, fear of losing children, fear of having drug-affected babies, and fear of having AIDS (Miller, 1997; Woodhouse, 1990). Wechsberg, Craddock, and Hubbard (1998) found that women in treatment for substance abuse were more likely than men to have been raised in homes in which drug use occurred. Women's choice of substance appears to be different than men's, although reports vary of each gender's most common substances of abuse (Greenfield, Back, Lawson, & Brady, 2010). Some research reports that women are more likely to be addicted to hard drugs such as crack or heroin, while others suggest that men are more likely than women to abuse the same illicit substances (Arfken, Klein, di Menza, & Schuster, 2001; Fattore, Melis, Fadda, & Fratta, 2014; Langan & Pelissier, 2001; Pelissier, Camp, Gaes, Saylor & Rhodes, 2003; Wechsberg et al., 1998). Additional reports suggest that men and women use stimulants at similar rates; women more commonly misuse prescription opioids and men abuse alcohol at higher rates than do women

(Greenfield, Back, et al., 2010). Reports also vary on poly substance use rates between genders (Shand, Degenhardt, Slade, & Nelson, 2011). Women who use cocaine, opioids, or alcohol appear to progress from initial use to addiction more quickly than their male counterparts and thus, typically enter treatment with more severe addiction-related symptoms than do men (Greenfield, Back, et al., 2010; HHS, 2016).

Women are less likely than men to enter treatment for substance abuse, although, once in treatment, gender does not appear to be a factor in treatment outcomes, retention, or completion (Greenfield, Back et al., 2010). Differences do exist, however, between the modes of treatment delivery. Traditional SUD treatment models were designed for men and due to the gender differences in substance initiation and abuse, recent research has focused on gender-specific treatment, and the emerging results are promising (Greenfield, Back, et al., 2010).

Preliminary research suggests that gender-specific treatment may be more supportive than mixed-gender treatment in addressing areas of need that are unique to the experience of being a woman addict (Greenfield, Back, et al., 2010; Greenfield, Trucco, et al., 2007). Women in gender-specific treatment report feeling more safe and comfortable to address women-related addiction issues, such as motherhood and pregnancy, domestic violence, social services, sexual trauma, intimate relationships, and feelings related to self-perception such as shame and vulnerability (Greenfield, Back, et al., 2010; Greenfield,

Cummings, et al., 2010; Kauffman, Dore, & Nelson-Zlupko, 1995; Roth, 2010). Women also appear to benefit from treatment that pays special attention to self-care and coping skills (Greenfield, Cummings, et al., 2010). Currently, gender-specific treatment is recommended for women with SUD who are pregnant or have dependent children (Greenfield, Trucco, et al., 2007). Additionally, a study revealed sustained improvements in recovery for women who attended single-gender groups rather than mixed-gender groups at a six-month follow-up (Greenfield, Trucco, et al., 2007). Experts suggest that the women-focused content of single-gender treatment allows for the exploration of unique gender dynamics that aid in satisfaction rates, sustained improvements, and ultimately, successful recovery (Greenfield, Trucco, et al., 2007; Roth, 2010).

Higher levels of self-efficacy upon entering treatment seem to reduce substance use outcomes (number of drinking days, drinks per drinking days, number of days per month of any substance use during treatment and post-treatment) following treatment (Greenfield, Cummings, et al., 2010). Greenfield et al. (2010) found that women in gender-specific treatment with lower levels of self-efficacy at baseline had greater treatment outcomes than even the women in the same women-only group with high levels of self-efficacy at baseline. This study points out that single-gender groups might be especially effective in treating women with low self-efficacy.

Researchers note a need for more experimental studies on the subject of gender-specific treatment (Greenfield, Back, et al., 2010). Evidence for gender-

specific treatment's influence on treatment efficacy is inconclusive in terms of retention (Greenfield, Back, et al., 2010), which is a known supportive factor of positive treatment outcomes (Greenfield, Trucco, et al., 2007). Research also suggests a relationship between treatment satisfaction, treatment engagement, and positive treatment outcomes (Hawkins, Baer, Kivlahan, 2008; Simpson, Joe, Rowan-Szal, & Greener, 1995), and in a study by Greenfield, Trucco, et al. (2007), women reported higher levels of treatment satisfaction in all-female groups when compared with women's reports from mixed-gender groups. Initial reports of gender-specific treatment suggest its effectiveness in addressing problems more common to women with SUD and subgroups of this population (Greenfield, Trucco, et al., 2007).

Systems

Addiction reaches beyond the user and has destructive effects on the individual's social system, particularly the family. Many women who are in treatment for substance addiction have children, hold jobs, are married and have other social obligations. Ample research indicates the negative effects that addiction has on all of those systems (Arria, Mericle, Meyers, & Winters, 2012; Barnard, 2007; Orford, Velleman, Natera, Templeton, & Copello, 2013). An estimated 100 million adults worldwide are affected by a family member's substance abuse (Orford, et al., 2013). Research indicates that affected family members experience severe stress, and increased incidence of psychological and physical problems as a result of having an addicted family member or loved

one (Barnard, 2007). Roth (2010) emphasized that addiction is a family disease and suggests the need for all family members to heal following the impact of addiction. Further evidence indicates that the presence of emotional stress and conflict in personal relationships may impede recovery (Harris, Fallot, & Berley, 2005), which supports the notion that a relationship exists between addicts' health and their family's health, or lack thereof.

Evidence continues to show that parental drug problems have a large impact on the wellbeing of their children. Children whose parents abuse substances have an increased risk for developing SUD themselves and may also have an increased incidence of conduct, behavioral and education problems (Arria, et al., 2012; Barnard, 2007; Seay & Kohl, 2015). Additionally, over half of the women who enter treatment for SUD have had contact with child welfare services, a higher percentage of contact than families without substance abuse, which suggests the safety and well-being of children whose parents are addicted to substances may be compromised (Barnard, 2007; Greenfield, Back, et al., 2010; Seay & Kohl, 2015). Children of parents with SUD suggest that parental impairment decreases the likelihood for positive parenting behaviors, such as effort, confiding, and understanding, behaviors that, when present, are correlated with decreased risk of developing SUD for children of parents with addiction (Arria, et al., 2012). However, treatment seems to encourage improvements in maternal parenting for mothers with SUD (Luthar, Suchman, & Altomare, 2007).

Motherhood plays a large role in addiction, treatment, and recovery. Research shows that being a mother increases a woman's likelihood of entering treatment and remaining sober in recovery. However, according to Heil et al. (2011), opioid-abusing women become pregnant more than the general population and their study found that in opioid-abusing women 86% of pregnancies were unintended as compared with 31-47% in the general population, which indicates that substance abusing women might not be prepared for motherhood when it occurs. Additionally, the need for childcare can be a deterring factor in women entering treatment (Nelson-Zlupko, Kauffman, & Dore, 1995). However, more research shows that pregnancy is a contributing factor to achieving sobriety (Nelson-Zlupko, et al., 1995) and that women with SUD view children as a motivation for change (Kruk & Banga, 2011).

While the occurrence of substance abuse has the potential to negatively impact affected family members, a supportive social system is shown to have a positive impact on addiction treatment outcomes and sustained recovery for women with SUD. Healthy, caring relationships have been found to provide important supports for sustained recovery (Harris, et al., 2005). Trucco, Connery, Griffin, and Greenfield (2007) found that married addicts had significantly higher levels of self-efficacy at baseline than unmarried counterparts. High self-efficacy levels indicate a decreased likelihood of relapse after treatment. On the contrary, married participants reported lower levels of self-esteem than unmarried participants. The researchers indicated that this points to couples' tendency to

have similar drinking patterns, which can perpetuate addictive cycles. Outcomes from similar studies agree that partner substance use patterns to be predicative of women's substance use patterns (Salomon, Bassuk, & Huntington, 2002). Literature suggests the importance of treatment that emphasizes boundary management and other relationship skills for women with SUD (Harris, et al., 2005).

Ample evidence suggests a relationship between traumatic experiences and substance misuse, particularly in women (Greenfield, Back, et al., 2010; Matheson, et al., 2015). Research suggests a strong association between women's dysfunctional family background and interpersonal violence and the development of SUD and other mental illness (Matheson, et al., 2015; Shand, et al., 2011), and women with SUD report traumatic experiences such as intimate partner violence, sexual assault, childhood abuse, etc., as motivating factors in the development of SUD (Salomon, et al., 2002).

Reports estimate that 55-99% of substance-abusing women have experienced physical or sexual abuse and women in treatment for SUD often present with symptoms of PTSD, if not a dual diagnosis of PTSD and SUD (Greenfield, Back, et al., 2010). Exposure to traumatic experiences such as interpersonal violence leaves physical and emotional scars, which can cause the woman's sense of self and identity to erode and inhibit sustained recovery by perpetuating substance misuse (Greenfield, Cummings, et al., 2010; Matheson, et al., 2015; Salomon, et al., 2002). Research agrees that when an individual

develops SUD in response to unresolved trauma, recovery may likely be stymied until the individual reconstructs her identity and integrates dissociated and fragmented emotions, sensations, and memories of the traumatic experience (Matheson, et al., 2015; Punkanen, 2010; Salomon, et al., 2002). Therefore, addiction treatment must address and enable women to deal with underlying issues brought by residual trauma.

Music Therapy and Addictions

Substance use disorder is a complicated process and treatment must target the individual needs of each client, a concept that is inherent to music therapy (AMTA, 2013). Music therapy is an effective non-threatening modality in multidisciplinary substance abuse treatment due to the potential for music to address multiple systems at once (Dijkstra & Hakvoort, 2010; Punkanen, 2010).

Research examining the use of music therapy in the addictions and recovery process is increasing. Music therapy has been used as a treatment for substance abuse with adolescents, adults, individuals in prison, and in conjunction with mental health treatment for over 40 years (Silverman, 2003). Substance use disorder is often comorbid with other mental health diagnoses (Sanchez et al., 2015). Music therapy aids individuals with mental health disorders in personal and social recovery, particularly in terms of social support, communication, emotional expression, and positive self-identity (AMTA, 2013; Solli, Rolvsjord, & Borg, 2013). Mental health is rather well-represented in the music therapy literature and individuals with addiction often take part in larger

mental health studies. However, substantially less music therapy research examines the use of music therapy for individuals with addictions exclusively (Silverman, 2003).

Early literature presents case studies of music therapy treatment in addiction programs, namely outpatient groups. Still, a foundation of literature was built indicating the successful use of music therapy in substance abuse treatment. Miller (1970) was the first to write directly of using music therapy interventions for substance abuse treatment and discussed the use of “instant music” to engage hesitant members in the group process. Others also found that music therapy supported engagement in the treatment process and also encouraged more feelings, aided in developing coping skills, and increased communication for individuals with substance abuse (Brooks, 1973; Dougherty, 1984; Wheeler, 1985).

Music therapists work in all levels of substance abuse treatment from detox to short-term and long-term inpatient and outpatient programs (Silverman, 2009a). Each phase of treatment may bring unique treatment needs and therapeutic foci. Borling (2011) identifies three foundational levels in substance abuse treatment that music therapists can address: physical, emotional, and spiritual.

Physical needs surface almost immediately upon entering recovery, as individuals with SUD often must stop regular use of their substance of choice and go through a physical detoxification, referred to as detox (Borling, 2011). The

individual may feel uncomfortable physical and psychological effects as they withdrawal from using substances. During detox, music therapy can address the bio-physical symptoms associated with withdrawal including irritability, anxiety, fever, muscle pain, insomnia, and nausea. Additionally, high levels of treatment eagerness and therapeutic working alliance during detox are important factors in future treatment success that music therapy has been used to support (Silverman, 2009b; 2011). Music therapists report using music-assisted relaxation, physical movement to music, active music making (drumming), lyric analysis, and music games during withdrawal (Borling, 2011; Silverman, 2009b; 2011). Significant differences in effectiveness have not been found between specific interventions, such as recreational music therapy and a “rockumentary” music therapy intervention, but research indicates that these two interventions, group songwriting, and lyric analysis are as effective or more effective than other treatment methods used during detox (Silverman, 2009b; 2011; 2012).

Emotional recovery, which often begins following detox, is essential for long-term recovery from substance abuse (Borling, 2011). Psycho-emotional issues that were driven or hidden by substance abuse may begin to emerge and will need to be addressed, possibly for the first time. After detox, music therapy may be used to address social and relational needs that influence emotional health including increased autonomy and control, emotional well-being, personal empowerment, and healthy decision making, increased emotional maturity, self-esteem, and self-expression and development of support systems. Music

therapists frequently use lyric analysis and discussion, songwriting, guided imagery, improvisation, and music assisted relaxation to meet psycho-emotional needs in addiction treatment (Borling, 2011; Jones, 2005; Silverman, 2009a).

Music therapy is well-suited to address spiritual needs across a variety of populations (Aldridge, 1995), including individuals with SUD (Borling, 2011; Walker, 1995). Some successful addiction recovery programs, such as Alcoholics Anonymous and Narcotics Anonymous are built on the spiritual foundation of recovery (Borling, 2011; Mustain & Helminiak, 2015). Alcoholics and Narcotics Anonymous regard belief in a Higher Power (HP) as a prerequisite for recovery and music therapists who treat addictions most frequently work in facilities that use the 12 Step Model (Borling, 2011; Silverman, 2009a). Many individuals with addiction and mental health professionals find the idea of a HP controversial, while others draw loose interpretations for personal growth from the concept. Regardless of the specific treatment ideology, healing the spirit and psyche is necessary for recovery from substance abuse (Borling, 2011).

Mustain and Helminiak (2015) identify three factors that they see as necessary for reintegrating the psyche for substance abuse recovery: reestablishing a sense of self, developing a sense of connectedness with others, and developing the ability to regulate emotions. Borling (2011) notes that spiritual recovery resides in a personal meaning that may be felt, experienced, and/or acknowledged throughout one's whole being. Nearly all literature previously

mentioned gives evidence that music therapy is a particularly well-suited treatment medium to aid in spiritual reintegration as the field defines it.

As evidenced above, music therapy is effectively used across the span of the entire substance abuse treatment process (Borling, 2011; Silverman, 2009a), which makes it a particularly valuable therapy for treating individuals with SUD. While more literature is needed to indicate if certain interventions or approaches are more effective than others, a base of literature indicating that music therapy is a useful treatment for individuals with SUD has been established. However, as indicated previously, addictions research suggests that different subsets of the substance abuse population may benefit from different approaches to treatment (Greenfield, Back, et al., 2010) and similarly, the music therapy approach utilized by the therapist will likely impact the outcomes of music therapy treatment. Although a few studies discuss the influence of the specific music therapy treatment approach on outcomes (Albornoz, 2010; Baker, Gleadhill, & Dingle, 2007; Ghetti, 2004; Lesiuk, 2010), further understanding of how different music therapy approaches impact outcomes for individuals with SUD is needed.

Humanistic Music Therapy. Music therapists who work with consumers in substance abuse rehabilitation report using Humanistic Music Therapy techniques (Silverman, 2009a) and case descriptions suggest this approach is well-suited for treating individuals with SUD (Pickett, 1991). The Humanistic Music Therapy approach emerged from humanistic psychology, which is concerned with the uniquely human constructs related to well-being, meaning

and value including “being, selfhood, hope, self-esteem, love, creativity, individuality, and authenticity” (Abrams, 2015, p. 149). Self-actualization through expression of musical potential is the primary goal of Humanistic Music Therapy, which is encouraged through a healing, therapeutic relationship and environment. Addictions literature supports the notion that sustained recovery is achieved through positive changes in self-perception and awareness (Kearney, 1998).

The humanistic therapist emphasizes empathy, unconditional positive regard, and congruence (transparency), in her therapeutic approach. In a survey of music therapists who work in substance abuse rehabilitation, respondents reported that empathy was the therapeutic technique they used most prevalently (Silverman, 2009a). Humanistic Music Therapy is concerned with the relationship between humanistic processes (being, holism, agency (determinism), and relationship) and the elements of music therapy (the clients, music, therapy goals, and therapy processes) (Abrams, 2015) and attempts to emphasize the client’s strengths and healthy tendencies, which is important, because internal strengths are the basis for self-help and encourage sustained recovery from addictions (Fearday & Cape, 2004). Spiritual transcendence may occur as a result of the self-actualization process, which is inherent to music therapy practice and evidence indicates the supporting role of spirituality in recovery from SUD (Borling, 2011; Fallot & Heckman, 2005).

Elements of Humanistic Music Therapy occur throughout practice and all music therapy interventions can be employed in Humanistic Music Therapy, given the underlying goal is ultimately self-actualization through ways of being in music. In Humanistic Music Therapy, interventions are not isolated, but understood together within the larger context of the client's whole being, and in the case of group work, within the larger context of the group as it exists in that moment. From this perspective, evidence-based approach is "about understanding the best ways to support clients in actualizing their agency, given certain musical opportunities, in the context of who they are" (Abrams, 2011).

One piece of literature presents a humanistic view of music therapy for the treatment of substance abuse. Pickett (1991) discusses her experience of using the Bonny Method of Guided Imagery in Music with a woman with dual depression and addiction diagnoses. The humanistic approach informs her practice as evidenced by the case study's emphasis on self-exploration and developing a therapeutic alliance, and references to empathy, holistic assessment, and music as a container to move through states of consciousness and difficult issues.

Engagement in treatment. High levels of treatment engagement are associated with positive treatment outcomes, well-established therapeutic relationships, and treatment completion (Simpson, et al., 1995; Simpson & Joe, 2004). Individuals with SUD indicate high levels of engagement in music therapy treatment and indicate a link between music therapy and increased engagement

in substance abuse treatment overall (Dingle, Gleadhill, & Baker, 2008; Dougherty, 1984; Gallagher & Steele, 2002; Miller, 1970; Wheeler, 1985). These reports suggest that music therapy treatment was an important part of sustained recovery for individuals with SUD.

Dingle et al. (2008) studied the effectiveness of cognitive behavioral music therapy in engaging patients in treatment on a detox and acute treatment unit. Researchers utilized lyric analysis, songwriting, instrument improvisation, and song singing/listening in the 90-minute music therapy sessions. Motivation to participate and enjoyment levels were measured and patient responses were uniformly high for both measures. The vast majority of patients reported they would attend music therapy again and feeling part of the group was the most commonly cited reason patients would return to group. This is notable, because treatment motivation is considered a determining factor in treatment outcomes and sustained recovery from addiction (Simpson, et al., 1995). Additionally, individuals with SUD indicate that isolation or lack of connection with others are contributing factors in substance misuse (Harris, et al., 2005).

Silverman (2012) explored the impact of a single-session group songwriting intervention on motivation and treatment readiness for individuals with SUD on a detoxification unit. The results indicated that after one group songwriting session, the participants in the experimental group were significantly more motivated and ready for treatment than participants in the wait-list control

group. A content analysis of the composed song lyrics indicated themes concerning action, feelings and emotions, and change.

These two studies confirm that music therapy treatment as a whole has the unique capacity to encourage treatment motivation and engagement in substance abuse treatment.

Music therapy, mood, and emotion. Music has the ability to alter mood and emotional states in a variety of ways, a connection to substances that should not be overlooked. Women with SUD report using substances to avoid negative emotions such as stress, anxiety and depression or despair (Corcoran & Corcoran, 2001; Harris, et al., 2005; Langan & Pelissier, 2001). Studies indicate that music therapy has the capacity to elevate mood in individuals with substance abuse disorder (Baker, et al., 2007; Van Stone, 1973; Walker, 1995). Van Stone (1973) noted that music was able to provide positive feelings similar to those produced by drugs and alcohol without the use of substances. Music therapy has also been shown to decrease depression (Albornoz, 2011), stress and anxiety (Hammer, 1996), guilt and fear, and to increase acceptance and joy for individuals in substance abuse treatment (Jones, 2005).

Baker et al. (2007) examined the exploration of emotions in music therapy and found that 87% of group music therapy participants had previously used music to regulate mood. Lyric analysis, songwriting, improvisation, and song singing/listening facilitated the experiencing of a moderate to high degree of positive emotions, namely happiness, after one session. Other patients reported

exploring negative emotions in the session and the researchers encouraged future music therapists to allow patients to explore negative emotions in the safe space of treatment. The study illuminated that music therapy is useful in exploring emotions in a healthy way, without the need for substances.

Interpersonal relationships. Substance abuse has detrimental effects on individuals with SUD's interpersonal relationships (Orford, et al., 2013) and the quality of those personal relationships may impact treatment and recovery outcomes (Harris, et al., 2005). Hedigan (2010) conducted a phenomenological inquiry to examine the experience of group music therapy for adults in treatment with SUD, with particular attention paid to relational authenticity and verbal processing. Grocke (1999) notes that phenomenological inquiry is particularly well-suited to capture the nuances of music therapy processes, as it illuminates complex and mysterious elements of existence, of which, music is one (as cited in Hedigan, 2010). In depth, semi-structured interviews with eight music therapy participants yielded six major themes indicating participants experienced intimate, honest, interactions with others and increased understanding of the self and others as a result of music therapy treatment. In addition, the participants indicated that, while improvisation was challenging and confronting, music therapy was enjoyable, fun, and increasingly comfortable over time. This study concludes that music therapy has lasting effects outside of the duration of therapy, which deserves more attention in further research, because generalization outside of the therapeutic setting is crucial for lasting change that

allows individuals with SUD to reach their full potential, which is the ultimate definition of recovery (SAMHSA, 2015).

Music Therapy and Women with Addictions

Women with addictions face unique challenges for recovery due to biological, cultural, societal, and systemic factors. Literature shows that music therapy provides a highly personal treatment that has been shown to be useful in helping individuals with addiction recover physically, emotionally, and spiritually. Few studies have been conducted that examine the use of music therapy for women with addictions; however, these studies are increasing and indicate that music therapy is indeed useful for women in treatment for substance abuse (Cevasco, et al., 2005; Gardstrom & Diestelkamp, 2013; Gardstrom, et al., 2016; Silverman, 2003).

Music therapy for negative emotions. Cevasco et al. (2005) measured the effects of three music therapy interventions (movement-to-music, rhythmic activities, and competitive games) on depression, stress, anxiety, and anger in participants enrolled in an all-female outpatient substance abuse treatment program. The researchers found no significant differences in dependent levels among music therapy interventions, but a number of participants reported decreased depression, stress, anxiety and anger levels immediately following music therapy sessions. Regardless of the intervention used, music therapy decreased negative feelings for participants who had high levels to begin with. Cevasco, et al. call for future research to identify additional techniques that

address depression, anxiety, stress, and anger and to help determine the stage of rehabilitation in which music therapy treatment is most beneficial for women with addictions.

Women report anxiety and depression as a trigger for substance use or relapse more frequently than do men. Gardstrom and Diestelkamp (2013) conducted a quasi-experimental study at an all-female residential facility to determine if music therapy could reduce anxiety. Music therapy consisted of Bruscia's four music therapy methods: composition, receptive methods (listening), instrumental and vocal improvisation, and recreation of pre-existing music (performing). The vast majority of music therapy participants who reported pre-session anxiety indicated a decrease in post-session anxiety; however, the authors note that a lack of a control group or isolated interventions prevent them from suggesting a causal relationship between music therapy and decreased anxiety.

The authors used a decision tree model to select session content based on the women's immediate clinical needs rather than conducting a randomized control trial to isolate specific interventions. This allowed for the session to unfold more authentically and a more humanistic delivery of quality services, which the researchers felt was important.

Music therapy as an effective and useful treatment. Silverman (2003) was the first to publish a music therapy study with an all-female treatment group and examined perceived enjoyment and effectiveness of four different music

therapy interventions for women in in-patient substance abuse rehabilitation. The researcher compared music games (rock-and-roll bingo), relaxation training (music and imagery and music and movement), lyric analysis (“Desperado” and “That’s Why I’m Here”), and songwriting (rewriting preexisting and creating original songs) and found no significant difference between interventions. However, ratings for enjoyment and effectiveness were high across all interventions. Of all research concerning women with SUD and music therapy, this was the only study completed by a male therapist/researcher.

The study also examined how music therapy addressed treatment in the context of 19 other treatment groups (Silverman, 2003). Participants reported that music therapy helped address specific treatment areas more consistently than other groups and half of the participants rated music therapy as the most enjoyable and therapeutically effective group of all. A number of participants reported music therapy was the most effective treatment in decreasing impulsivity. Silverman recommends future researchers to explore the relationship between music therapy and decreased impulsivity and acknowledges a general need for more quantitative data regarding effective music therapy interventions for individuals with substance addiction.

Understanding what women with addictions experience in music therapy is crucial for developing effective clinical practice. Gardstrom, et al. (2016) examined the group music therapy process to understand what women with addictions perceive as useful for recovery. Sessions were conducted at a

residential treatment facility for women with addictions, primarily heroin. Three of Bruscia's four music therapy methods were used in sessions (receptive methods, instrumental and vocal improvisation, and music recreation) and participants were invited to write or describe anything from each session that was useful toward their ongoing recovery. Responses were analyzed for content and the researchers noted that emergent themes were similar to Yalom's notions of therapeutic factors that effect change (Altruism, Group Cohesiveness, Universality, Catharsis, Self-Understanding, Instillation of Hope, and Existential Factors).

Patient responses indicated that overall, music therapy was perceived as a useful treatment modality. Yalom's themes that correlated with the most common effective music therapy treatment themes were catharsis, self-understanding, group cohesiveness, and instillation of hope. Additionally, aspects of music therapy patients identified as useful that did not relate to the group process were intrapersonal in nature; participants reported that music therapy facilitated desired changes in mood state, energy, sense of self, and level of enjoyment.

Research consistently indicates that music therapy is useful in treating women with addictions, but has not successfully created evidence for the use of one intervention over another. Gardstrom and Diestelkamp (2013) acknowledge the benefit of empirical evidence in music therapy, but suggest it is important to build a stronger foundation of effective clinical practice for this population. The

authors suggest that future qualitative research in this area will help answer questions regarding the experience of music therapy as related to specific problems women face in recovery from SUD. Gardstrom and Diestelkamp (2013) also argue for conducting individual and group interviews to more completely understand women with addictions' idiosyncratic responses to music therapy. They suggest that having a better understanding of the women's lived experiences of music therapy treatment will enable music therapists to implement more meaningful interventions that will allow women to tap into personal resources for recovery. Upon a stronger clinical understanding, comparisons between music therapy interventions and treatment practices can be studied more effectively and evidence of true best practices may begin to emerge.

Music therapy is a useful treatment in helping to decrease negative symptoms that put women at risk for relapse or prolonged substance abuse (Cevasco et al., 2005; Gardstrom & Diestelkamp, 2013) and encourages positive emotions that contribute to positive treatment outcomes and well-being (Gardstrom, et al., 2016; Silverman, 2003). A number of music therapy interventions have been studied independently with encouraging results, however, none have emerged as significantly different from another in terms of effectiveness (Cevasco et al., 2005; Silverman, 2003). Case studies and qualitative inquiries yield equally affirming accounts of the music therapy experience, but little literature has addressed what it is about music therapy treatment that makes it such a positive experience for women with addictions.

Music therapy researchers present a need to hear the women's perspective of group music therapy treatment. This research will further investigate the personal narrative of women with addictions in music therapy and results will provide insight into the experience of group music therapy treatment for women in inpatient treatment for SUD.

Chapter 3: Method

This phenomenological research examined the experiences of women with addictions after participating in group music therapy treatment. I provided nine twice-weekly music therapy sessions over five weeks at an inpatient facility for women with addictions. After the treatment sequence, I conducted individual interviews with 11 participants who attended three or more of the sessions. Interview participants were invited to discuss their experiences in music therapy. I chose three interviews to transcribe and analyze for content. The individual and collective essences of the experience of music therapy are presented in the results.

Phenomenological Inquiry

Phenomenological inquiry is an interpretivist research methodology that explores the nature of a phenomenon through first person experiences in an attempt to understand the phenomenon as the subject experienced it (Jackson, 2016). Phenomenological philosophy is founded on the works of Husserl, Kant, Giorgi, and Moustakas and assumes that meaning is created through individual interpretations of phenomena (Creswell, 2014; Moustakas, 1994).

I used essential phenomenology to extract the true nature of group music therapy as experienced by women in treatment for drug addiction (Jackson, 2016). Essential phenomenology collects the lived experiences of multiple individuals and compares them to extract the implicit structures of a given phenomenon. This research attempted to articulate how the women at RWRP

experienced and made meaning of the group music therapy sessions they experienced.

Facility Description

I conducted this research at the Rural Women's Recovery Program (RWRP), a residential treatment facility for women with addictions. The facility is located in rural Appalachia, just outside of Athens, Ohio and houses up to 16 women at a time. RWRP operates under Health Recovery Services, Inc. (HRS), an addiction treatment organization with inpatient and/or outpatient services in five Ohio counties. The facility treats women from all over Ohio and neighboring states, although the majority of consumers at RWRP are from rural communities in Southeast Ohio. Children under the age of five are permitted to live at the facility with their mothers.

The average length of stay in the program is three months. The majority of consumers at RWRP are court ordered to treatment, some ordered by Child Protective Services, and a small number enter treatment voluntarily. Some consumers choose to leave treatment prior to completing the program; of those who complete the program, the majority are discharged to their home. RWRP is a stabilization program and recommends that consumers enter a longer-term transitional living facility upon completion and those who are court ordered to follow recommendations will pursue further programming. Consumers who live in the five counties where HRS provides services may pursue outpatient services,

however, no further services are required or guaranteed upon completing the program.

RWRP sits at the top of a hill in the country and the facility resembles a log cabin with raftered ceilings, many large windows, and garden spaces on the property. The house includes consumers' living spaces as well as staff offices and a large group space. RWRP emphasizes holistic health and incorporates practices such as healthy eating, outdoor walks, meditation, tapping, and physical exercise into more traditional services, based on an adapted 12 Step program.

Participants

A consistent cohort of 16 women with addictions participated in music therapy treatment sessions. According to a case manager at RWRP, all group members met the criteria for substance use disorder (E. Nagy, personal communication, October 10, 2016). Participants most frequently sighted heroin as their primary substance of addiction, followed by methamphetamines. Group members were also in treatment for marijuana and alcohol abuse. Although RWRP treats the primary substance of abuse, the majority of participants engaged in polysubstance abuse. According to the facility staff, an estimated 85-90% of participants are dually diagnosed with other mental health disorders. Facility staff commented that it takes a few times in treatment to truly get clean, but with each admission, it gets easier to stay cleaner longer. It was unknown

how many times any of the participants in music therapy were previously in inpatient treatment SUD.

All of the women enrolled in the program at the time of the study were from Ohio and the majority were from rural communities in Southeast Ohio (as mentioned above). All participants were Caucasian and ranged in age from 18 years old to mid-40s; the average age of consumers at the facility is 33 years. At least one participant was pregnant while in treatment and all others indicated they were already mothers and two different children attended music therapy sessions with their mothers throughout the treatment.

Recruiting. Participation in the study was optional, and eligibility was based on enrollment at the facility and interest in music therapy. At the beginning of each session, I reminded the participants that they were free to participate in the music, or not participate, at any level they felt comfortable. Subjects who attended three or more of the nine music therapy sessions had the opportunity to volunteer for a semi-structured interview following treatment. I received approval from the facility and the Ohio University Institutional Review Board prior to conducting the study.

Consent. Members were asked to sign a consent form explaining the risks and benefits of participating in the study prior to joining the music therapy group (see Appendix B). Participants who chose to be interviewed signed a consent form from the facility agreeing to be audio-recorded and an additional

consent form giving me permission to use clips from audio files for educational or presentation purposes (see Appendix C).

Final participants. All 16 group members met the session attendance criteria for post-treatment interviews and 11 expressed an interest in being interviewed. Of the 11 women I interviewed, I chose interviews from three participants to transcribe and analyze. The three interviews were chosen in an attempt to get the broadest picture of experiences that was also representative of the group experience.

During the interviews, all participants were asked to briefly describe themselves and those words were used in the following descriptions of the three participants whose interviews were chosen for analysis.

Pseudonyms. I gave each interviewee the opportunity to choose a pseudonym she would like me to use when reporting the findings. The three interviewees I chose for further analysis chose the names Memory Rider, Tiffany, and Kaycee. When I gave the first participant the option to choose a pseudonym, she immediately said “Memory Rider,” explaining that nickname has been meaningful in her life. The second participant chose Tiffany, indicating that her sister with the same name had died, eluding to drugs as a contributing factor. The third participant chose the name Kaycee Kane, but she didn’t indicate if it had any personal significance to her.

Memory Rider. Memory Rider is a 35-year-old mother of four, originally from the Southern part of the United States, who recently moved to Ohio.

Memory Rider identified herself as an alcoholic and drug addict but did not specify her drug of choice. She grew up in the foster care system after her mother passed away when she was four; Memory Rider described her biological father as a bad alcoholic. Memory Rider noted that she had previously worked as a housekeeper at a hotel. She did not indicate if she had been in inpatient rehabilitation before, but did say that she has been in therapy and classes to deal with her addiction her whole life.

Memory Rider attended three practice groups and five treatment groups. She missed four groups in August while she was in the hospital for major surgery and returned to the group when she was physically capable, although she indicated that she was still in a lot of pain from the surgery. Memory Rider had been at the facility for two months and two weeks at the time of her interview. A month after I completed the interviews, I attempted to set up a meeting with Memory Rider for member checking and the facility reported that she left the program before completing treatment two weeks after the final music therapy session. Her interview recording lasted 30 minutes.

Tiffany. Tiffany is a 31-year-old mother of three from a large city in Ohio. She identified herself as a heroin and crack addict and made reference to alcohol and marijuana use during her interview. Tiffany noted growing up around drug users and thinking it was “normal.” She was the victim of a human trafficking experience, which she cited as her introduction to crack and heroin and the catalyst for her own drug addiction. Tiffany said she was homeless for a number

of years after she was trafficked. When I met Tiffany, she was completing her fourth rehab experience and at the time of her interview, she had been at the facility for three months and one week.

Tiffany attended all nine music therapy treatment sessions and the three practice sessions. She was the first of the group to complete the program after music therapy finished and left four days after the final music therapy session. Her interview recording lasted 48 minutes.

Kaycee Kane. Kaycee Kane is a 40-year-old mother of three teenagers from rural Ohio. She stated alcoholism as her reason for being in treatment but also referenced getting clean from crack and meth nine years ago. Kaycee Kane mentioned working in an assisted living facility and taking care of her teenage daughter who has paraplegia. Kaycee emphasized that music has always been a huge part of her life and referenced playing music with friends outside of rehab. Kaycee recently finished her bachelor's degree in Social Sciences and Women and Gender Studies and plans to get her master's degree when she completes the program. She ultimately wants to be a substance abuse counselor, or work with adolescents. Kaycee also mentioned being homeless and having been arrested in the past.

Kaycee attended all nine treatment sessions and at the time of her interview, she had been in the program for one month and two weeks. Kaycee completed the program five weeks after the last music therapy group. Her interview recording lasted 48 minutes.

Other personnel. At least two case managers were present in the therapy room during all music therapy sessions. An undergraduate research assistant helped transport musical instruments and attended most sessions.

Therapy Environment

Most music therapy sessions were conducted in a group therapy room on the ground floor of the facility where all other large groups and classes take place. Participants sat on couches and chairs forming a large oval and all musical instruments were placed on the floor in the middle of the circle. I sat as a part of the circle near the door and the other case managers sat off to the side along the wall.

The therapy room had two doors that remained closed during the groups, but were not locked. Staff sometimes pulled participants out of group for individual therapy appointments. Occasionally, noise pollution from the kitchen would enter the space at the end of the session. At the participants' request, one session took place in a secluded garden area on the facility grounds.

I conducted interviews in a case manager's private office in the basement of the facility. Office doors locked automatically and were located in secluded parts of the facility. It is unknown whether or not offices are sound-proofed; participants' individual counseling sessions take place in case managers' private offices and participants appeared comfortable disclosing private and sensitive information during music therapy interviews.

Procedure

Music therapy researcher. I am a Caucasian female in my mid-late 20's from rural Ohio and board-certified music therapist. I have lived in the Athens community for the better part of eight years. I have previous experience working with adults with addictions and completed a pilot music therapy project at RWRP over a year ago. I conducted all music therapy groups and interviews alone.

Intervention delivery. I led a total of 12 music therapy sessions over seven weeks; three of the sessions qualified as practice sessions and the remaining nine were considered treatment sessions for the research project. However, I did not make the distinction between practice and treatment sessions clear to the participants and all three chosen interviewees were present during practice sessions as well as treatment session.

The research study consisted of nine twice-weekly 60-90-minute group music therapy sessions over five weeks. This timeline roughly correlates with the standard 28-day treatment cycle for addictions, although residents live in this particular facility for approximately three months. Generally, all 16 enrolled participants would attend the group and throughout the session, attendance would decrease to 12-13 participants as individuals left for other appointments.

Music therapy protocol. Treatment philosophy and session content are discussed below.

Treatment philosophy. I primarily drew from Humanistic Music Therapy, as I felt its approach to music therapy most adequately met the needs of the

group. The substance abuse literature suggests an emphasis on healthy relationship skills, reintegrated and strengthened sense of self, and improved connection with others as treatment goals for women with SUD (Harris, et al., 2005; Kearney, 1998; Mustain & Helminiak, 2015). These goals mirror the therapeutic intent intrinsic to Humanistic Music Therapy: self-actualization through musical expression of human potential with emphasis on holistic understanding of the self and agency, which is, essentially, empowerment (Abrams, 2015).

Feminist music therapy also influenced my treatment philosophy. Greenfield, Back, et al. (2010) suggest that gender-specific treatment is most useful in addressing the issues women face that are uniquely female. In this work, I was aware of the potential impact of oppressive individuals or systems on the women's lives and addictions and provided opportunities in the music for the women to feel empowered because of, not in spite of, their gender. I was deliberate in choosing music that did not further contribute to systemic oppression, which is essential to Feminist Music Therapy practice (Adrienne, 2006) and provided alternatives with supportive lyrics and intent. The other Feminist notion I employed was that of an egalitarian relationship between myself and the women (Curtis, 2006), which further strengthened the therapeutic alliance necessary for lasting change through self-actualization in Humanistic Music Therapy practice (Abrams, 2015).

Ultimately, I attempted not to bring in any certain agenda to the sessions, other than to support the women and to let their music speak for itself and guide them in their recovery journey. The women frequently chose to engage in active music making themselves, which made the music even more significant in the therapeutic process toward self-actualization and empowerment.

Instruments and materials. I took as many different rhythm instruments to the sessions as I could access, so the participants could express themselves as freely as possible through music. I brought the following rhythmic instruments to each session: large and medium tubanos and djembes, a buffalo drum, egg shakers, small plastic maracas, open-tambourines, finger cymbals, a ratchet, plastic rainsticks, a wooden stir xylophone, an African seed rattle, triangles, wooden kokorikos, wooden rhythm sticks, wooden guiros, plastic castanets, small cabasas, and multipurpose mallets. I brought the following melodic instruments (in the key of C major, where applicable): chromatic choir chimes, diatonic resonator bells, a mini HAPI drum, a pentatonic xylophone, a kalimba (African thumb piano). Recorded music was delivered through a Bose SoundLink Mini Bluetooth speaker and iPhone.

Music selection. I pre-selected music for the first session based on my previous experience working with women with SUD. During the first practice session, participants completed a musical preferences and experiences survey (see Appendix D). I considered the participants' responses when selecting additional music to bring to the sessions. After the participants experienced a

number of different music therapy interventions, they began to request certain songs or interventions.

Music used in sessions. The music used in sessions included pre-composed popular music and pre-composed chants, and client-created improvised music.

Pre-composed music. On few occasions, I used my guitar to performed pre-composed music for the participants. Examples include “I am Light” by India.Arie and “The Buddhist Blessing,” a Buddhist prayer set to music by Dr. Joni Milgram-Luterman. I taught a number of Afro-Caribbean and West African drum patterns and folk songs by rote; as one example, the women learned to play Nyabinghi, a Rastafarian rhythm from Jamaica, which we played together while singing “Thank You for This Day Spirit,” by Karen Drucker.

Improvised music. The participants and I created a large amount of the music used in the sessions through both referential improvisation, which represents something other than the music itself, and nonreferential improvisation, during which the music stands for itself without depicting anything else (Bruscia, 1989).

Intervention strategies. Session content included a variety of music therapy interventions: instrumental and vocal improvisation, therapeutic singing, music-assisted relaxation, active music making, hand drum instruction, musical games, musical storytelling, and music recording. Common treatment goals for this population include increased self-expression, mood elevation, decreased

anxiety, development of coping skills and communication (Cevasco et al., 2005; Silverman, 2009a). Twice, the case manager met me outside before the session to inform me of group conflict occurring outside of music therapy with the potential to come out in the group. Therefore, group cohesion was an additional treatment aim.

A typical group consisted of an assessment check-in, a small “warm up” intervention, two substantial, interactive interventions, music-assisted relaxation, a brief closing statement or check-out, before ending with group singing. However, sessions were fluid to meet the needs of the group any given day. Murphy (2015) encourages music therapists working with individuals with SUD to always ask: “What does the client need from the music today?” (p. 355). Although most sessions followed a similar format to the one described below, during some sessions, the women needed something completely different and so that is what we did.

Generally, I started each session with a way to assess the needs of the group and individuals that day and the changes in the group dynamics that had occurred since the previous session. This varied from asking the women to self-report pain and anxiety to a giving everyone a chance to comment briefly on their current state of mind verbally or musically, such by passing around and playing a drum.

As I mentioned previously, I gave the women ample freedom to decide what they wanted to do or felt they needed from the sessions. Often, after the

check-in, the group engaged in a short intervention designed to guide the women from their pre-group reality to a more ready and open mentality. These interventions ranged from musical games to toning and usually lasted 5-7 minutes.

Instrumental improvisation. Generally, after a short, active intervention, the women were ready for more demanding groupwork. Often, especially after the women were familiar with how to play all of the instruments, the women would choose to improvise at this point in the session. I tailored suggestions for improvisation to the energy or needs of the day as the women expressed them at the beginning. A typical prompt for a nonreferential improvisation was, "Feel free to choose an instrument that resonates with you today. You can change instruments at any time throughout. Remember, there is no right or wrong and whatever you have today is enough." When all group members had chosen an instrument, I would simply say, "Let's play" and wait for a group member to break the silence. As the women became more familiar with the process, improvisations would consistently last 12-15 minutes and come to a natural end without facilitation on my part. I generally opened up a discussion about the music with "What do you think?" and sometimes the women processed the improvisation amongst themselves at length, while other days, they let the improvisation speak for itself and indicated they wanted to keep making music, whether through additional improvisation, or more structured drumming and singing.

Hand drum instruction and audio recording. A typical group continued with more active music making; often, the women requested we practice and learn more rhythms on hand drums. Ultimately, the group learned three one-part rhythms and one two-part rhythm, which allowed the group to split and play two complimentary rhythms simultaneously. I taught all rhythms by rote and suggested adaptations or simplifications in the moment for any women who were struggling to coordinate their hands, which was common, especially early on. The women also shared ideas for successful playing with those around them as they saw a need. At the women's request, I made an audio recording of the entire last session, during which the women performed all of the rhythms and songs they learned during the treatment sequence. I made a copy of the recording for each participant and gave it to her as a parting resource.

Music assisted relaxation. Most sessions, music-assisted relaxation was the penultimate intervention and the women were adamant in their desire to relax at the end of each session. I improvised music in 4/4 time on a mini HAPI drum (steel tongue drum) tuned to C major pentatonic. I improvised a meditation script each session based on the content of the session up to that point, or the needs the group expressed. The meditation scripts focused heavily on diaphragmatic (deep) breathing, released muscle tension, and being present in the relaxation experience with frequent reminders to "listen to the tones of the drum" as an alternative to mental distraction. At the participants' request, I recorded a

meditation as a resource that was very similar to those I did in the groups; the recorded improvised music was approximately 76 beats per minute.

Therapeutic singing. Again, the women requested that we closed each session by singing an adapted version of “Human am I,” “Woman am I.” The group stood in a circle and sang it *a cappella*; I encouraged participants to close their eyes and take big breaths from time to time, which added to the volume and resonance within the circle. Finally, I facilitated one, large inhale and audible exhale together to close the group for the day. If it felt appropriate during the transition between the music-assisted relaxation and therapeutic singing, I would reassess the group with a brief “check-out,” such as self-reported pain and anxiety or “a word or phrase to describe what you’re taking from the group today.”

Treatment fidelity. I received supervision from two university faculty members during the practice sessions, which informed and improved my clinical decision making for the treatment sessions. I consulted with the case manager multiple times to ensure the facility received the music therapy content and delivery as useful and appropriate. After each session, I engaged in extensive journaling to reflect on and monitor my own intervention delivery.

Data Collection and Data Analysis

I immersed myself in established phenomenological thematic analysis methods and examples of phenomenological research in music therapy literature prior to choosing the procedure I would use for data analysis (Brinkmann &

Kvale, 2015; Forinash & Grocke, 2005; Jackson, 2016; McFerran & Grocke, 2007; Moustakas, 1994).

McFerran and Grocke (2007) present an original model of phenomenological microanalysis that provides an in-depth exploration of the participants' perception of a music therapy experience. Clients' rich descriptions of music therapy allow the researcher to identify the phenomenon's essential features for those involved.

The phenomenological microanalysis I used had two distinct phases: analyzing individual experiences via participants' separate interview protocols and using the outcomes from the individual analyses to suggest/discover a collective essence of the group music therapy experience.

The model consists of seven discrete procedures: 1) transcribing the interview word for word, 2) identifying Key Statements, 3) creating Structural Meaning Units, 4) creating Experienced Meaning Units, 5) developing the Individual Distilled Essence, 6) identifying Collective Themes, and 7) Creating Global Meaning Units and the Final Distilled Essence. Before analysis could begin, I had to develop my *epoché*, that is, bracket out my biases and expectations, gather data through phenomenological interviews and select participant interviews for analysis.

Epoché. The *epoché* is crucial to phenomenological inquiry as it allows the researcher to assume the phenomenological attitude necessary for conducting a rigorous phenomenological analysis. To construct the *epoché*, I

became aware of and wrote down the assumptions I held about the data I would collect; in this case, I bracketed out my expectations about what the participants would say during the interviews. Doing so allowed me to consciously put aside any biases I hold so that a truer essence of the phenomenon would emerge in the next phases on analysis (Jackson, 2016; McFerran & Grocke, 2007). I

combined my biases into one paragraph, found below:

I believe participants will say music therapy is useful and meaningful. I believe interviewees will say that improvisation is a creative and safe way to express feelings. I believe the women will say that playing music helps them relate better to their emotions. I believe the participants will say they have memorable moments or favorite interventions. I believe they will say music therapy is a life-saving therapy. Finally, I believe they will say music therapy is more useful than the other groups.

At this point, I put the *epoché* aside until after I completed coding the data.

Before drawing conclusions for the individual essences of the phenomenon, I revisited the *epoché* and compared the data with my biases to ensure the data were constructed without the unconscious influence of my personal expectations.

Post-treatment interviews. My primary sources of data for the research were phenomenological interviews with members of the music therapy group. I conducted semi-structured interviews with individuals who attended three or more music therapy sessions and were interested in being interviewed. My previous pilot experiences at the facility indicated that after three sessions, most participants are comfortable enough with music therapy to participate enough to benefit. Through phenomenological analysis, the participants' individual

experiences came together to provide the final shared essence of what women with addictions experience in music therapy.

All 16 music therapy participants met the session attendance criteria for an interview; I briefly explained the interview purpose and process to the group during the 6th treatment session. After the music therapy group, I placed a piece of paper in the therapy room for anyone who would like to participate in an interview. I left the room to allow participants time to sign up or not without my presence being a determining factor. Eleven of 16 participants volunteered for an interview.

I conducted interviews with participants over three days and they lasted 15-50 minutes each. I conducted interviews in a case manager's office and only the interviewee and I were present. Prior to the interview beginning, participants gave informed consent for me to take audio recordings of the entire interview and after the interview, participants gave informed consent for me to use clips of audio files for educational purposes or at conferences.

I asked open-ended and non-leading questions to elicit details of the participants' experience in music therapy (see Appendix A for interview guide). I did extensive reading on phenomenological interviews and conducted two pilot interviews with fellow music therapy students prior to beginning interviews with participants (Brinkmann & Kvale, 2015; McFerran & Grocke, 2007). Interviews were recorded on my Zoom H4n Handy Recorder and transferred to my personal password-protected laptop for analysis.

Selecting three participant interviews for analysis. After I collected all 11 accounts of the music therapy phenomenon, I chose interviews from three participants to analyze. To extract the most authentic essence of the group music therapy phenomenon, I attempted to find the broadest perspective of the experience with only a few participants. To narrow down the participants, I first noted my initial impressions of all of the interviews as well as demographic facts about each interviewee, including age, drug(s) of choice, and length of time in treatment program. I also considered the participant's ability to articulate her unique experience of music therapy during the interview. I narrowed the interviews down to six that met the criteria for clearly articulating their experience of music therapy. I compared those six interviews on the demographic criteria and eliminated two due to similarities with other participants. I re-listened to and transcribed all four remaining interviews word-for-word to get a better sense of their whole. Ultimately, I chose three to analyze based on average consumer age at RWRP and the participants' unique experiences in music therapy.

Phenomenological microanalysis. The procedures for the microanalysis are described below in Table 1.

Table 1

Procedures for Phenomenological Microanalysis

<i>Transcribing the Interviews</i>	Interviews must be transcribed word for word.
<i>Identifying Key Statements</i>	Data is reduced to essential elements that focus on the phenomenon. Irrelevant material is discarded and long paragraphs are separated into individual statements.
<i>Creating Structural Meaning Units</i>	Structural Meaning Units are created by classifying Key Statements into concrete categories defined by physical and explicitly expressed meaning. Structural Meaning Unit titles are derived from the actual language of the interviewee and directly convey the content of the assigned statements.
<i>Creating Experienced Meaning Units</i>	Experienced Meaning Units are created by reexamining the interview and categorizing statements by implicit meaning, or the underlying experience. Experienced Meaning Unit titles are derived from the interviewee's language and provide an alternate lens through which the phenomenological researcher can view the data in further stages of microanalysis.
<i>Reviewing the Epoché</i>	After creating meaning units, the <i>epoché</i> must be revisited to ensure the meaning unit titles are not influenced by the biases the researcher acknowledged before beginning analysis. This procedure confirms the integrity of the data that emerged during the first phases of microanalysis.

Table 1: continued

<i>Developing the Individual Distilled Essence</i>	Experienced Meaning Unit titles are arranged together to create the Individual Distilled Essence of each interview protocol. The Individual Distilled Essence is a cohesive description of the core essence of the phenomenon for the individual participants. Individual Distilled Essences are returned to the participants to ensure authentic representation of their perspective.
<i>Identifying Collective and Significant Themes</i>	Collective Themes are created by comparing the Experienced Meaning Units from all participants and identifying common themes expressed by all three participants. Significant Themes are created by comparing Experienced Meaning Units from all participants and identifying the underlying themes that are represented by two of the three participants.
<i>Creating Global Meaning Units</i>	Collective and Significant Theme titles are written in the researcher's clinical language to ensure all participants' perspectives are represented. Global Meaning Units emerge from grouping similar Collective and Significant Theme titles.
<i>Developing the Final Distilled Essence</i>	Global Meaning Units are arranged to create a cohesive description of the broad concepts underlying the participants' shared lived experience of the phenomenon. This is the final result of the phenomenological microanalysis.

Reliability and Validity

I conducted a member check with one participant, Kaycee Kane. I met with her individually at the facility and gave her a copy of her Individual Distilled Essence to read. I asked her to circle anything that didn't feel or sound right, but Kaycee Kane immediately said "looks great" upon reading it and reassured me she didn't feel the need to change anything. I was unable to conduct a member check with Memory Rider and Tiffany because they were no longer enrolled in the program at the time of analysis.

Chapter 4: Results

Data Analysis

The phenomenological microanalysis yielded insight to both the individual and shared lived experiences of three women in treatment for SUD. After several attempts at analysis, I arrived at nine Structural Meaning Units and 89 Experienced Meaning Units across the three interview protocols. When I compared the individuals' Experienced Meaning Units, I identified nine Collective Themes and ten Significant Themes. The Collective and Significant Themes were reduced to four Global Meaning Units, which ultimately describe the overall essence of what these three women with substance abuse disorder experienced in group music therapy.

Results from Individual Analysis

Memory Rider. Below are the individual results from the microanalysis I conducted of Memory Rider's interview protocol.

Structural Meaning Units. I assigned eight Structural Meaning Units to Memory Rider's interview protocol. They are displayed below in Table 2.

Table 2

Memory Rider's Structural Meaning Units

Outcomes from music therapy	Using things from music therapy to cope	What it's like to be in music therapy
Recovery from drugs and alcohol	Experiences outside of music therapy – still relevant	Rehab/RWRP
Before music therapy	Group dynamics	

Experienced Meaning Units. I created 23 Experienced Meaning Units from Memory Rider's interview protocol. I listed them in order of frequency, from most to least frequently used codes, and they are displayed below in Table 3.

Table 3

Memory Rider's Experienced Meaning Units

I didn't expect all that I got out of music therapy (20)	I got a lot of healing out of it (10)	Music therapy helped me get in touch with my spirit (7)
That meditation experience was amazing and life changing (6)	The songs, I sing those songs. It helps me a lot (6)	Playing instruments relieves my stress and lessens my pain (6)
Rehab can be exhausting and difficult but music therapy helps with that (4)	Music therapy is a break; it's a time and space for something different (4)	It was a learning experience (4)
Music therapy helped me deal with complications and chaos (3)	Whatever it takes (3)	All of us are on the same page when music therapy is going on (3)
I don't have to listen to the junk I used to listen to. It's bad music for me (2)	The music reminds me of how I want my life to be (2)	We can be ourselves when music therapy is going on (2)
It's given me something I can be a part of (2)	It's like nature, music, vibration, and my spirit are all connected (2)	Other stuff just going away in music therapy (2)
I got a lot of peace inside my spirit (1)	I put all my pain into the drum (1)	I felt most connected to the music therapy after my surgery (1)
We can really be ourselves when music is going on (1)	I wanna introduce it to my kids (1)	

Memory Rider's interview was characterized largely by the healing she got out of music therapy following her major surgery. Her most frequently used code

“I didn’t expect all that I got out of music therapy” supports the differences in Memory Rider’s experience of music therapy before and after her surgery.

MR: Before the surgery, I just felt good, you know. That’s when I had the meditation experience which was *amazing!* I love it so much. I’ll never forget that. And it was just enjoyable. And just learning the instruments and seeing all that.. I just thought it was great. But after the surgery was when like, I felt the most connected to it. Because I’ve had severe anxiety, severe pain. I barely was able to walk, you know. And it’s [music therapy] just been real healing for me.

Memory Rider described how the music therapy contributed to her physical, emotional, and spiritual well-being. The songs sung during the treatment had an impact on Memory Rider and, in particular, she connected with the song messages and the vibrations from humming or singing.

MR: Well, the words in itself just reminds me of how I want my life to be. I want to be in touch with my spiritual self. I don’t want to go back to the person that I was. I don’t wanna not be in connection with the universe and things that’s going on. I’m a really good - I’ve turned into a really great person. I care about other people. I don’t want that to go away. So I wanna keep that. And so the words remind me of what I wanna be, who I wanna be. The humming is the vibration part, cuz I always remember what you said about vibration. The vibration, cuz we’re um.... our beings, what’d you say, something about our beings?

AD: I said we’re rhythmic beings.

MR: *Rhythmic* beings, yeah.

Additionally, the vibrations produced during drumming helped Memory Rider imagine her body being healed.

MR: Sometimes when we would be doing the drums when I came back after my surgery, I would just lay my chest over on the drum that I had cuz I could feel the other drums like vibrating through my chest.

Altogether, the vibrations helped Memory Rider feel connected to her spirit and the universe, which she had been struggling to reconcile early in her treatment.

MR: I had a very small mindset about this. It was mostly religion, for me. I was raised in a very strict religious background... the person that had me after my parents. So, I've had an issue with that since I've gotten sober. I've had a hard time grasping spirituality or a Higher Power for myself or something I can really go to or believe in, you know. So it's come down to just accepting the fact that I'm part of the universe and the universe is part of me and I'm one with everything and I mean, I think music has a lot to do with that. I just think it [music] really plays a role in that, the spirituality part of my life.

Reviewing the epoché. After I created Experienced Meaning Units for Memory Rider's interview protocol, I compared both the Structural Experienced Meaning Units and the Experienced Meaning Units with my *epoché*. I identified two biases that fulfilled my expectations, which are displayed in Table 4 below.

Table 4

Comparing the Epoché and Memory Rider's Analysis

Epoché Bias	Experienced Meaning Unit
I believe people will say they have memorable moments or favorite interventions	That meditation experience was amazing and life changing
I believe people will say music therapy is more useful than other groups.	Music therapy is a break; it's a time and space for something different Rehab can be exhausting and difficult but music therapy helps with that

Favorite interventions. I reviewed the original protocol to confirm that Memory Rider referenced meditation as an amazing and life-changing experience on multiple occasions. I didn't ask Memory Rider if she had a most memorable music therapy moment, as I did some other participants. Therefore, the fact that she spontaneously referred to the meditation experience so positively on multiple occasions speaks to its authentic value for her and the Experienced Meaning Unit's objectivity.

More useful than other groups. The corresponding Experienced Meaning Units relate to my epoché bias that participants will believe music therapy is more useful than other groups. However, the fact that Memory Rider doesn't say music therapy is better or worse than another group, just a break, validates the lack of bias in the analysis.

Individual Distilled Essence. I used the 23 Experienced Meaning Units to create the Individual Distilled Essence for Memory Rider's interview protocol.

Rehab can be exhausting and difficult, but music therapy helps with that. Music therapy is a break; it's a time and space for something different. Other stuff just goes away in music therapy. We fight and argue because we're in this house together all the time. But all of us are on the same page when music therapy is going on. We can be ourselves when making music together.

At this point in my life, I'm willing to try whatever it takes. I didn't expect all that I got out of music therapy. That meditation experience was amazing and life changing. Playing instruments relieves my stress and lessens my pain. I got a lot of peace inside my spirit. It's given me something I can listen to and be a part of without having to listen to the junk I used to listen to, because that's bad music for me. It was a learning experience and I want to introduce my kids to music therapy.

Music therapy helped me get in touch with my spirit. It's like nature, music, vibration, and my spirit are all connected and they're all going into one little circle thing. The music reminds me of how I want my life to be.

Music therapy helped me deal with complications and chaos after my surgery. I felt most connected to it after my surgery and it gave me an opportunity to put thought into my body being healed. I was in a lot of pain, so I just put all my pain into the drum and I sing those songs. I got a lot of healing out of it. It's helped me tremendously.

Tiffany. Below are the results from the phenomenological analysis I conducted of Tiffany's interview.

Structural Meaning Units. I assigned nine Structural Meaning Units to Tiffany's interview protocol. They are listed below in Table 5.

Table 5

Tiffany's Structural Meaning Units

Outcomes from music therapy	Using things from music therapy to cope	What it's like to be in music therapy
Recovery from drugs and alcohol	Experiences outside of music therapy – still relevant	Rehab/RWRP
Before music therapy	Group dynamics	Therapeutic relationship

Experienced Meaning Units. I created 32 Experienced Meaning Units from Tiffany's interview protocol. I listed them in order of frequency, from most to least frequently used codes and they are displayed below in Table 6.

Table 6

Tiffany's Experienced Meaning Units

Learning about myself (13)	Music helps me get closer to my Higher Power (10)	I felt that I was heard (10)
Support from others in the group (8)	Giving and receiving; sharing self with others (7)	Being brave; trying new things (7)
That's been a change since music therapy's been brought into my life (7)	Expressing myself (6)	Helpful/therapeutic (6)
We were allowed to join in however we needed to. There's no right or wrong (6)	What the music meant to me was joy (6)	Listening to the music; taking it in (6)
The music was showing me that I have potential to change my old ways (5)	Being connected to others through the music (5)	Becoming open; being open; openness (5)
I feel beautiful when I sing (4)	Beautiful (4)	I can release or soothe myself by releasing into the instruments (4)
Music therapy made the whole time at RWRP go better (4)	I can make a mistake and it's still okay; I can find my way back (4)	It felt better than familiar, like a new normal. It was a good feeling, but maybe I haven't felt that feeling before. I felt new (4)
I feel like those times were meant for me; what the music meant to me (4)	Trusting in something good and safe and enjoyable (3)	I enjoyed learning about and from the music (3)
Feeling a part of (3)	I can connect with the music, vibration, sound, and myself (3)	Harder to express verbally than musically (3)

Table 6: continued

I listened to a lot of horrible music, but then it wasn't horrible (2)	Gratitude (2)	I feel like it's definitely a coping skill I'm going to use forever (1)
We can be ourselves when making music together (1)	I can forgive myself; it's going to be okay (1)	

Tiffany was completing treatment at RWRP at the time of her interview and the content reflects the progress she made in treatment. She describes an internal transformation that occurred while she was at RWRP and credits music therapy for encouraging those important changes within herself.

T: It felt like I was heard and that people supported me and it felt comfortable and it felt right. It didn't feel... not normal.

AD: Mmhmm. It felt maybe.....familiar?

T: Yeah. Well, no, um... better than that. Like a new normal. Like not normal to *my* life.. *laughs* but like a new normal. And it was cool. It was really cool, I enjoyed it a lot. I felt new. I felt new and normal, because I'm assuming that's what we're supposed to be feeling. Like it was a good feeling, but maybe I haven't felt that feeling before.

The new feelings from the music encouraged her to try new things and open up in music therapy. She began to connect with the music and see herself in a new light.

T: The instruments have potential and so do we. Yeah... definitely. And at that time, that's what it was doing for me, the music, period. It was showing me that, you know, I have potential. I don't have to stay in my old ways. You know, I can get out of this.

Tiffany's comments on singing were also indicative of the changes occurring within as she engaged in music therapy.

AD: How else do you feel when you're singing?

T: Happy. Joyful, I don't know. It just gets me closer to my Higher Power. I feel beautiful. I feel beautiful when I sing. Yeah.

Tiffany further explained the relationship between her Higher Power and music. At the time of the interview, she was working on steps two and three of the 12 Step Program. When the music showed Tiffany her full potential, she was encouraged to take a leap of faith toward her recovery.

T: I'm working on step two and it's: "Come to believe a power greater than myself could restore me to sanity." So it's like, I had to try. I had to take a leap of faith. And I can relate that back to music therapy and it meant something to me. Like I said, that full potential. Whenever I said that, I said that outta my heart, outta my soul. And I feel like my Higher Power was involved in all of that and how I felt, which was spiritual at that time. And it intensified everything... for the good.

Tiffany also emphasized how the vibrations from singing and drumming helped her feel a part of something outside of herself.

T: And it's just in my heart. In my heart I know that there's something for music. I mean, music's supposed to be heard. You know.

AD: And that's a new feeling? That's a new revelation?

T: Mhmm. Yeah. Definitely playing it, too, like, I feel the vibrations, too. Like, that's awesome. That's really awesome.

AD: You had said the vibrations help you to know yourself?

T: Mhmm. Yeah, and to really feel, like to really be, like you said, I *am* some of that. Like, I am a part of that, because I'm playing it or I'm doing this. So, to be a part of, too, helps a lot. Whereas before, I didn't really feel a part of. Just kind of felt outside.

Tiffany's least frequently used Experienced Meaning Unit "I can forgive myself; it's going to be okay" only needed saying once, proving the frequency of the codes used is not more important than the meaning expressed within.

T: And it's opened my spirit, too, I guess. I wish I could explain how it has happened, but it did and I'm fine with that.

AD: You've opened your spirit?

T: Yeah

AD: And drugs and alcohol didn't do that?

T: Right. Well and it's forgiveness, too. You know. I feel like something calming and maybe it's, you know, whatever, but, it feels like I can forgive myself, it's going to be okay.

Reviewing the epoché. After I created Experienced Meaning Units for Tiffany's interview protocol, I compared both the Structural Experienced Meaning Units and the Experienced Meaning Units with my *epoché*. I identified two Experienced Meaning Units that were closely related to one epoché expectation, which are displayed in Table 7 below.

Table 7

Comparing the Epoché with Tiffany's Analysis

<u>Epoché Bias</u>	<u>Experienced Meaning Unit</u>
I believe interviewees will say music therapy is useful and meaningful	What the music meant to me was joy I feel like those times were meant for me; what the music meant to me

I examined the original protocol for instances where Tiffany and I talked about usefulness and meaning. Tiffany explicitly expressed that the music was meaningful on multiple occasions without prompting, as in this conversation about improvisation:

T: There were other times when you came around and asked us questions about how we felt, or how did the music sound to us?

AD: Kind of the after the improv, the processing?

T: Yeah. Those things stuck out to me, because it got me thinking about the music and what it means to me. And I feel like that's special, too. I feel like those times were meant for me in a way.

AD: Can you put into words what the music meant for you?

T: The music meant to me the very first day was like... it was joy. You said to pick an instrument that will reflect how you're feeling and that was one of the days I think I had the triangle, I can't remember. But that was one of the days where I had something and I felt heard. It felt like I was heard and that people supported me and it felt comfortable and it felt right. It didn't feel... not normal.

I determined that the Experienced Meaning Unit titles "What the music meant to me was joy" and "I feel like those times were meant for me; what the music meant to me" were created without bias.

Individual Distilled Essence. I used the 33 Experienced Meaning Units to create the Individual Distilled Essence for Tiffany's interview protocol.

If I never would have tried to play, I never would have known that I liked it. After I made the first mistake, I looked around and no one cared. We were allowed to join in however we needed to. There's no right or wrong. So I learned I'm brave enough to continue to try. I never really felt a part of before, but I felt connected to the other women through the music. I felt that I was heard by others and I felt like I heard myself. I could practice giving and receiving and sharing myself with others. It's a beautiful thing. We can be ourselves when making music together and I felt comfortable

expressing myself in the music. Feeling support from others in the group was really nice. Music therapy made the whole time at RWRP go better.

For me, music is my enjoyment of listening, taking it in and feeling. I can connect with the music, vibration, sound, and myself. I can soothe myself by releasing into the instruments. And singing makes me feel beautiful. I enjoyed learning about and from the music. I used to listen to a lot of horrible music, but then it wasn't horrible. My eyes have been opened since music therapy's been brought into my life. It's a coping skill I'm going to use forever. I'm very happy you were here for me to be able to learn about myself.

I feel like it was meant for me to do what we did each day, like the music was meant for me. What the music meant to me was joy. If I wouldn't have experienced the joy from others supporting my music, I wouldn't have known I could feel like that. It felt better than familiar, like a new normal. It was a good feeling, but maybe I haven't felt that feeling before. I felt new in my soul and my spirit. The potential in the music was showing me that I have potential to change. I don't have to stay in my old ways.

Music therapy helps me get closer to my Higher Power. It shows me I can trust in something good and safe and enjoyable. I know I can make a mistake and it's still okay; I can find my way back to the music and myself. I can forgive myself and I feel like it's going to be okay.

Kaycee Kane. Below are the results from the phenomenological analysis I conducted of Kaycee Kane's interview protocol.

Structural Meaning Units. I assigned nine Structural Meaning Units to Kaycee Kane's interview protocol. They are displayed in Table 8 below.

Table 8

Kaycee Kane's Structural Meaning Units

Outcomes from music therapy	Using things from music therapy to cope	What it's like to be in music therapy
Recovery from drugs and alcohol	Experiences outside of music therapy – still relevant	Rehab/RWRP
Before music therapy	Group dynamics	Therapeutic relationship

Experienced Meaning Units. I created 34 Experienced Meaning Units for Kaycee Kane's interview protocol. I listed them in order of frequency, from most to least frequently used codes, which are displayed below in Table 9.

Table 9

Kaycee Kane's Experienced Meaning Units

Music as a trigger and learning how to deal with that (10)	I could see myself really using music as a way to cope with triggers and stress (9)	Music is something we could do together as a family. It might bring us closer (9)
I believe you have to play; make music, work through, feel better (8)	Music (therapy) is life-saving at times; I was homeless and dying and music kept me going (8)	Working through things in music therapy; going from unhealthy to healthy (8)
Sometimes I get angry and anxious because of the triggers (7)	Accept/recognize what it is so something good can come (7)	Being in tune with myself; the real me (7)
Music therapy just brings everyone together (7)	Playing and singing music empowers me; it makes me feel worthy (6)	What's my hobby besides lifting a bottle of liquor? (5)
Music is a big part of active addiction/substance use (5)	You just always have to try new things; but it takes guts (4)	You can't fail in music therapy (4)
I am at peace after music therapy (4)	That's gonna continue once we get out (4)	Music puts that little beat in your body that gets you going (4)
Music just allows you to be yourself and to act like a fool and it's okay (4)	Music therapy is way different than other therapies at RWRP (3)	Making things we can give as gifts builds up our self-esteem (3)
Music is something fun (3)	Music therapy wakes me up, inspires me, motivates me to live (3)	The singing is very powerful (3)
It seems like it's always the right things we do in that music therapy session that is related to my feelings (3)	We're not as involved in those other groups. So we don't get as much out of it (3)	Being a part of the group/family with music (2)

Table 9: continued

Music therapy makes me think more about situations (2)	Music therapy is a necessary part of drug addiction and alcoholism rehabilitation (2)	I was kind of skeptical at first; but I would say just give it a chance (2)
Something new that I achieved and learned (2)	We can really act silly as an adult and everyone else is acting the same way (2)	The improv seems to help because we can do whatever we want (1)
The small little things that make a difference (1)		

During the interview, Kaycee Kane acknowledged that music saved her life in the past, which had an impact on her engagement in music therapy sessions.

KK: All those times I was in the bar partying or all those times I was at a crack house smoking crack there was always music around, you know? And I think there's just times that I've heard certain songs that almost told me, "You deserve better, don't give up." I just remember being really down and out and just hearing music, even at a bar, or walking past a bar, and it almost gave me a chance to like, have a second chance, to be like, "You are worth more than... Even though you're homeless, even though you only have one outfit..." I just think that at that time, just hearing certain music sometimes saved my life. Because you wanna give up and you're suicidal because you don't know what to do. You're helpless, you're hopeless, you just don't know what to do and where to turn and you've already given up faith on Higher Power or God, you know. I just remember hearing music and it kinda gave me that little oomph to keep walking, like one more step, one more foot in front of the other. Even though I was exhausted, even though I was so tired and I was ill and starving and weak and just deprived and decrepit and it was just a bad time. Music I think is what kept me going at that time, you know, nothing else.

Kaycee Kane commented how her connection with music created challenges in dealing with triggers during music therapy.

KK: So when you show up, I'm like, "Okay, I'm gonna be triggered, it's okay, we're gonna work through it by playing drums or singing, so I'll be all right at the end."

AD: So you know that you can get through it by playing?

KK: By playing music for sure. If not, if we just sat there, no, there wouldn't, no

After she learned to work through her triggers, Kaycee found she was more involved music therapy treatment than in other groups.

KK: Even if you didn't bring drums in and you just played guitar and had us sing, we're still all involved in it. And we're dealing with our feelings. I really didn't think I was going to be able to sit in music therapy because my triggers were so bad and my anxiety was so bad, but each time you came, I just worked through it and I was fine at the end. If I feel that way during another group, I don't get a chance to work through those feelings. I just sit there full of anxiety and suffer until afterwards and then I can either talk to somebody or go somewhere and take a few minutes to try to pull myself back together.

Kaycee also felt the music allowed her and the other women to be themselves, which brought them closer and allowed for a better treatment experience.

KK: And then a lot of those instruments, I kinda knew how to use them, but still it takes a little bit of guts to get up and actually do it. Because you've got so many people in the room that know you really well, but don't know you at all. They know they can relate to you in addiction, because they've been most likely where you've been. Whether it was homeless or through a sexual assault, or anything; drunk driving, jail, prison. So you guys relate. They know you in that way, but they really don't know the real you. [...] They just know the horrible parts and they know your personality, but really they don't know what your passions are. They might know about your family, but do they really know about your family or your likes or your dislikes? They don't know all that stuff, they don't know the real you. So when you get up there and you play the drum and we all kinda like laugh together and smile and act like idiots, it does bring us together as a group, it really does.

In music therapy, Kaycee Kane drew from her strong connection to music to work through triggers, develop coping skills, and express authentic herself while connecting with the other women at RWRP.

Reviewing the epoché. After I created Experienced Meaning Units for Kaycee Kane's interview protocol, I compared both the Structural Experienced Meaning Units and the Experienced Meaning Units with my *epoché*. I determined that a number of her Experienced Meaning Units were very similar to the biases outlined in my *epoché*. These instances are outlined and further explored below in Table 10.

Table 10

Comparing the Epoché with Kaycee Kane's Experienced Meaning Units

<u>Epoché</u>	<u>Experienced Meaning Unit</u>
I believe people will say music therapy is useful and meaningful	I could see myself really using music as a way to cope with triggers and stress
I believe people will say that improvisation is a creative and safe way to express feelings	The improv seems to help because we can do whatever we want
I believe people will say that playing music helps them relate better to their emotions	It seems like it's always the right things we do in that music therapy session that is related to my feelings
Music therapy is a life-saving therapy	Music (therapy) is life-saving at times; I was homeless and dying and music kept me going
Music therapy is more useful than other groups	We're not as involved in those other groups. So we don't get as much out of it

Useful and meaningful. I reviewed the original transcript and found multiple occasions when Kaycee Kane discussed her plans to use the material she learned in music therapy to cope with things outside of rehab. The first time Kaycee Kane mentioned using music as a tool was in response to my question, “What else comes to mind when you think of music therapy?” I coded Kaycee Kane’s interview protocol with the Experienced Meaning Unit “I could see myself really using music as a way to cope with triggers and stress” nine times, the second most frequent code for her. Kaycee Kane’s persistent introduction of this topic reassured me that the Experienced Meaning Unit regarding her feelings about music therapy’s usefulness is authentic.

Improvisation. When Kaycee Kane talked about improvisation, the Experienced Meaning Unit that emerged partially fulfilled the epoché bias I held about improvisation. Although Kaycee Kane’s Experienced Meaning Unit does not explicitly describe improvisation as creative or safe, I felt I needed to consult the original context before proceeding. When I revisited Kaycee Kane’s original interview protocol, I determined that Kaycee’s ideas about improvisation were indeed original and emerged through non-leading questions. The following conversation occurred while Kaycee Kane and I talked about working through triggers in the session:

AD: And so once you start playing, how do you feel?

KK: It’s almost like I have relief, I mean it starts like real tense and then as we move on to each thing, whether it’s just, “Okay, just play whatever,” like how you do with improv... The improv seems to help because we can do whatever we want. We can stop whenever we want. Not that we can’t

do that anyway, in the middle of it, but it just seems more acceptable at that time to just be like, "Okay, I'm done playing the drums, I'm going to pick up something else," and it's okay.

Therefore, I determined that the Experienced Meaning Unit "The improv seems to help because we can do whatever we want" was justly created and not influenced by my personal bias.

Relating to emotions. Kaycee Kane made the following statements when I asked about the relationship between her strong connection to music and her experience of being in music therapy:

KK: I'm not the same every time you show up, so I need to deal with those feelings and it seems like it's always the right things we do in that music therapy session that is related to my feelings. So it's just kinda strange how it works out, I guess.

KK: Each time you show up, it's like somehow it seems like whatever we do, I can completely relate to it. It's almost like, "Oh this was set out and played for me, exactly for my feelings today." And I know it wasn't, but.. I can relate that way, I always find a way to relate to it and it always helps me.. for sure.

When I looked at her own words, I determined that I created the Experienced Meaning Unit "It seems like it's always the right things we do in that music therapy session that is related to my feelings" without influence from my bias.

Life-saving therapy. Kaycee Kane didn't refer specifically to music therapy when she was talking about music saving her life; she was referencing a time in her life many years ago. When she talked about music therapy being life-saving, she was actually referring to what she has seen music therapy do for others:

AD: So what sticks out other than your triggers when you think of music therapy? What other things come to mind?

KK: I worked in a nursing home, they would bring music therapy in and you could see, it's almost like you relate that with someone almost like waking up in a way. Like you know, someone who's a stroke victim who typically doesn't talk, but is singing because music therapy came in and it's almost like life-saving at times I think. For me, it actually wakes me up, makes me think more about situations.

Her words helped me determine that the Experienced Meaning Unit "Music therapy is life-saving at times" was created without bias.

More useful than other groups. Strong Experienced Meaning Unit titles come directly from the participants' words (McFerran & Grocke, 2007). The Experienced Meaning Unit title "We're not as involved in those other groups. So we don't get as much out of it" is a direct quotation from Kaycee Kane's interview protocol in response to my question, "How does music therapy relate to the other therapies or groups that you have?" I determined that Kaycee Kane does truly perceive music therapy as more useful than other groups and the similarity between her Experienced Meaning Unit and my bracketed bias is not of concern.

Individual Distilled Essence. I used the 34 Experienced Meaning Units to create an Individual Distilled Essence from Kaycee Kane's interview protocol.

Music is a trigger for me and I had to learn how to deal with that. Sometimes I get angry and anxious in music therapy because of the triggers. I had to accept and recognize what it was so something good could come from the music. I believe you have to play, make music, work through feelings, and feel better. Music therapy makes me think more about situations. I worked through things in music therapy; going from unhealthy thoughts to healthy thoughts, from negative to positive. I'm at peace after music therapy.

I was kind of skeptical at first, but I would say just give it a chance. You just always have to try new things, but it takes guts. To actually learn the beats and to be able to remember them and then work together with someone else, that was something new that I achieved music-wise. Playing and singing music empowers me. It makes me feel worthy. The

improv seems to help because we can do whatever we want. You can't fail in music therapy.

It seems like it's always the right things we do in each music therapy session that relates to my feelings. The connection from the music you play lets me release feelings. Music therapy wakes me up, inspires me, and motivates me to live. Music puts that little beat in your body that gets you going and it's life-saving at times. I was homeless and dying and music kept me going.

Music therapy is way different than other therapies at RWRP. We're not as involved in those other groups, so we don't get as much out of them. But music is something fun. It's the small little things that make a difference. Music just allows you to be yourself and act like a fool and it's okay. The other women here know a lot about me, but they don't know the real me. In music therapy, we can really act silly as adults and everyone else is acting the same way. It just brings everyone together.

Music is a big part of active addiction and substance use. Therefore, music therapy is a necessary part of drug addiction and alcoholism rehabilitation. I could see myself really using music as a way to cope with triggers and stress. What's my hobby besides lifting a bottle of liquor? Making things we can give and share builds up our self-esteem. Music is something I could do together with my family and it might bring us closer. It's gonna continue once I get out.

Results from Collective Analysis

Identifying Collective Themes. I identified nine Collective Themes. All three of the participants expressed these common themes in their interview protocols. The Collective Themes are displayed Table 11 below.

Table 11

Collective Themes

Music therapy made the participants feel a part of something	Singing songs provided valuable experiences of power, beauty, and hope	Learning about the music, instruments and other cultures was interesting and new
Music therapy is a time when everyone comes together as a group	Music therapy encouraged valuable feelings participants hadn't felt before	Participants learned things that will carry over as lifelong coping skills and can be shared with family once they get out
Participants were comfortable enough to let loose and be themselves	Playing instruments and singing helped participants work through and release feelings	As music therapy progressed, participants became less skeptical and open to changes they didn't expect

Identifying Significant Themes. In addition to the nine themes that all three women expressed, I identified ten Significant Themes that two of the three participants expressed in their interview protocols. The Significant Themes are displayed in Table 12 below.

Table 12

Significant Themes

The women are more involved in music therapy than other groups	Music therapy made the overall treatment experience better	The participants felt it was helpful that they couldn't fail, but could make music however they wanted to
The participants got a lot of peace from music therapy	It was meaningful that the participants could relate the music to what they needed each day	Music therapy allowed participants to deepen their relationships with themselves
The women better understood and more fully experienced their own spirituality and Higher Power through the music	Participants were glad they were brave enough to try new and scary things in music therapy despite the fear of failing	Exposure to new music helped participants realize the music they used to listen to had a negative impact on them
The vibrations allowed for the connection between the music, self, and spirit		

Creating Global Meaning Units. Four Global Meaning Units emerged from analyzing the Collective and Significant Themes: music forms connections, desirable intrapersonal shifts, qualities of the music therapy, and music therapy's impact on treatment and recovery. These are the broad concepts that underpin the participants' shared lived experience of group music therapy.

Final Distilled Essence. I used the four Global Meaning units to create a Final Distilled Essence of the women's experience of music therapy.

Music therapy had an impact on treatment and recovery for three women with addictions. The music formed connections between the women and themselves, each other, and something bigger, like a Higher Power. Learning new things, singing songs, and feeling like they couldn't fail were

qualities of the music therapy treatment that the women found valuable. As the music therapy progressed, the women identified desirable shifts in their emotional processing, emotional experiences, and relationships with themselves.

Chapter 5: Discussion

This study compared multiple perspectives of the group music therapy phenomenon to better understand women with addictions' experience of music therapy treatment. The essence of the women's shared experience emerged through phenomenological microanalysis, which yielded nine Collective Themes, shared by all participants, and ten Significant themes, shared by two of three participants. Finally, four Global Meaning Units were derived from the Collective and Significant Themes and articulate the overarching concepts that define the experience of group music therapy for three women with addictions. The four final themes are music forms connections, music therapy's impact on treatment and recovery, desirable intrapersonal shifts, and useful qualities of music therapy.

While this discussion examines the four themes independently, it is important to note that the themes are best understood within the context of the whole experience and, therefore, discussions will draw connections between multiple Global Meaning Units. This analysis confirmed that what the women experienced in music therapy is inseparable from the music and the uniqueness of each woman's recovery journey as described in the women's interviews. Both the music therapy and substance abuse literature support the interconnectedness and complexity of these issues and further authenticate the need this study attempted to meet by painting a clearer picture of what women with addictions experience in group music therapy.

Music Forms Connections

The Global Meaning Unit “Music forms connections” contains six Collective and Significant Themes, the highest frequency of all Global Meaning Units and the analysis indicates that music therapy encouraged connections between the women and the music, the women and each other, the women and themselves, and the women and something bigger, like spirituality or a Higher Power. This outcome is consistent with other studies that find individuals with SUD experienced increased connection as a result of music therapy treatment (Gardstrom, et al., 2016; Hedigan, 2010; Treder-Wolff, 1990).

Connection, or lack thereof, appears to be a key factor in substance abuse. Addiction, referred to as “the ultimate condition of separation” (Sparks, 1993, p. 91), leads to the deterioration of one’s self-concept, social systems, and existential understanding and research shows that women cite connection as a highly supportive factor in recovery (Harris, et al., 2005). Additionally, Herman (1997) describes trauma, a commonly sighted contributing factor in women’s addiction, as a disease of disconnection that shatters an individual’s psychological structures of the self and systems of interpersonal attachment in equal measure. In the current study, all three participants acknowledged the impact of isolation, disconnection, and trauma on their addiction processes and reported that music therapy had a positive impact on those factors of addiction.

The women acknowledged music’s presence in their addictive processes inside and outside of treatment, which is consistent with the ancient relationship

between substances and music that is widely recognized in society (Aldridge, 2010; Horesh, 2010; Silverman, 2003). Indeed, music and substances are not so different in the effect they have on the human brain and body. Aldridge (2010) explains that music is a clear, physical connection to reality and to other consciousnesses simultaneously and that “this visceral contact with reality through music is in the same mode as drugs or alcohol – direct and immediate” (p. 16). The women indicated the relationship they felt between music and their addictions extended into music therapy treatment. Memory Rider explained that the “floaty” feelings she felt after her first music-assisted relaxation experience made her feel as if she was high, which allowed her to see that there are other things she can do to achieve altered consciousness that are not drugs or alcohol. Kaycee Kane often played or listened to music while using substances and reported that playing drums in music therapy was initially very triggering of past experiences. However, she explained that her anxiety dissipated each time she began to play the music, which supports the idea that musical experiences in music therapy are safe and orienting (Aldridge, 2010; Hedigan, 2010).

Little research has explicitly explored the relationship between individuals with addictions and the music component of music therapy treatment. However, those that have discussed this relationship support the outcomes from this study. In a quest to identify what about music therapy women with addictions find useful, Gardstrom, et al. (2016) found that music therapy fosters musical connections and note that the participants in their study often personified the

music with comments such as “music was there to carry us through” (p. 31). The analysis indicated a similar intimacy between the women and the music as did this study, whether the music was a guide revealing new things, a vehicle for connecting to the self, or a container in which participants felt safe and supported, all of which the women in this study indicated. In particular, the women in this study reported that no matter what the musical content of the session, they felt they could relate to it. This is important because individuals with addiction struggle to form connections.

While the women report that they felt a deep connection to the music itself, it is difficult to isolate the particular elements that allowed such a strong connection. The women’s prior personal experiences with music, the biopsychosocial factors that contributed to their addiction initially, music and substances’ similarities, or the content of the music used in therapy are all viable influences on the strength of the women’s connection with music that are worthy of further examination. However, the current study’s research question is answered by the fact that the women’s strong connection with music emerged as an essential element of the music therapy experience. Kaycee Kane captured the essence of the interplay between music, addiction, and recovery and how that relates to music therapy treatment.

KK: But I think music therapy is a necessity in recovery, just as much as music is necessary as part of our addiction. Like, we used it when we were getting high and drinking and now we’re using it as recovery.

Ultimately, the women reported that they connected to the music on physical, social, emotional, and spiritual levels, which suggests that music therapy is an integrative and holistic experience for women with addictions.

The women reported that music therapy fostered interpersonal connections and all three women agreed that music therapy is a time when everyone came together as a group. The analysis indicates that music therapy gave the women the opportunity to improve their relationships with each other and to feel that they were a contributing part of the group. Cohesion and contribution are important because women frequently cite isolation and lack of meaning or purpose as feelings that are both induced and self-medicated by drug use (Harris, et al., 2005; Kearney, 1998). Tiffany illustrated this when she said, "Before, I never really felt a part of. I just kind of felt outside," and the others made similar comments. Relational-cultural theory (RCT), a psychological theory that was developed based on the unique psychological needs of women, suggests that developing relationships and establishing a strong sense of connection with others are at the cornerstone of psychological growth and development, particularly recovery from addiction (Covington, 2008; Duffey & Somody, 2011; Kearney, 1998). Additionally, research shows that interpersonal relationships have the potential to support or impede a woman's recovery, depending on the quality of the relationship (Harris, et al., 2005) Therefore, the fact that the analysis emphasizes music therapy's positive impact on connection between group members speaks to a unique quality of music therapy treatment

that is particularly relevant for women who are in treatment and recovery from addiction.

All three women acknowledged that arguments and tension between group members outside of music therapy had a negative impact on their overall treatment experience and that music therapy was a place where they could put their differences aside and feel united. The final themes from the analysis did not necessarily reflect the level of conflict present in the house. However, anecdotal evidence from the case manager indicated that mounting conflict between group members was problematic and hindering treatment progress. Therefore, music therapy's contribution to group connection, despite the level of conflict in the facility, is especially meaningful. This finding is consistent with current literature that supports the connecting qualities of music therapy between group members (Gardstrom, Carlini, Josefczyk, & Love, 2013; Gardstrom, et al., 2016; Hedigan, 2010; Treder-Wolff, 1990).

The women also reported that music therapy helped them to deepen their relationships with themselves. This connection contributed to greater authenticity, the capacity to fully represent oneself honestly in a relationship, which is a key factor in healthy connection (Duffey & Somody, 2011; Kearney, 1998). Shame, oppression, and a number of other fundamental inequalities (i.e. biological or socioeconomic differences) may impede one's ability to be authentic and develop meaningful relationships. The women reported that, initially, they were skeptical of music therapy and feared others would judge them based on their musical

contributions. However, the women indicated that as the sessions progressed, they became more comfortable expressing themselves authentically while making music with or in front of others, which benefitted both group and intrapersonal connections. This finding is consistent with other research that suggests that music therapy, particularly group instrumental improvisation, encourages honesty, genuineness, and ultimately leads to deeper connections with the self and others (Hedigan, 2010; Murphy, 1983), which is a necessary element of recovery from addiction (Kearney, 1998).

The women indicated that participation in music therapy treatment also contributed to a deeper connection with the self through increased self-perception, a term that includes views of the self, including, but not limited to self-awareness, self-esteem, self-concept and self-understanding (Trucco, et al., 2007). Covington (2008) refers to addiction as “the chronic neglect of self in favor of something or someone else” (p. 150) and suggests that addiction strips the sense of self and ability to truly connect with others, which makes rebuilding a healthy self-perception a priority in treatment. Research is still inconclusive concerning an ideal relationship with the self in regards to relapse and recovery. Contrary to popular belief, research does not show a clear relationship between self-esteem and addiction, partially due to inconsistencies in defining and measuring self-esteem (Greenberg, Lewis, & Dodd, 1999; Trucco, et al., 2007). However, research does indicate that the more global concept of self-perception plays a clearer role in addiction and, in particular, self-acceptance, self-efficacy,

and self-concept have a more conclusive impact on relapse and recovery (Kearney, 1998; Payne, 2010; Trucco, et al., 2007). Ultimately, more research is needed to better understand how the different elements of self-perception relate to addiction and relapse; however, the current study and other music therapy literature support the notion that music therapy has the potential to positively impact global self-perception (Gardstrom, et al., 2016; Treder Wolff, 1990).

Self-concept, which is constructed from the views one holds about oneself (Kearney, 1998), plays a role in female substance addiction. Negative self-concept encourages substance use initiation, continuation, and relapse and in turn, substance abuse disintegrates women's self-concept (Kearney, 1998). The women indicated the presence of negative self-concept in their own addiction processes during the interviews, which manifested through low self-esteem, feeling disconnected from the self, and being afraid to express themselves in the music. Kearney (1998) suggests that addiction is a misguided, self-destructive attempt at self-nurturing and provides a model for women's recovery from addiction that emphasizes improved self-understanding and healthful self-care. She argues that recovery comes when a woman's awareness gradually shifts and she realizes that the substance, which was intended to provide comfort from physical and/or psychological pain, has been destroying all areas of her life. When the individual sees the substance's impact clearly, she must come to terms with and learn how to nurture her true self by meeting her own needs (Kearney, 1998). This process involves an honest appraisal of one's limitations and

potential. The women reported that numerous aspects of the music therapy experience encouraged greater self-understanding and self-acceptance, which are shifts in self-concept that are crucial for sustained recovery (Kearney, 1998). The women explained that music therapy allowed them to hear themselves more clearly and develop positive self-awareness, which is critical for learning how to take care of oneself in a healthful way. Additionally, the women indicated that achievements in music therapy (achievements that individuals who do not abuse substances might consider small or insignificant) helped them to see themselves in a new, more positive way, which will be discussed in more depth later. These outcomes support previous research that suggests music therapy encourages improved self-concept (Gardstrom, et al., 2016; Hedigan, 2010).

Seeing both the self and the substance in a new way is crucial to lasting change, but shifts in self-concept can be difficult to achieve and take a long time (Kearney, 1998). Teague, Hahna, and McKinney (2006) found that music therapy significantly decreased depression and anxiety in women recovering from intimate partner violence, but the effect on self-esteem was not significant. Their outcomes could indicate just how deep-seeded negative self-concept is for women who have survived traumatic experiences and how significant it is when positive shifts in self-concept do happen. The analysis indicates that music therapy initiated positive internal shifts that allowed the women to see themselves differently, begin to reconstruct their demolished self-concept, and

express a more authentic self, all of which are consistent with sustained recovery.

Greater understanding of the self may lead to a heightened spiritual understanding (Kearney, 1998), which was the case for Tiffany and Memory Rider. Borling (2011) asserts that psycho-spiritual recovery is essential for long-lasting recovery and the analysis indicates that the women better understood and more fully experienced their own spirituality through participation in music therapy. The definition of spirituality differs widely and, although it can serve as an element of religiosity, spirituality is uniquely experienced by each individual (Fallot & Heckman, 2005; Miller, 1998). Words like connection, universe/universal, transcendent, meaning, nature, peace, God, relationship, and spirit often appear in descriptions of spirituality and Harris, et al. (2005) describe spirituality for women with addictions as the reflection of “a woman’s recognition of her place in the cosmos and her appreciation of all the small and natural things that have the power to make a life rich and full.” They suggest that “being a part of something bigger than oneself and one’s immediate problems” helps women with addictions “put their own concerns into a larger perspective,” which encourages them to resist temptations that lead to relapse (p. 1294-1295).

Overall, the women indicate that the spiritual outcomes from music therapy were not associated with religion, but with examining matters of the soul and existential meaning. Spiritual healing is a common goal in drug addiction treatment and some common approaches to treatment, such as the Alcoholics

Anonymous 12-step approach, are entirely spiritually-based (Borling, 2011; Murphy, 2015). In the current study, the women explained that during active addiction, and in some cases, in the time leading up to initiation, they felt disconnected from things outside of themselves. Drug abuse furthers this disconnection from external forces, as it involves putting a substance inside of one's body in a misguided attempt to take care of oneself by feeling better (Kearney, 1998). Unsurprisingly, research suggests a relationship exists between engaging in positive spiritual practices and long-term recovery from addiction (Carter, 1998; Fallot & Heckman, 2005; Ficken, 2010).

The results from this study support the suggested need an individual with addiction will likely have for psycho-spiritual healing (Borling, 2011; Miller, 1998; Murphy, 2015), however, anecdotal case studies are the only other pieces of music therapy literature that examine how music therapy is used to address the issue of the spirit for individuals in substance abuse treatment (Gardstrom, et al., 2013; Soshensky, 2011). This is surprising, considering the widely accepted transcendent and connecting qualities that spirituality and music share. An explanation for this could be that music therapy researchers simply are not asking research questions related to spirituality and addiction and therefore, spirituality could only have emerged as an outcome of a phenomenological inquiry of music therapy treatment. To date, this is the only study I know that meets that criteria.

The women indicated that the unseen and deeply personal nature of spirituality that makes it difficult to define also contributes to its importance in their recovery and natural relationship to music therapy treatment. In particular, the women indicated that vibrations produced from singing and drumming served as a link between the self and something external, which they described as spirituality or a Higher Power. Research suggests that vibration waves have the potential to stimulate or relax the central nervous system, depending on the frequency of the wave (Skille & Wigram, 1995). Vibroacoustic therapy (VAT) is an approach which utilizes low frequency sound vibrations for therapeutic intervention and a study of its effects on teenage girls with anxiety, low self-esteem, and/or body image issues indicated that VAT was a beneficial experience that provided balancing self-discovery and tension release (Rüütel, Ratnik, Tamm, & Zilensk, 2009). In the current study, the women explained that as they absorbed the vibrations, they felt inner peace and that they were a part of the music, which helped them to see themselves in a new, more meaningful dimension. These results are important because women with addictions cite isolation and hopelessness as factors in addiction initiation and relapse (Harris, et al., 2005; Kearney, 1998).

Desirable Intrapersonal Shifts

In addition to a strengthened connection with the self, the women reported that they experienced other desirable changes within as a result of the music therapy treatment. Barriers that hinder recovery from SUD may come from

internal or external influences and research shows that internal changes must be made before the individual can achieve lasting recovery (Baker, et al., 2012; Kearney, 1998). All but one of the five themes within the “Desirable intrapersonal shifts” Global Meaning Unit were Collective Themes identified by all three participants, which indicates that the women’s experience of intrapersonal change was a mutual and meaningful result of group music therapy treatment.

The women in this study recognized that the music could be a vehicle for working through addiction-related issues and had the courage to use it as such. Emotional and physical release are widely accepted outcomes of music therapy treatment with nearly all populations and the current study joins previous research in suggesting that music therapy interventions reduce the same negative mood states that women with addictions report induce substance use and relapse, including anxiety, anger, depression, frustration, triggers, physical pain, and stress (Cevasco, et al., 2005; Corcoran & Corcoran, 2001; Gardstrom & Diestelkamp, 2013; Harris, et al., 2005; Langan & Pelissier, 2001). Additionally, experiential avoidance, or reluctance to experience certain undesired emotions, images, memories, etc., is a contributing factor in relapse (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996), and in the current study, the women indicated that music therapy allowed them to work through issues and feelings they might have previously avoided by using drugs and alcohol.

In particular, the women reported that playing instruments and singing allowed them to actively work through and release feelings, while their reports of

the music-assisted relaxation experiences indicate the women also achieved desired change through more receptive methods. Some of the things the women worked through in music therapy were obvious and demanding, while other shifts were unexpected and subtle, yet still necessary, as they would have otherwise impeded forward progress in music therapy treatment.

Catharsis, which was defined as “any open expression of affect” was the most frequent outcome of a similar study with women with addictions (Gardstrom, et al., 2016, p. 23). Like the researcher clinicians in that study, I did introduce the clients to a number of interventions specifically designed to encourage emotional awareness and expressive output (i.e. a drumming intervention called “Let it Go into the Drum” that the women frequently cited). However, the women in this study also explained that they used the music to help themselves release and work through things even when that wasn’t the intended intervention outcome, as was the case with Memory Rider releasing her pain during the music-assisted relaxation, which suggests a natural propensity for processing and release inherent to music therapy treatment. The analysis suggests that the ability to work through and express internal issues was essential to the women’s experience of group music therapy.

The women’s previously addressed belief that music therapy motivated a number of changes in self-perception, elements of which are known factors in relapse and recovery (Trucco, et al., 2007), further emerged in the “Desired Intrapersonal Shifts” Global Meaning Unit. In particular, the women explained

that they felt comfortable being themselves, experienced a sense of newness, became open to unexpected changes, and felt a sense of inner peace.

Comfort in being oneself indicates openness and self-acceptance, which are different from reports of what women experience during active addiction (Kearney, 1998). This essence of the analysis is consistent with other literature that suggests music therapy strengthens the sense of self for women with addictions (Gardstrom, et al., 2016). That the women felt comfortable being themselves indicates an increased sense of self, which is valuable as the women rebuild their sense of identity and develop a healthier self-concept, which, as previously mentioned, is necessary for sustained recovery (Kearney, 1998).

The word “new” emerged in a number of themes during analysis. The women indicated music therapy allowed them to see themselves in a new way, which enabled them to form new habits and adopt a new awareness of both the self and the drug necessary for lasting change, as mentioned in the “Music forms connections” section (Harris, et al., 2005; Kearney, 1998).

The women also indicated that music therapy allowed them to feel new feelings, such as hope, and the joy and self-satisfaction that the women reported from keeping a steady beat or having the courage to express oneself on a unique instrument during improvisation illustrates the deep need women with addictions have for improved experiences with the self. This outcome also supports other evidence that music therapy allowed individuals with addictions to experience desirable feelings without substances (Baker, et al., 2007).

Additionally, the women reported that learning new things, both about the music and about themselves, was an essential quality of music therapy treatment. During the interviews, two of the three women referenced something I said in a session (“We are rhythmic beings”) and described how much they enjoyed learning about their brains and bodies, and music’s effect on both. While these concepts are difficult to isolate in the research, the women’s descriptions indicated that the new feelings and information were inspiring and incited a sense of hope, meaning and forgiveness. In particular, Tiffany indicated that the new feelings she had about herself in music therapy let her see that she had the potential to change her old ways and allowed her to forgive herself. Shame, a feeling more commonly experienced by women with addictions than women without addictions, occurs when an individual believes that internally, she is bad and inadequate (O’Connor, Berry, Inaba, Weiss, & Morrison, 1994). From the women’s descriptions, it seems that learning more about the brain, body, and potential for change allowed them to reconsider the negative conclusions they had made about themselves and their potential to start over, to learn to do better, try again, and to embrace a new way of living.

Finally, peace is a specific and notable state of being that the women reported feeling as a result of the music therapy treatment. In particular, the music-assisted relaxation experience promoted peaceful feelings. Tiffany also indicated that she felt peace after opening new parts of herself and forgiving herself, which is a different, more long-term peace than absence of anxiety

following a meditation experience. The analysis supports the established notion that music therapy has the potential to provide desired mood shifts, new feelings, and openness on many different levels of treatment or progress (Borling, 2011).

The women indicated that multiple elements of music therapy treatment came together as a whole and contributed to the positive intrapersonal shifts they experienced from participating in music therapy. Music therapy's ability to incite new feelings and encourage improvements in self-perception are notable and speak to the qualities of the music therapy experience that made an impact on the women.

Qualities of the Music Therapy

Four qualities of the music therapy session emerged for the women: valuable personal experiences from singing, learning new and interesting things, having courage to try new things, and making music however they wanted, despite the fear of failing. Music therapy literature is discrepant in identifying qualities of music therapy women, and men, for that matter, value most. The large majority of quantitative studies find music therapy to be better than other therapies for myriad measures, but results do not indicate significant differences between music therapy interventions when treating men and women with addictions (Cevasco, et al., 2005; Jones, 2005; Silverman, 2011, 2012, 2015). The women identified the features of the music therapy experience that were meaningful or notable, rather than isolating specific interventions, which indicates that the complete music therapy experience was more valuable than any given

intervention. One individual theme was created to describe the women's experience of singing, which occurred throughout the sessions in conjunction with other modes of musicking, including drumming and instrument improvisation, and was a significant part of the music therapy experience.

Studies that examine music therapy as a whole have positive results, but, until recently, did not indicate the specific elements of the music therapy experience that prompts therapeutic change for women with addictions (Alboronz, 2010; Gardstrom & Diestelkamp, 2013). Gardstrom, et al. (2016) conducted a qualitative study in response to previous stagnant outcomes from music therapy research with this population. Rather than isolate specific interventions, they exclusively examined the aspects of music therapy women with SUD found to be useful. The outcomes of that study are relevant and similar to the results of this study across the board and one finding in particular relates to the qualities of music therapy that emerged for the women: the instillation of hope. Gardstrom, et al. (2016) define hope as the belief "that treatment can and will be helpful," which makes the women feel motivated to make changes (p. 24). The women I interviewed echoed that music therapy, particularly singing, provided experiences of hope, motivation, power, and inspiration.

Singing is the only intervention to emerge by name in the final thematic analysis. Specific aspects of the interventions were not measured, therefore, the results do not allow for suggestions or comparisons between interventions. However, the results do speak to the impact singing had on the women, which

was overwhelmingly positive. Literature supports the notion that singing has a unique capacity for therapeutic change, particularly when working with individuals who have survived trauma, as is the case for the women in this study (Austin, 2008, 2011).

Literature that supports using the voice for therapy suggests that voice is the most intimate instrument of all because it resides within us from the time we are born (Austin, 2008). Austin (2011) explains the relationship between the individual, the voice, and therapeutic change: “We produce sounds with our own body, using the support of our own breath. Our musical tones vibrate inward, connecting us to our physical sensations and breaking up blocked energy and relieving emotional stress and tension” (p. 13). Ample research indicates that addiction often develops as a reaction to an unresolved trauma, and when this is the case, therapeutic work should aim to integrate residual dissociations and fragmentations of the traumatic experience (Punikanen, 2010). Trauma survivors indicate the impact of powerlessness, self-blame, hypervigilance, and anxiety on their psychological state (Cantón-Cortés, Cortés, & Cantón, 2012; Levine, 1997) and Austin (2002) suggests that “the traumatised person often survives by forfeiting her own voice” (p. 234). Music therapy has been shown to motivate the processes of reconnection and transformation necessary for the integration of traumatic experiences (Herman, 1997; Levine, 1997; Punikanen, 2010). Reconnection and transformation allow survivors a chance at recovery and the

women in the current study suggested that singing helped them to move toward this kind of progress.

Levine (1997) indicates that transformation requires something to change to its polar opposite and the women indicated that singing allowed them to feel empowered and beautiful and hopeful, which is a large change from powerlessness and self-blame characteristic of traumatic experiences. The analysis supports the notion that song can be a safe container for expressing things that might otherwise be too threatening (Austin, 2002). Additionally, the internal vibrations produced from singing encourage the release of blocked, unresolved, residual energy from the traumatic event and allow for enhanced vitality and equilibrium that is characteristic of self-regulation (Austin, 2002; Levine, 1997). Finally, the women indicated that hearing one's own voice resounding within was confirmation of their own existence and survival, which was important, because the women expressed that they felt lucky to even be alive after all that they had been through as a result of their addictions.

Again, the women reported that singing in music therapy provided experiences of power, hope and beauty, and the songs I chose to share with the women were chosen with those themes in mind. However, literature also indicates that intentional use of the voice often leads to positive outcomes regarding the self. Austin (2008) explains that "the self is revealed through the sound and characteristics of the voice. The process of finding one's voice, one's own sound, is a metaphor for finding one's self" (p. 21). Indeed, the women

acknowledged that after years of heavy drug and alcohol use, they began to hear and better know themselves through singing in music therapy. Winnicott (1971) suggests that using the voice enables revealing self-reflection and the women explained that the self-realization that occurred because of singing allowed them to open new parts of themselves that had been closed off, and ultimately, contributed to the kind of necessary psychological growth for recovery (Covington, 1998).

I have already discussed the theme that supported the idea that music therapy encouraged interpersonal connections in women with addictions and at this point, the voice's ability to connect individuals should be noted. The women indicated that a sizeable part of the reason singing was so powerful was because they did it all together. Austin (2011) suggests that sound and energy exchanged during group singing enables individuals to "resonate with each other, helping to break through the walls of loneliness and isolation to form bonds and community" (p. 13). Suggestions for best practice acknowledge the therapeutic benefits of group singing for women with addictions, however, no research has been done that examines the relationship between singing, addiction and recovery more closely (Gardstrom, et al., 2013).

The women also reported that they valued learning about music and cultures from different parts of the world. I used drum beats and folksongs from Jamaica and West Africa to avoid triggering music, to equalize the level of familiarity to the music, and to encourage spontaneous, authentic engagement in

the musical experience (Moreno, 1988). Other research with this population suggests the benefit of a drum circle style of drumming, which often includes West African-styled rhythms and instruments (Cevasco, et al., 2005; Gardstrom, et al., 2013), however, little attention is paid to the deliberate choice of unfamiliar music, which I did here with positive outcomes.

Music therapy was an eye-opening experience for the women and being exposed to new and foreign things genuinely seemed to intrigue and inspire them. They indicated that music therapy was a learning experience in the sense that they learned about music and cultures they didn't know existed. They explain that the more they learned, the more they wanted to know. The women's descriptions about learning new, unfamiliar things further supports two previously discussed conclusions: first, feeling a part of something larger than oneself can lead to increased perspective and new ways of viewing the self and contextual problems, which could inspire recovery (Harris, et al., 2005). Second, the women learned many new things in music therapy and reported that was a valuable aspect of treatment.

The women also reported that music therapy interventions let them express themselves and alter their moods in new, healthy ways, which, while unfamiliar, was welcome. The women seemed to resound with new alternatives to help themselves, since addiction and recovery have been a lifelong struggle for many of them. Women indicate that destructive habits impede recovery and, as mentioned earlier in the discussion, this research suggests that music therapy

can be used to help women with addictions develop new habits and learn new, better ways take care of themselves and avoid relapse (Harris, et al., 2005). Memory Rider indicated that at this point in her life, she would try anything to do something different and get better. Indeed, the analysis suggests that because the music used in therapy was something different, it allowed the women a new chance at recovery.

The women indicated that because there was no right or wrong in music therapy, they were able to look past their fear of failure and engage in new, rewarding experiences. The qualities of the experience that emerged align with the elements of a Humanistic Music Therapy practice, which encourages self-actualization through musical expression of human potential (Abrams, 2015). In Humanistic Music Therapy, achievement is viewed as any progress toward self-actualization and therefore, achievement is not measured by musical products, which alleviates the potential for musical failure. Through this model, the women came to understand that in music therapy, the process of the therapy is the product and any perceived “mistakes” are simply parts of the experience; therefore, music therapy was not something the women could “mess up,” which encouraged them to continue to toward their own potential with more confidence. Previous research supports that music therapy treatment can help individuals with SUD confront fears of failure (Murphy, 1983), which Ghetti (2004) argues can “stymie long-term substance abusers” (p. 88). This aspect of the music therapy experience is important because internal strengths are the basis for self-

help and therefore, recovery treatment is most helpful when the women's strengths are emphasized (Fearday & Cape, 2004). In music therapy, the women got to experience what it felt like not to fail, and as a result, reported increased confidence. Confidence is an important factor in self-efficacy, which is the belief that one can cope with high-risk situations (Bandura, 1986), and has a known impact on relapse and recovery (Trucco, et al., 2007).

On a similar note, the women also valued the lack of judgment in the music therapy session and reported that they felt proud of their musical achievements and had a sense of self-satisfaction, which is a positive factor in recovery (Kearney, 1998). Tiffany described the time that she made what she thought was a mistake and nobody cared; she realized that she was able to keep going and continue to try, which she translated to her recovery when she said "And that relates to me because when I relapse, I can find my way back." As addiction is a chronic disease, an incidence of relapse does not indicate failed treatment (O'Brien & McLellan, 2013) and Tiffany's connection suggests that she gained insight in music therapy that contribute to a healthier and more practical understanding of her disease and treatment process.

Finally, the women reported that music therapy was a time when they could do things exactly how they wanted to do them, with no rules or repercussions. Almost all of the women referenced being in jail previously and expressed that rehab itself can be limiting. Research suggests that confrontational treatment strategies may be counterproductive for women and

reinforce feelings of negative self-perception (O'Connor, et al., 1994). The women indicated that the freedom they had in music therapy encouraged increased authentic engagement, because they were allowed to join in however they needed to. Treatment motivation and engagement contribute to positive treatment outcomes (Simpson, et al., 1995) and the women indicated that certain qualities of the music therapy sessions, which were qualities of a Humanistic Music Therapy approach, encouraged optimum engagement.

Music Therapy's Impact on Treatment and Recovery

In all of the Global Meaning Units previously discussed, the women expressed that music impacted their recovery in a number of ways, specifically, through increased connections, desired internal shifts, and by providing safe opportunities to work through feelings and issues. Numerous studies find music therapy to be equal to or greater than standard treatment modalities in effectiveness for depression, treatment eagerness, treatment motivation, readiness to change, and therapist-perceived working alliance (Albornoz, 2011; Silverman, 2009b, 2011, 2012). However, in comparison, music therapy researchers have paid very little attention to how music therapy impacts other aspects of addiction treatment, such as engagement in other therapies, overall treatment experience, and relapse (Lesiuk, 2010; Silverman, 2003, 2009b). In the current study, the women explicitly indicated that music therapy improved their overall treatment experience at RWRP and personal recovery process and that

music therapy's impact on treatment and recovery emerged as a substantial part of the women's overall experience of music therapy treatment.

The women described music therapy as enjoyable and interesting and indicated they were more engaged in music therapy than they were other groups at RWRP. Participant engagement in treatment is perhaps the strongest indicator of treatment success, but standard cognitive-behavioral therapies often struggle to capture participants' attention, leading to decreased treatment retention and increased relapse incidence (Garrett, Landau-Stanton, Stanton, Stellato-Kabat, & Stellato-Kabat, 1997; Simpson, et al., 1995). Outcomes from this study uphold the notion that music therapy has a unique ability to improve treatment engagement among individuals with SUD (Dingle, et al., 2008).

Kaycee Kane and Memory Rider reported that they valued music therapy groups because they were something different from routine treatment groups, which used talking as the primary expressive outlet and had the tendency to be boring and/or difficult. The women reported that music therapy allowed them alternative ways to work through their addiction-related issues, including triggers and pain, as opposed to standard treatment groups, which adopted a "one size fits all" (i.e. verbal processing) approach to working through issues. Tiffany indicated that music therapy supported the qualities of standard treatment that she valued, which was the treatment of her whole self. These women and participants in a similar research study (Gardstrom, et al., 2016), agreed that music therapy offered a welcome break from the difficulties of addiction treatment

and, in turn, eased the women's day-to-day struggles, which was a valuable component of music therapy and overall rehab experience.

The women also indicated it was valuable that music therapy was non-confrontational and gave them space and time to work through things on their own terms, in their own way, allowing them to help themselves however they saw fit that day. While describing what the music therapy meant to her, Memory Rider said, "I look forward to it every week. Just being able to have that space." These outcomes are consistent with research that advocates for the increased use of alternative, non-confrontational therapies, such as music therapy, for treatment of addictions (Garrett, et al., 1997; Jones, Latchford, & Tober, 2016; Madden, Fogarty, & Smith, 2014).

Ultimately, the women agreed that the benefits of music therapy extended beyond the sessions and positively impacted the remainder of their inpatient treatment. Longer treatment retention is consistently linked to favorable substance abuse treatment outcomes, but, typically, retention is not high (Simpson, Joe, Rowan-Szal, & Greener, 1997). Interview analysis indicated that music therapy contributed to a better overall treatment experience and, interestingly, during the five weeks of music therapy treatment, none of the women in the cohort left the program early, which was unexpected and inconsistent with pilot experience at the same facility. None of the women explicitly said that music therapy was the reason they stayed in the program, but they did indicate that music therapy helped the time between sessions go better

and gave them something to look forward to. Tiffany explained that she got more out of other therapy groups on the days of music therapy groups. The women's accounts show that positive outcomes from music therapy improved life outside of music therapy and heightened the outcomes of other treatment groups, which suggests successful treatment in and out of music therapy (Simpson, et al., 1995).

Learning to use music as a coping skill and relapse prevention tool was an essential part of the women's experience of music therapy treatment. Coping skills consist of healthier ways to meet one's needs and strategies to avoid substance use (Kearney, 1998). Although coping skills alone aren't sufficient for recovery, they are necessary to help prevent relapse while other areas crucial for lasting recovery develop (Harris, et al., 2005; Treder-Wolff, 1990). The notion that music therapy can help women with SUD develop healthy, generalizable recovery skills is not unfamiliar and, in some ways, music therapy's potential to be used as a resource is intrinsic to what makes music therapy a useful treatment for this population (Gardstrom, et al., 2016; Ficken, 2010; Silverman, 2003). However, no music therapy research has explicitly studied music therapy's impact on relapse and recovery beyond music therapy treatment sessions. Results from the current study indicate that music therapy's contribution to the women's overall recovery was a substantial part of the experience.

Considering the absence of research in this area, music therapy's capacity to aid the women's recovery was surprising. The women were like sponges as they soaked up elements of the treatment that they could transfer to sober living, which suggests a substantial, albeit anticipated, deficit in healthy self-care skills (Harris, et al., 2005; Kearney, 1998). Kaycee Kane illustrated her need to develop healthy living skills when she explained that, for 26 years her hobby was lifting a bottle of liquor. She continued that it has been difficult for her to find a hobby once clean and sober, because she hasn't known who she really is or what she truly likes, and recognized music as a potential hobby that could help her live a healthier life and deal with triggers after leaving treatment.

Women cite destructive habits, depression or despair, pain, and lack of personal control as reasons for relapse (Corcoran & Corcoran, 2001; Harris, et al., 2005; Langan & Pelissier, 2001) and during music therapy, the women were able to address some issues related to these obstacles. Memory Rider explained that when she left the facility to have major surgery, she sang the songs from music therapy to herself to help her deal with stressful complications and stay sober at a time when she "could have easily just messed up" and relapsed, but instead, she returned to treatment and continued her recovery. Memory Rider also noted that music therapy helped to promote physical healing and pain reduction that provided her relief enough to deal with being back in groups following her traumatic surgery. In this case, music therapy served as a tangible coping skill Memory Rider could use to avoid relapse due to lack of personal

control or pain, both of which could have had detrimental effects on her recovery process (Corcoran & Corcoran, 2001; Harris, et al., 2005; Langan & Pelissier, 2001).

As indicated in the “Music forms connections” section, Tiffany explained that being in music therapy allowed her to escape the feelings of isolation that arose during active addiction and perpetuated her substance abuse. Additionally, Tiffany explained that music therapy helped her trust that she could trust in something enjoyable other than drugs and alcohol, which encouraged her to decide to explore her full potential in life and continue on the path to recovery. Music therapy gave Tiffany the chance to practice putting her trust in something positive and alleviate relapse-inducing feelings of depression and despair. Women in recovery also report difficulty building trusting relationships with others, which enhances depression and isolation (Harris, et al., 2005). Tiffany explained that music therapy served as a basis for practicing trust in relationships, which she could then apply to trusting her Higher Power.

Research indicates that treatment that supports sustained recovery emphasizes the development of healthy relationship skills (Harris, et al., 2005). The women expressed their desire to share the skills they learned in music therapy with their families, particularly their children, which revisits the interpersonal connections that music fosters. As mentioned earlier, connection is crucial for substance abuse recovery and interpersonal relationships have a big impact on recovery outcomes, with the potential for positive or negative impact,

depending on the quality of the relationship (Harris, et al., 2005). Personal relationships suffer due to substance abuse (Baird, 2011) and all three women alluded to having lost custody of their children due to drug use either in the past or immediately prior to entering treatment. The idea of sharing songs and playing drums together with family seemed to encourage the women that, with the help of music, they can establish a healthier sense of normalcy and rebuild aspects of their damaged relationships with their children. In the time that I knew her, Memory Rider only mentioned her four children once, and it was when she talked about sharing the music with them. The music allowed these women to be proud of being a “recovering parent” and pass on a more positive legacy to younger generations than the one they previously imagined (Hiersteiner, 2004). Evidence does show that music therapy encourages healthy interactions between addicted mothers and their infants, however, no research has examined music therapy’s impact on the relationship between addicted mothers and their adult children or other family members (Loveszy, 2005).

Some music therapy approaches suggest that music therapy should encourage changes within the larger intrapersonal, sociocultural, and historical contexts of the woman’s life, although research does not exist to indicate that music therapists working with women with addictions are addressing the women’s external systems in treatment (Abrams, 2015; Curtis, 2006; Rolvsjord, 2010). All three women indicated a need to change the music they used to listen to, which is common when individuals with addictions enter recovery (Horesh,

2010). Both Memory Rider and Tiffany indicated that the music they listened to in active addiction was harmful because the lyrical content supported a social system that is oppressive and disrespectful toward women. Both Tiffany and Memory Rider were glad to be exposed to different kinds of music in music therapy and indicated that the content of music therapy sessions gave them a library of music they will be able to listen to and be a part of rather than the “junk” they used to listen to. Although the women did not specify which musical genres they were referring to during the interviews, a pre-treatment survey indicated that the majority of the women preferred to listen to rap and hip-hop. I am not intending to label all music from these genres as “junk,” and acknowledge the successful use of rap and hip-hop when treating addictions (Baker, et al., 2012). It is my intention, however, to share the women’s voices, which indicated that the negative lyrical content common in some genres of popular music contributed to their poor self-image. When describing the pre-recorded music I brought to sessions (popular music with a positive message such as “I am Light” by India.Arie), Tiffany used the word “open,” which was a strong contrast to the way she described the music she used to listen to: “horrible.” Kaycee Kane and Memory Rider also recognized that listening to previously preferred music would trigger urges to drink or use drugs. The women noted that the content of the music used in music therapy was empowering and supported them as they built a new, different life for themselves.

Little other music therapy research has paid attention to music therapy's direct impact on recovery and relapse, but it emerged as an essential part of the experience for these women. The findings of this study echo factors that other mental health disciplines define as recovery supporting. Harris, et al. (2005) identified connection, self-awareness, sense of purpose and meaning, and spirituality as four themes that relate to sustained recovery and all four of those elements emerged as essential to what these three women with addictions experienced as a result of music therapy treatment. Ultimately, the analysis indicates that the women believe that music therapy is a positive contribution toward sustained recovery.

Limitations

The results from this study present the experience of group music therapy for women with addictions. While the analysis paints a picture of three women's shared experience, the phenomenological method does not allow for empirical generalization of findings. The outcomes are not evidence, but a piece of the larger puzzle of emerging best music therapy practice for women with addictions. That being said, the essences shared here were crafted with the upmost rigor and honesty and I believe the results are indicative of what Memory Rider, Tiffany, and Kaycee Kane experienced collectively. However, a larger sample size with more demographic variety might have resulted in a broader view of the experience.

Another possibility is that this study could have been limited by the person effect, as I was the music therapist, the interviewer, and the researcher. During the interviews, a number of women referred to the spirit and energy I brought to the music therapy sessions. I acknowledge that my personality enabled a strong therapeutic alliance to develop with the women and the clinical work came naturally. I do feel that my age, race, and cultural background benefitted my therapeutic relationship with some of the women. Of course, this does not diminish the outcomes in any way, just reaffirms that both music therapy and addiction are complex and dynamic processes and the impact of the individual humans engaging in these experiences together should not be minimized.

I feel that the study was limited by the fact that music therapy is not a typical part of treatment at RWRP. It is possible that the women inflated their responses because they knew music therapy was not going to continue after the study. The women made it clear in the interviews that they hoped the facility would incorporate music therapy into the programming and interview content that focused solely on the desire for continued music therapy was not included in the analysis. Additionally, I intentionally asked questions that emphasized the women's personal experiences of music therapy and redirected back to the research questions if necessary. However, that I had no relationship with the clients prior to starting the study could also be considered a benefit to the integrity of the distilled essences.

Additionally, I felt the potential for therapeutic impact was limited by the fact that I do not work at the facility. Many common treatment approaches with this population emphasize the need to address the woman's greater social context, which I would have done had I more freedom than I did as a short-term student researcher. However, as the women were in an inpatient program, the primary focus of treatment was the individuals and the facility was extremely gracious and accommodating throughout the entire research process.

Implications for Further Research

All three women finished their interviews by saying they wanted to share music therapy with others and that they wished others in their situation could experience music therapy. When I finished the research, a number of staff members expressed that they wished the music therapy could continue. And although providing a case for using music therapy in addiction treatment wasn't the primary focus of this research, this research was done so a better practice could emerge and women with addictions could receive better music therapy services. As indicated in the results and discussion, the women reported that music therapy was an engaging and useful treatment modality, but access to music therapy services is limited to a small percentage of drug and alcohol treatment programs. I recommend further research that examines the impact of music therapy on the overall treatment experience, including treatment retention and re-admittance rates.

The participants in this study revealed a need for healthy coping skills and identified a number of things they learned in music therapy that could aid in relapse prevention. However, the women won't get to practice some of the coping skills until after they leave treatment and therefore, this study could only report that the women planned to use music in recovery. I recommend further research that examines the experience of group music therapy at the outpatient level, which will likely provide a more accurate understanding of how music therapy can help women with addictions avoid relapse while transitioning to or living in the community again, without the support of an inpatient program.

This study provided a collective perspective of the group music therapy experience as it occurred at one facility, with 16 women, and one music therapist in 2016. While I stand by the legitimacy of the results, I acknowledge that the study was limited by sample size, demographic homogeneity, and my specific therapeutic expertise. I see a continued need for phenomenological inquiry with larger and more diverse samples, particularly in terms of race, sexuality, and socioeconomic background. The results from additional phenomenological research could contribute to a meta-analysis that could give a more supported suggestion of what women with addictions experience in inpatient group music therapy.

Finally, I see a need for both clinical practice and research that more thoroughly involves the individual's life context in music therapy treatment. Substance abuse literature provides continued evidence of the large impact the

user's context has on both her recovery and addiction and therefore, best practice is that which treats both the individual and the context, such as resource-oriented music therapy, feminist therapy, and relational-cultural theory, which were addressed in this paper. For example, I see a need for research that examines the role of music therapy on dynamics of family relationships, such as mother-child attachment, or domestic partner relations, as the quality of both are known to contribute to recovery outcomes.

Conclusion

The purpose of this study was to gain insight into the experience of group music therapy for women with addictions with the hope that results would contribute to the emerging best music therapy practice for this population. Following nine twice-weekly music therapy sessions, I conducted a phenomenological microanalysis of three women's semi-structured interviews about the phenomenon. The outcomes from this study align with suggestions for successful addictions treatment for women, which emphasize spiritual healing, connection to others, the self, and spirit, and the development of healthy coping skills. The analysis highlighted some less commonly addressed outcomes of the music therapy experience, particularly in terms of music therapy's impact on the relationship with the self and the beneficial qualities of the music therapy treatment sessions. The discussion illustrates the intricate interactions between addiction, recovery, and music therapy and suggests that a stimulating and supportive therapeutic environment, the inability to fail, and ample opportunities

for genuine music making and singing contribute more to best practice than any one individual intervention. The women reported that they believe music therapy should be a part of substance abuse treatment programs and that it impacted their overall treatment experience for the better. Further inquiry into the impact of music therapy treatment on the women's personal relationships and larger social context is recommended, as the women suggested that music therapy may be beneficial in addressing addiction-related issues across the span of the recovery journey.

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Appendix A: Interview Guide

KEY PHRASES, follow up questions

Tell me more.

Can you elaborate on that?

How else might you say that?

How did that make you feel?

And so you felt...

How did you feel then?

How did you experience it?

How did you do it?

How did your body react?

How did your mind react?

How do you remember it?

How do you think of ____ today?

Then what happened?

What was that like for you?

What did you experience?

What did you think about that?

What did you do then?

What do you take that to mean?

What does that mean to you?

Why is that?

Have you felt that before?

Have you experienced that yourself?

Did that surprise you?

Do you have another example of this?

pause

Rephrasing

I heard you say _____. Is that correct?

PART ONE: intro - getting into it, setting the stage

Researcher questions	Interviewer questions
What is the demographic of the sample?	Tell me a little bit about yourself.
What are their prior experiences in music?	What did music mean to you before you started music therapy?
	How did you think of music before you started music therapy?

PART TWO: the experience - the meat, heart, essence, explaining, describing of the experience

What was meaningful to you

What came out of the sessions

What sticks out when you think of music therapy sessions?

What is your most memorable music therapy moment?

Researcher questions	Interviewer questions
Tell me about your experience in music therapy.	What was it like for you to be in music therapy?
	If you were going to describe this experience to a friend how would you describe it?

	If you could tell yourself something before you started music therapy, what would you tell her?
	If you could go back in time one month and tell yourself something, what would you tell her?
	If you were going to write a tweet or Facebook status about being in music therapy (just a short phrase), what would you say?
How does the music affect the participants on a short term/immediate basis?	How do you (normally) feel during the music therapy sessions?
	How do you (normally) feel after the music therapy sessions?
How did the participants benefit from being in music therapy?	What do you get from participating in music therapy?
	What has happened (changed?) for you as a result of being in music therapy?
	If you were going to give advice to a music therapist just starting music therapy groups at this facility what would you tell them to do?
	How does your experience in music therapy relate to your experience in other therapies at the facility?

	What do you think the group got out of music therapy?
Which interventions were most useful	What did you look forward to in music therapy sessions?

PART THREE: Generalizing, moving forward, incorporating into life and recovery, outcomes, what stands out

Researcher questions	Interviewer questions
	If your future self could come back in time to talk to you right now, what would you want her to say?
Does music therapy affect the participant's recovery?	Do you see a connection between music therapy and your recovery?
	How does music therapy relate to your recovery?
	If you were going to tell your child(ren) about music therapy, what would you tell them? How would you describe it to them?
What has changed?	How do you think of music now?
	How do you feel now?
	If you could tell your future self something, what would you tell her?
	Is there anything else you would like to say?

Appendix B: Ohio University Group Participation Consent Form

Ohio University Adult Consent Form with Signature

Title of Research: The Group Music Therapy Experience at RWRP

Researcher: Amy Dunlap, MT-BC

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study

Much like addiction, music therapy is a very individual process. This study is being done because understanding more about your experience in music therapy at RWRP will help the field of music therapy become a better treatment option for those recovering from addictions. If you agree to participate, you will attend up to eight music therapy groups and will be given the opportunity to answer some questions about your experience in the music therapy group. There are no right or wrong answers, I just want to know more about what you experienced in the group. You should not participate in this study if you feel you were pressured to agree to attend music therapy groups or participate in an interview. Your participation in the study will last for up to eight, 60-minute music therapy sessions and the duration of the interview, approximately 15-60 minutes.

Risks and Discomforts

Risks or discomforts that you might experience are uncomfortable feelings that could come with discussing personal experiences. If you feel uncomfortable, you may choose to stop participating in sessions or discontinue the interview at any time. RWRP counselors will also be available to process with you afterward if need be.

Benefits

Research shows that music therapy is an effective treatment for substance use disorders. This study is important to society because the results will inform other music therapists about the essence of what you experienced by participating in music therapy. This information will help music therapists provide better services.

Individually, you may have benefitted from participating in the music therapy group. By participating in the interview, you might gain increased insight about your experience in music therapy, which could benefit your therapeutic process.

Confidentiality and Records

Your study information will be kept confidential by the researcher. All interviews will be recorded without identifiers and audio files will be kept on the researcher's password-protected computer and will not be shared with anyone else. Audio files will be destroyed no later than September 2018.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:

- * Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
- * Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;

Contact Information

If you have any questions regarding this study, please contact the investigator Amy Dunlap, ad203008@ohio.edu, 330-843-8114 or the advisor Laura Brown, brownl5@ohio.edu, 740-593-4234.

If you have any questions regarding your rights as a research participant, please contact Dr. Chris Hayhow, Director of Research Compliance, Ohio University, (740)593-0664 or hayhow@ohio.edu.

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered;
- you have been informed of potential risks and they have been explained to your satisfaction;
- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study;

- you are 18 years of age or older;
- your participation in this research is completely voluntary;
- you may leave the study at any time; if you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

Signature _____ Date _____

Printed Name _____

Version Date: **[06/17/16]**

Appendix C: Ohio University Audio Recording Consent Form

Ohio University Adult Consent Form with Signature

Title of Research: The Group Music Therapy Experience at RWRP

Researcher: Amy Dunlap, MT-BC

Now that you have completed participation in music therapy sessions and an interview about your experiences, you are being asked to give the researcher additional consent regarding the use of your audio files. This form describes the purpose, procedures, possible benefits, and risks of allowing your audio recording to be used for educational purposes. It also explains how your personal information will be used and protected. Once you have read this form and your questions are answered, you will be asked to sign it. This will allow your audio files to be shared in educational settings. You should receive a copy of this document to take with you.

Explanation of Study

Much like addiction, music therapy is a very individual process. This study is being done because understanding more about your experience in music therapy at RWRP will help the field of music therapy become a better treatment option for those recovering from addictions. You previously agreed to and participated in up to eight music therapy groups and were given the opportunity to answer some questions about your experience in the music therapy group in an audio-recorded interview. I would like to ask your permission to use audio clips of your interview at conference presentations and for educational purposes. All efforts will be made to remove names from audio clips. You should not give permission for your interview audio to be used for educational purposes if you feel you were pressured to agree or don't feel comfortable with anyone other than members of the research team hearing your story in your own words. By signing below, you agree for audio recordings of your interview to be used at conference presentations and for educational purposes.

Risks and Discomforts

One potential risk of consent is that, if audience members know you personally, they could recognize your voice. If you are not comfortable with that risk, please do not give consent.

Benefits

Hearing your experience in your own words will help music therapists better understand your perspective and provide better services to others. You may not benefit directly from giving consent for your audio to be used, however, the field of addiction treatment may benefit from hearing your words.

Confidentiality and Records

Your study information will be kept confidential by the researcher. All interviews will be recorded without identifiers and audio files will be kept on the researcher's password-protected computer and will not be shared with anyone else. If any identifying information exists within the interviews, the researcher will edit the audio to remove the identifying information. Audio files will be destroyed no later than September 2018.

Contact Information

If you have any questions regarding this study, please contact the investigator Amy Dunlap, ad203008@ohio.edu, 330-843-8114 or the advisor Laura Brown, brownl5@ohio.edu, 740-593-4234.

If you have any questions regarding your rights as a research participant, please contact Dr. Chris Hayhow, Director of Research Compliance, Ohio University, (740)593-0664 or hayhow@ohio.edu.

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered;
- you have been informed of potential risks and they have been explained to your satisfaction;
- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study;
- you may contact the researcher at any time and request that your audio files be destroyed immediately

Signature _____ Date _____

Printed Name _____

Version Date: **[08/02/16]**

Appendix D: Musical Background Survey

Music & Me

Name:

1. What are your favorite kinds of music? (i.e. country, rap, rock, pop, classical, gospel)
2. Who are some of your favorite bands and/or musical artists?
3. Do you know how to play any instruments? If so, which ones?
4. What is something you would like to get from music therapy?
5. Tell me a little bit about how music has been present in your life. Some questions to consider are: How often do you listen to music? Do you listen to music when you are happy or sad? Do you have any negative associations/habits with certain music? Do you ever exercise, dance and/or sing to music?



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