The Role of Music Therapy in Increasing Motivation for Change in Individuals with Dual Diagnosis: Alcohol Abuse and Depression in an Inpatient Short-Term Psychiatric Setting

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The Role of Music Therapy in Increasing Motivation for Change in Individuals with Dual Diagnosis: Alcohol Abuse and Depression in an Inpatient Short-Term Psychiatric Setting

by

Ann C. Charoonsathvathana

A Master's Thesis Submitted to the Faculty of Montclair State University

In Partial Fulfillment of the Requirements

For the Degree of Master of Arts in Music Therapy

August 2008
THE ROLE OF MUSIC THERAPY IN INCREASING MOTIVATION FOR CHANGE IN INDIVIDUALS WITH DUAL DIAGNOSIS: ALCOHOL ABUSE AND DEPRESSION IN AN INPATIENT SHORT-TERM PSYCHIATRIC SETTING

A THESIS

Submitted in partial fulfillment of the requirements for the degree of Master of Arts in Music Therapy

by

ANN C. CHAROONSATHVATHANA

Montclair State University

Montclair, NJ

2008
Abstract

The role of music therapy in increasing motivation for change in individuals with dual diagnosis with regard to alcohol abuse and depression in an inpatient short-term psychiatric setting is explored in this pilot study. This study involves a total of ten participants attending five music therapy sessions which consist of music improvisation, drumming, sing along, lyrics discussion, song writing, and music relaxation. A Readiness to Change Questionnaire (RCQ), Music Therapy Questionnaire and Music Therapy Survey form are administered at different times of the sessions. The $t$-tests (within-subject design) are used to analyze the data. The study also includes descriptive data obtained from a Music Therapy Survey form at the time of the participants' discharge. The goal of this study is to investigate whether or not the participants with dual diagnosis will report: a) an increase in motivation to change their alcohol use behavior as measured by an increase in an RCQ score, b) a difference in stage of change before and after the sessions, c) changes in their behavior as a result of music therapy, and d) an increase in their willingness to seek professional, and psychological help after discharge from the hospital. At the end of this study, the participants report an increase in RCQ scores, report differences in stage of change, though they did not attribute all changes to only music therapy sessions, and report their willingness to continue treatment after discharge.
Acknowledgements

This writer would like to take this opportunity to thank Prof. Goodman for her knowledge, her organization style, her encouragement and constant follow up to make sure I am always on track, to Prof. Alleyne for her inspiration, her availability for comments and suggestion especially with regards to statistical analysis, and to Prof. Witten for sharing with me his passion for music and for agreeing to be on the committee. I would also like to thank my patients for allowing me to make music with them. I hope that in some ways I influenced their lives as well as they did mine. Most of all, to my family, for everything, thank you.
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Many recent government data suggests an increase in individuals diagnosed with a dual diagnosis; both a Depressive Disorder along with Alcohol Abuse receiving treatment in an inpatient short-term psychiatric setting. Based on the literature review, researchers of many disciplines including music therapists have found helpful and effective treatment for each diagnosis. However, supportive research in music therapy intervention used in treating individuals with a dual diagnosis is still limited. Many therapists reported one of the challenges in treating this population occurs due to the patients' lack of motivation for treatment or motivation to change their behaviors. This combined with a constant decrease in average length of stay in an acute psychiatric hospital throughout the country (Center for Substance Abuse Treatment, 2005) makes it difficult for therapists to work with patients in a shorter time.

During the past decade, more music therapists have been focusing on developing and improving their treatment approach for this population. Motivation Interviewing (MI) model of treatment recently became popular among mental health professionals used to help increase the patients' motivation to change their addictive behaviors. By combining music therapy intervention along with MI, this researcher believes the patients with dual diagnosis will increase their motivation for treatment of Depression and increase their motivation for change in their alcohol abuse behaviors.

**Introduction**

The Center for Substance Abuse Treatment (2005) reported that it is more common among mental health professionals to receive patients with dual diagnosis especially with both a mental disorder and a substance abuse. Since the 1970s, the program for substance abuse treatment reported having approximately 50 to 75 percent of
their clients diagnosed with more than one disorder. While in mental health settings, the dual diagnosis was reported to be approximately 20 to 50 percent (Sack et al., 1997). Many researchers have found that in addition to depression, a wide range of mental disorders were associated with substance abuse (De Leon, 2000; Sciacca, 1991).

The Epidemiologic Catchment Area (ECA) study sponsored by the National Institute of Mental Health (NIMH) found approximately one-third of those with a lifetime history of major depression also had a lifetime history of a substance use disorder (Regier et al., 1990). The National Comorbidity Survey found 48.5% of women and 24% of men who had a lifetime history of alcohol dependence also had a lifetime history of major depression (Kessler et al., 1997). Therefore, it is important for healthcare professionals including music therapists to consider this association in order to help provide a quality care for the patients.

New approaches and adaptations of traditional treatments were introduced in current practice due to an increased awareness of the interrelationship between the disorders (Evan & Sullivan, 2001; Lehman, 1996; Center for Substance Abuse Treatment, 2005). In addition, the treatment for those presented with a combination of mental disorder and substance abuse were found to be challenging and often reported less than satisfying outcomes (Drake et al., 1998; Woody & Blaine, 1979). Mental health professionals agreed that there are some challenges in working with this population due to its high relapse rate and its unwillingness to acknowledge or change their behaviors (Rothschild, 1995).

In the past decade, more researchers have been focusing on developing and improving models of treatment for clients with both diagnoses. Various forms of music
therapy have been noted to be effective in treatment for individuals with psychiatric diagnosis including depression (Goldberg, 1989; Tyson, 1984). In treating clients with substance abuse problems, music therapy also has been found to help create group cohesion, promote a safe environment for self-expression, and engage members in finding positive coping skills (Garrett et al., 1997; Heaney, 1992; Doweiko, 2002).

Motivational Interviewing (MI), developed by Miller and Rollnick (2002), have been found to be effective and helpful in increasing the clients’ motivation to change their substance use behaviors (Rollnick & Miller, 1995; Prochaska & Norcross, 1999; Project MATCH Research Group, 1997; Miller & Rollinck, 2002). By adapting Motivation Interviewing technique into music therapy sessions, this researcher believes the patients with dual diagnosis will increase their motivation for treatment of Depression and increase in their motivation for change in their alcohol abuse behaviors.

**Literature Review**

*Dual Diagnosis*

The term “dual diagnosis” is a general term used to describe individuals with two coexisting disorders or with both mental and developmental disorders (The Center for Substance Abuse Treatment, 2005). However, among mental health professionals, the term “dual diagnosis” refers to an individual with both a substance abuse or dependence problem and a coexisting psychiatric disorder (Lehman, 1996). Many terms have been used to describe those conditions, and many of them are still being used in the literature and in the treatment settings (CSAT, in press). Those terms include Chemically Abusing Mentally Ill or Chemically Addicted and Mentally Ill (CAMI), Mentally Ill Chemical Abuser (MICA), Mentally Ill Substance Abuser (MISA), Mentally Ill Chemically
Dependent (MICD), Substance Abusing Mentally Ill (SAMI), Co-Occurring Disorder (COD), Co-Occurring Addictive and Mental Disorders (COAMD), Dually Diagnosed, Dually Disordered, and Addiction and Co-occurring Disorders (ACD) (Center for Substance Abuse Treatment, 2005). Recently, the research literature has seen more use of the term “dual diagnosis” (Drake & Wallach, 2000). To avoid further confusion of multiple names and/or abbreviations, the term “dual diagnosis” in this study referred to individuals with diagnosis of alcohol abuse and major depression.

Margolis and Zweben (1998) reported individuals with substance abuse problem can develop symptoms similar to those with psychiatric disorders. Many therapists, therefore, face the assessment questions of what is the primary problem or diagnosis in individuals with dual diagnosis. What caused the secondary problem? Are those problems caused by the substance use or the psychiatric disorders? Which diagnosis comes first, the alcohol use or the depression? (Schuckit, 1986). Regardless of what diagnosis is primary, many therapists agreed that the goal of treatment for the dual diagnosed individuals is “dual recovery”, meaning, recovery and treatment for both disorders simultaneously (Daley & Zuckoff, 1999; Daley & Thase, 2000; Evan & Sullivan, 2001).

Alcohol Abuse and Alcohol Dependence

The standard use of the term “alcohol abuse” arrived from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V) (American Psychiatric Association [APA] 2000). It describes a clinically significant impairment or distress in individuals caused by the maladaptive patterns of behaviors due to alcohol use. These maladaptive patterns of substance use “manifested by recurrent and significant adverse consequences related to the repeated use of substances” (APA 2000, p. 198). APA (2000)
also describes the behaviors include; neglecting work, home, or school responsibilities; using substances in physically hazardous situations; having recurrent legal problems; or having social or interpersonal problems.

Alcohol dependence is considered more severe than abuse (Evans & Sullivan, 2001). The individuals in this category have increased tolerance for the substance. The greater amount of alcohol has to be used in order to achieve the desired effect (Doweiko, 2002). The individuals with alcohol dependence may display their attempts to cut down or control drinking, their preoccupation with getting, using, and recovering from their uses. They may also have withdrawal symptoms, have lost interest in other life activities, and have difficulty stopping the substance use despite knowing it causes harm to them physically and psychologically (APA, 2000).

**Depression**

Clinical features of a major depression can be described as deeply sad, “down”, or irritable mood, accompanied by additional symptoms that lasts at least 2 weeks (Evan & Sullivan, 2001). According to DSM-V (APA, 2000), the additional symptoms include the following: (1) a depressed or irritable mood most of the day, nearly every day; (2) markedly diminished interest or pleasure; (3) significant weight loss or gain while not dieting; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation nearly every day; (6) fatigue or loss of energy nearly every day; (7) feeling of worthlessness or excessive or inappropriate guilt; (8) diminished ability to think or concentrate, or indecisiveness; and (9) recurrent thoughts of death, suicidal ideation or attempt with or without a specific plan. Five (or more) of the above symptoms are needed to make the
diagnosis. For Major Depression, the symptoms are more severe and last more than two months.

Short-term Psychiatric Setting

The mental health system provided its priority services on acute crisis intervention and stabilization of an ongoing treatment and rehabilitation services for individuals with severe and persistent mental illness (Center for Substance Abuse Treatment, 2005). Individuals with depression often end up on the psychiatric unit, either voluntary or involuntary, due to their suicidal ideation (Daley & Moss, 2002). Due to a sudden increase in population with dual diagnosis, many treatment programs in a psychiatric setting offer not only mental health treatment but also substance abuse treatment including detoxification (Center for Substance Abuse Treatment, 2000).

Models of Treatment

Stage of Change Model

Developed by Prochaska and DiClemente (1992), this “Stages-of-change” model examined multiple theories about how changes occur and applied the finding specifically to modify the behavior of the individuals with substance abuse. Their modal suggests five stages or processes a person experiences when considering, starting, and trying to maintain a new behavior (Prochaska & DiClemente, 1992).

First stage, Precontemplation, is the stage where the individuals with substance abuse may be partly or completely unaware of their problems therefore do not consider making changes in their behaviors. Second stage, Contemplation, is the stage where the individuals begin to notice the problem and begin to consider making changes. They, however, remain ambivalent in deciding between to continue using or to stop. Third
stage, Preparation, is the stage where the individuals begin to vision the advantages of change. The attempts to reduce or stop using by the individuals may already have been made (Prochaska & DiClemente, 1992). The individuals goals often are set and the commitment are made at this stage (Hodgson & Rollnick, 1992).

Fourth stage, Action, is the stage where the individuals begin to follow through with the plan. The changes in their lifestyles are made include modifying their habits and environment. At this stage, the individuals often face the difficulty coping with psychological and physiological effects of withdrawal (DiClemente & Prochaska, 1998).

Fifth stage, Maintenance, is the stage where the individuals have established new behaviors. They have worked to sustain sobriety and to prevent relapse (Marlatt & Gordon, 1985). At this stage, the individuals may have learned to detect and to become aware of triggers that may lead to substance use. Throughout the stages of change, the individuals can “remain stable, progress, or recycle” among each stages (Evans & Sullivan, 2001, p. 194).

Many researchers (Carroll, 1996; Kadden et al., 1994) suggested strategies used to facilitate change in individuals. Carroll (1996) focuses on changing individuals’ behaviors and their ways of thinking regarding their substance use by using cognitive-behavioral approach. Osher and Kofoed (1989) suggested the therapist adopt model of motivation by using: (1) Engagement, where the therapists’ goals is to convince the individuals that treatment is necessary; (2) Persuasion, where the therapists convey to the individuals that abstinence is needed; (3) Treatment, where the therapists help the individuals develop coping skills needed to maintain sobriety, and (4) Relapse prevention, where the therapists help the individuals identify triggers for continued
substance use and help them to develop coping skills in order to handle the situations without having to use (Gorski, 2000).

Rollnick and Miller (1995) developed a Motivational Interviewing (MI) technique that focuses on helping the individuals explore their diseases, resolve their ambivalence, and change their behaviors. Schuckit (2000) along with many researchers found higher success rate of treatment in highly motivated patients than a lesser motivated one (Alloy, Jacobson, & Acocella, 1999; Miller & Rollnick, 2002).

**Motivational Interviewing (MI)**

Motivational Interviewing (MI) is a brief treatment intervention developed with a goal to facilitate change of addictive behaviors by increasing an individual’s motivation to change (Miller & Rollnick, 1991). The principle of MI is drawn from literature on motivation, stages of change, and client-centered approach which considers the responsibility and capability for change belonging to the individuals (Miller & Rollnick, 1991). The therapist’s task, therefore, is to provide an intervention that will increase the individual’s motivation for and commitment to change (Rollnick & Miller, 1995). Many researchers’ data supporting the effectiveness of MI in various setting recently has increased rapidly (Project MATCH Research Group, 1997; Miller & Rollinck, 2002).

Miller and Rollnick (1991) suggested the therapist’s use of five specific principles of MI to increase motivation for change of behaviors in the individuals with dual diagnosis. They recommended that the therapist express empathy, develop discrepancy and explore the advantages of changing the undesired behavior, avoid arguing with the patients and allow clients to acknowledge the need to change, to follow their resistance so
they could feel free to explore their feelings, and provide reinforcement for their effort to change (Miller and Rollnick, 1991).

Music Therapy

Music therapy interventions have been proved to be effective in treating individuals with dual diagnosis (Goldberg, 1989; Tyson, 1984). Many researchers support the use of music in treatment for patients with substance abuse due to its non-confrontational quality (Garrett et al., 1997; Heaney, 1992). Tyson (1984) reports music therapy sessions provide a safe environment for clients to develop trust and sense of self-discovery. Music therapy also has been shown to increase group cohesion, reduce stress, and alter mood and attitudes among individuals with substance use (Freed, 1987; Treder-Wolff. 1990). Treder-Wolff (1990) reports that the process of creating music also provides the patients an opportunity to be in touch with one’s thoughts and feelings about recovery. The emphasis on transferring what the patients had experienced, learned, or developed in music therapy sessions into the patients’ daily life was found to be helpful in preventing relapse in substance abusers (Doweiko, 2002).

Montello (1993) suggests that creative function of music in treatment setting allow for the individuals to make own decisions about changing their behaviors. The individuals can then be motivated as Montello (1993) wrote:

“This is where creative arts therapy can be so effective in facilitating deep change and growth in patients who are in the throes of disease. It helps them to connect with the healer archetype within through creative play. This archetype becomes empowered and the encouraged to promote healing on many levels” (p. 45)
Many substance abusers are found to have difficulty engaging in social interaction and communication with others (Evans and Sullivan, 1991). In music therapy sessions, Ghetti (2004) reported group music therapy provides opportunities for the individuals to practice those skills during the sessions. To help these patients increase self motivation for change, music can be used as a tool to help them discover their thoughts, feelings, desires, values, and hope for the future (Ghetti, 2004). In this study, the music therapy intervention provided included music improvisation, drumming, song writing, and song discussion to help increase the patients’ motivation for change.

**Improvisation**

Rudd (1998) defines music improvisation as a spontaneous process of creating or arranging music in a “here-and-now” and from moment-to-moment experience. It is considered a form of self-expression through music making (Brucia, 1987). The improvisation also occurs when the therapists and the patients become partners in creating products (Rudd, 1995). In music therapy session, the therapists can allow the patients to add in their own creative process and product in the space and time provided by the therapists as part of the improvisation (Kenny, 1982). Brucia (2001) defines various types of improvisations which include: (1) free improvisation, in which the patients create music or sound of their own will without any guidelines, directions or rules provided by the therapists, (2) guided improvisation, in which the therapists provide some form of direction such as verbal instruction as a base for the improvisation, (3) non-referential improvisation, in which the patients create music either freely or with specifics musical guidelines such as a melody, rhythm, tempo, chord progression etc., or instruction as a base for the improvisation such as a story, art work, title, emotion etc.,
and (5) processed improvisation, in which the therapists encourage the patients to reflect or discuss experience after making music (Brucia, 2001).

Because changes and transformation occur during the process of creating music, the patients then can gain insight and be aware of own ability to change not just in the music, but in real life behaviors (Bonny, 1977). The therapists can “meet” the patients at their musical levels and gradually shift or guide them to a different music level or stage (Soshensky, 2001). Through improvisation, patients are able to decrease their sense of isolation, which is one of the core symptoms of depression and substance abuse (Soshensky, 2001; Jones, 1998).

**Drumming**

Many researchers have found evidence that drumming can introduce patients to a relaxation state and altered states of consciousness (Friedman, 2000; Sobell, Ellingstad and Sobell, 2000). Some therapists considered this altered state as the same or substitute for the one introduced by substances (Winkelman, 2003; Winkelman, 2001; O’Connell, 1991). Drumming as a form of improvisation also increases group cohesiveness, creates hope, and provides safe environment for expression of emotional energy (Priestley, 1985; Yalom, 1985; Goldberg, 1989).

**Song Writing**

Turry (1989) suggests that therapists, through song writing, allow the patients to experience feeling of being supported by the therapists as well as other group members. By increasing self-expression in song writing sessions, a “healthy personality” emerges (Turry, 1989). Together as a group, the therapist can help the patients identify the emotions or problems related to substance abuse as well as identify different ways of
coping without the use of substances (Silverman, 2004; Freed, 1987; James, 1988; Doughtery, 1984). Rolvsjord (2001) reports that patients who are resistant to verbal therapy or not motivated for treatment can benefit from song writing sessions. The songs the patients created can later be used for future discussion if needed. Rolvsjord (2001) found that the patients tend to get more involved in the discussion when referred to songs they created. The process of creating a song from the beginning to end can also provide patients with a sense of achievement (Nolan, 1998).

**Music Listening**

The technique of using music listening to deliver the patients to the state of relaxation can help increase a sense of self-care (Nolan, 1989). In a group setting, choosing, sharing and accepting others choice of music, patients can learn to develop their own identity (Bednarz and Nikkel, 1992). Music, when used with guided imagery it can be considered as a replacement to substances due to its ability to lead patients to the altered state of consciousness (Gardstrom, 1987). Bonnie and Savary (1973) studied the use of music listening to explore human’s altered states of consciousness. This Guided Imagery and Music (GIM) was developed by Helen Bonny (Bonny and Savary, 1973) who uses music to aid the process of self-discovery. Classical music listening is used in the session along with a trained therapist who assist the individual’s entry into a relaxed state. The client can describe the images, feelings, and sensations evoked by this music listening experience to the therapist (Bonny and Savary, 1990). The Guided Imagery and Music’s therapists believe that the individual’s experience during the session is a reflection and an interaction of an ongoing life of the person (Bonny, 2002; Goldberg, 1989; Bonny and Savary, 1973).
"Song Discussion/Lyric analysis"

Freed (1987) found lyric analysis to help individuals increase social and listening skills. James (1988) suggests that patients develop a higher self-esteem and more positive attitude towards their recovery after attending a lyric analysis session. Individuals with substance abuse are also more willing to comply with treatment and be more willing to change in song discussion sessions (Walker, 1995). Jones (1998) found emotional change in the participants with substance abuse after a single song writing and lyric analysis session.

According to literature reviews, most treatments provided are mostly focus on one primary diagnosis. Though many new treatments are introduced due to the increased awareness of the interrelationship between the disorders (Evan & Sullivan, 2001; Lehman, 1996; Center for Substance Abuse Treatment, 2005), the treatments including music therapy for those presented with dual diagnosis are still limited. The researcher, therefore, wanted to focus on providing music therapy treatment specifically for this population based on hypothesis that music therapy interventions will help increase the motivation for change in an individual with both a Depressive Disorder along with Alcohol Abuse.

After the participants completed five music therapy sessions, the researcher believes: a) the participants will report an increase in motivation to change their alcohol use behavior as measured by an increased in a Readiness to Change score, b) the participants will report a difference in stage of change before and after music therapy sessions, c) the participant will contribute the changes in their alcohol abuse behaviors to music therapy sessions as reported by the music therapy questionnaire and music therapy
survey form, and d) an increase in their willingness to seek professional, and psychological help after discharge from the hospital.

**Methods**

*Design*

This study is a pilot study designed to test whether a combination of music therapy interventions affect the participants’ motivation for change regarding their alcohol abuse behavior. Both a quantitative and qualitative analysis was used to analyze the data. The T-Tests (within-subject design) was used to analyze the participants’ Readiness to Change Scores before and after the first and the fifth music therapy session. The same T-Tests was also used for the Music Therapy Questionnaire administered after the first and the fifth sessions. The study also included descriptive data obtained from a Music Therapy Survey form at the time of the participants’ discharge.

*Participants*

The study was carried out after it was approved by Montclair State University’s Institutional Review Board. A total of 10 participants (N=10) meeting the criteria for alcohol abuse and major depressive disorder, as determined by the unit’s psychiatrist, were used in this study. In accordance with the Declaration of Helsinki, the fifth and current revision in 2000, the research participants were asked for written consent after the researcher had fully explained the procedures, potential benefits and risks of this study. All participants were informed of their rights to withdraw from the study, their rights to receive routine treatments and discharge plan provided by their treatment team regardless of whether or not they decided to participate in this study, and their confidentiality.
The first ten participants admitted on the Psychiatric Intensive Care Unit and meeting the above criteria of dual diagnosis were selected. The patients who were incapacitated, declared incompetent, or have Power of Attorney were excluded.

**Setting**

The researcher conducted this study in an 18-bed Psychiatric Intensive Care Unit in a hospital on the East Coast. It is a short-term care facility with an average length of stay between 7-14 days. Program goals include detoxification, psychiatric stabilization, and referral to continuing follow up care. Treatment services include medical management, individual and group drug counseling, psychoeducational groups, family meeting, therapeutic activities and discharge planning. All participants were referred from the community psychiatric emergency screening center.

All the therapeutic groups on the unit were normally held in the community activity room or the art room. The groups provided include community meeting, exercise, recreation activities, topic focus group, medication teaching, clinician group, nutrition group, Mental Illness and Substance Abuse (MICA) group, expressive arts, pet therapy, art therapy, and music therapy. All participants were encouraged to attend these therapeutic groups especially music therapy groups daily as part of their treatments. The patients, however, had a choice whether or not they would like to participate.

During the music therapy sessions, the researcher arranged approximately 10-12 chairs forming a circle in the middle of the room. The musical instruments were arranged along the side of the wall included hand drums, bongos, tambourines, maracas, a keyboard, a guitar, shakers, an ocean drum, etc. A white board and a stereo were also available for use during the sessions.
Music therapy sessions were scheduled for 45 to 50 minutes each on Mondays, Tuesdays, and Fridays according to the unit's activity schedule. There was an announcement made through the unit's intercom five minute prior to the starting time of each music therapy sessions.

*Procedures*

After the participants agreed to be in the study, the first Readiness to Change Questionnaire (RCQ; CSAB, 1999) (Appendix C) was administered by the researcher prior to them attending the first music therapy session. Five music therapy sessions were provided for all 10 participants, whether or not they were in the same sessions. At five minutes after the first music therapy session, the researcher asked the participants to fill out the same RCQ and a Music Therapy Questionnaire (Appendix B). At the fifth music therapy session, the researcher asked the participants to fill out the RCQ before this session. After the fifth session was completed, the participants were asked to fill out both RCQ and Music Therapy Questionnaire. At the time of discharge from the hospital, the researcher brought the participants to the consult room and asked the participants to fill out the Music Therapy survey form (Appendix D) in private. After the participants completed the forms, they were asked to drop them off in the locked box.

*Music Therapy Sessions*

The participants in this study attended all the groups on the unit along with other patients. The identity of the participants remained anonymous in all sessions. Each music therapy session was divided into five activities as follow;

*Activity 1:* Introduction and establishment of group rules (approximately 5-7 minutes)
• The researcher welcomed all patients to the group, and briefly let the group members introduced themselves.

• The researcher oriented the group to music therapy and general rules such as be respectful, avoid cross talking, be willing to give and accept feedback from others in respectful ways, be concerned about safety by avoiding verbal or physical aggression action or language towards self, others, or instruments.

• All patients were encouraged to remain in the group throughout the session. The patients were allowed to leave the group if at some point they felt uncomfortable or unable to tolerate the group. They, however, were encouraged to come back and join the group after the activity was over.

**Activity 2:** Instrumental improvisation/ drumming: warm up, “who am I”, or “group cohesion” (5-7 minutes)

• The researcher put all musical instruments in the middle of the group. The example of instruments include hand drums, bongos, tambourines, maracas, shakers, glockenspiels, a keyboard, a guitar, an ocean drum etc.

• The patients were asked to pick the instrument that best represent them or represent how they feel at the moment.

• The patients were offered an option of playing out their feelings or emotion on the instrument.

• If the members feel uncomfortable playing, the researcher helped lead the group to start playing the same simple beat and ask that member to follow.
The patients were told they can add their own beat into the existing beat when they were ready.

The researcher can manipulate the music, for example, playing along with the group’s beats, adding new beat, changing tempo or timbre.

After the improvisation, the researcher asked the group to provide feedbacks, thoughts, or comments.

**Activity 3:** Preparation and setting goals (10 minutes)

- The patients were asked to briefly explore the events that led them to hospitalization.
- The researcher refocused the patients to the music therapy session and asked how they would like to benefit from music in this particular session.
- The researcher facilitated discussion about the motivational approach in specific to behavioral change.
- The researcher then introduced next activity based on the patients’ goals.

**Activity 4:** Sing along, Lyric discussion or Song writing based on patients’ goals (15-20 minutes)

- Songs that focused on the theme(s) apparent in the group were introduced.
- The researcher chose how to deliver the song either by live guitar sing along or by use of prerecorded music based on the energy level of the group.
- The patients were given song books with list of songs categorized by theme as presented in Table 1.
Table 1.

*Song lists: The list of songs presented for Sing along, Lyric discussion, and Song writing.*

<table>
<thead>
<tr>
<th>Song</th>
<th>Artist/Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Self efficacy, self image, self esteem</em></td>
<td></td>
</tr>
<tr>
<td>Swinging On a Star</td>
<td>Bing Crosby</td>
</tr>
<tr>
<td>Who I Am</td>
<td>Smile Empty Soul</td>
</tr>
<tr>
<td>Who I Am</td>
<td>Jessica Andrews</td>
</tr>
<tr>
<td>I Would Be</td>
<td>Alanis Morissette</td>
</tr>
<tr>
<td>That Don’t Impress Me Much</td>
<td>Shania Twain</td>
</tr>
<tr>
<td><em>Support</em></td>
<td></td>
</tr>
<tr>
<td>Jumper</td>
<td>Third Eye Blind</td>
</tr>
<tr>
<td>Don’t Give Up</td>
<td>Peter Gabriel</td>
</tr>
<tr>
<td>Anytime You Need A Friend</td>
<td>Mariah Carey</td>
</tr>
<tr>
<td>You’re Not Alone</td>
<td>Olive</td>
</tr>
<tr>
<td>I Am a Rock</td>
<td>Paul Simon</td>
</tr>
<tr>
<td>One Love</td>
<td>Bob Marley</td>
</tr>
<tr>
<td>You’re Only Human (Second Wind)</td>
<td>Billy Joel</td>
</tr>
<tr>
<td>Friends In Low Places</td>
<td>Garth Brooks</td>
</tr>
<tr>
<td><em>Relapse</em></td>
<td></td>
</tr>
<tr>
<td>Every Day Down</td>
<td>Joan Jones</td>
</tr>
<tr>
<td>Black Balloon</td>
<td>Goo Goo Dolls</td>
</tr>
<tr>
<td>I’m Not An Addict</td>
<td>K’s Choice</td>
</tr>
<tr>
<td>Good Night Elizabeth</td>
<td>Counting Crows</td>
</tr>
</tbody>
</table>
The Role of Music Therapy in Motivation for Change

<table>
<thead>
<tr>
<th>Song</th>
<th>Artist/Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to change</td>
<td></td>
</tr>
<tr>
<td>Stuck In the Moment</td>
<td>U2</td>
</tr>
<tr>
<td>Breakaway</td>
<td>Kelly Clarkson</td>
</tr>
<tr>
<td>Father and Son</td>
<td>Cat Stevens</td>
</tr>
<tr>
<td>The River</td>
<td>Garth Brooks</td>
</tr>
<tr>
<td>Nothing Really Matters</td>
<td>Madonna</td>
</tr>
<tr>
<td>You Won’t See Me Cry</td>
<td>Wilson Phillips</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping skills</td>
<td></td>
</tr>
<tr>
<td>You Learn</td>
<td>Alanis Morrissette</td>
</tr>
<tr>
<td>The Freshman</td>
<td>The Verve Pipe</td>
</tr>
</tbody>
</table>

- After the song was over, the researcher asked the group to provide feedback to the song. The discussion based on the theme the member selected. They can share their opinion about their agreement or disagreement with the lyrics.

- If appropriate, the researcher then guided the members to write their own songs. They were asked to replace the existing lyrics, or create their own version if needed. The researcher helped facilitate the product by playing the melody or chord on the guitar or keyboard.

Activity 5: Verbal Processing/Relaxation Close up (8-10 minutes)
The researcher asked the group to summarize what had happened in the session and let them evaluate whether they have achieved their personal goal for this group.

The researcher selected a song or instrumental music for the group to help induce calming effect. The example of the songs includes songs from a well known motion picture such as Forest Gump, Kikujiro, Winged Migration. More songs from different artists were used at the patients’ request such as songs from Enya, Kevin Kern, Daina Krall, Enio Morricone etc. The researcher also used classical music such as Pachelbel’s Canon in D Major, Bach, J.S. Suite #4 in E -3 Gavotte En Rondeau, Cimarosa’s Sonata in B Minor etc.

The researcher then played a selected recording music on the stereo while guiding patients to do a physical stretch i.e. bending neck forward and back, tilting neck sideways, rolling shoulders, stretching arms, bending back and waist forward and back, lifting and stretching legs and rolling ankles.

The researcher had an option of letting the members close their eyes and listen to the music.

When the session was over, the researcher affirmed patients for their participation.

**Measurement Tools**

The measurement tools used in this study included a Music Therapy Questionnaire (Appendix B), a Readiness to Change Questionnaire (RCQ) (Appendix C), and a Music Therapy survey form (Appendix D).
A Readiness to Change Questionnaire (RCQ) used in this study is a 12 item questionnaire developed by Rollnick et al. (1992) based on Prochaska and DiClemente stages of change model developed in 1986. It consists of three 4-items scales. Each of the three scales represents a stage of change from pre-contemplation (P), contemplation (C), and action (A). The answers are arranged in a 5-points Likert scale ranging from "strongly disagree" to "strongly agree". The score for each answer ranged from -2 (strongly disagree) through 0 to +2 (strongly agree). Therefore, the range for each scale is -8 through 0 to +8. The participant's appropriate stage of change was designated to a highest score. According to multiple researchers (Heather et al., 1993; Rollnick et al., 1992; Defuentes-Merillas, Dejong & Schippers, 2002), the RCQ has shown satisfactory psychometric properties, and very good concurrent validity on different measures (Heather et al., 1993).

A Music Therapy Questionnaire form used in this study was developed by this researcher based on the RCQ (Rollnick et al., 1992). Both the Music Therapy Questionnaire and Music Therapy Survey form were used in an attempt to obtain descriptive data of whether or not the participants based their change in their alcohol abuse behavior on the effect of music therapy sessions.

Data Collection

The RCQ scores and scores obtained from the music therapy questionnaire were examined in four phases. First, the RCQ scores obtained before and after the participants attended the first music therapy session were analyzed. Second, the researcher analyzed the RCQ scores obtained before and after the fifth music therapy session. Third, a t-test for correlated samples was used to compare the RCQ scores obtained before the first and
after the fifth session. Finally, a t-test was also used to compare the music therapy questionnaire scores obtained after the first and the fifth session. The researcher used SPSS statistical software program to analyze the above data. The descriptive data from the music therapy survey forms were categorized into similar themes and written as the participants reported.

**Results**

Throughout the study, none of the participants had requested to drop out of the study. A total of 10 participants were able to attend all five music therapy sessions as required. The participants consisted of 6 males and 4 females between the ages of 22 and 57 years with the mean age of 34.7. All of them were diagnosed with both a Depressive Disorder and alcohol abuse by the unit’s psychiatrist.

**Quantitative Results**

Although, not all participants attended the same music therapy session, the format of the session remained the same. The RCQ scores obtained prior to and after each participant attended the first session can be described in Figure 1. The results of the RCQ scores obtained prior to and after the participants attended the fifth music therapy session can be described in Figure 2.
The Role of Music Therapy in Motivation for Change

Figure 1.

*The RCQ scores obtained before the participants attended the first session in comparison with the scores obtained after the session.*

In this first session, the participants’ RCQ scores were considered significantly higher after attending a single music therapy session ($M = 2.9, SD = 5.875$) as compared to prior to the session ($M = -2.2, SD = 6.1065$), $t(9) = -2.61$, $p < .05$. 
In this fifth session, the participants' RCQ scores were considered significantly higher after attending this last music therapy session ($M = 9.2$, $SD = 5.1164$) as compared to prior to the session ($M = 5.2$, $SD = 4.158$), $t(9) = -3.69$, $p < .05$. 

The RCQ scores obtained before the participants attended the fifth session in comparison with the scores obtained after the session.

In this fifth session, the participants' RCQ scores were considered significantly higher after attending this last music therapy session ($M = 9.2$, $SD = 5.1164$) as compared to prior to the session ($M = 5.2$, $SD = 4.158$), $t(9) = -3.69$, $p < .05$. 

In this fifth session, the participants' RCQ scores were considered significantly higher after attending this last music therapy session ($M = 9.2$, $SD = 5.1164$) as compared to prior to the session ($M = 5.2$, $SD = 4.158$), $t(9) = -3.69$, $p < .05$. 

The RCQ scores obtained before the participants attended the fifth session in comparison with the scores obtained after the session.
Table 2.

_t-Test for correlated samples compares RCQ scores obtained before session 1 and RCQ scores obtained after session 5._

<table>
<thead>
<tr>
<th>t-Test for</th>
<th>Session 1</th>
<th>Session 5</th>
<th>t-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>correlated samples</td>
<td>Precontemplation</td>
<td>Contemplation</td>
<td></td>
</tr>
<tr>
<td>RCQ Scores</td>
<td>-2.2</td>
<td>9.2</td>
<td>6.1065</td>
</tr>
</tbody>
</table>

_Note. RCQ = Readiness to Change Questionnaire._

The participants’ motivation for change as determined by RCQ scores were significantly higher after attending all 5 music therapy sessions (M = 9.2, SD = 5.1164) as compared to after only 1 music therapy session (M = -2.2, SD = 6.1065), \( t(9) = -4.07, p < .05 \). The effect size for these samples is considered a large effect (\( d = \pm 1.286 \)) due to its results were over one standard deviation higher after 5 music therapy sessions as compared to one session. This information is described in Table 2.

Table 3 indicated the participants’ motivation for treatment as determined by the Music Therapy Questionnaires scores. The scores were considered to be significantly higher after the participants attended all 5 music therapy sessions (M = 8.9, SD = 8.3193) as compared to after only 1 music therapy session (M = 0.5, SD = 6.3289), \( t(9) = -3.86, p < .05 \). The effect size for these samples is considered a large effect (\( d = \pm 1.22 \)) due to its results were over one standard deviation higher after 5 music therapy sessions as compared to one session.
The Role of Music Therapy in Motivation for Change

Table 3.

**t-Test for correlated samples compares MT scores obtained after session 1 and MT scores obtained after session 5.**

<table>
<thead>
<tr>
<th>t-Test for</th>
<th>Session 1</th>
<th>Session 5</th>
<th>t-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>correlated samples</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>MT Scores</td>
<td>0.5</td>
<td>6.3289</td>
<td>8.9</td>
</tr>
</tbody>
</table>

*Note. MT Scores = Scores obtained from a Music Therapy Questionnaire.*

**Qualitative Results from the Music Therapy Survey**

All participants had filled out and returned the music therapy survey forms. Ninety percent of the participants reported their willingness to comply with follow up plan and treatment after discharge from the hospital. Ten percent of the participants reported they were willing to comply with follow up care “just to get discharged”. All the participants reported they benefited from the music therapy sessions, though 20% of the participants reported no changes in their thoughts about their drinking behaviors based on these sessions. Ninety percent of the participants reported positive outcome from attending music therapy sessions. Those positive outcomes included statements such as; a) “music helped relax me”, “helped relieved some stress”, b) it helped “take my mind off of unpleasant things” i.e. sadness, drinking, feeling alone, depression, c) “it brought back some good times”, “it helped me think of a good time without being drunk”, d) “it made me realized that I’m not alone”, and e) “it took me out of myself for a while”. Ten percent of the participants reported music therapy sessions “forces me to look at my problem, and now I have to do something about it”.
Regarding the second questions in the survey form, 90% of the participants reported they have changed during their hospital stay. They reported feeling less depressed and more alert mentally and physically. They reported feeling more comfortable communicating with others, less intimidated about being in group therapy, and more hopeful about their treatment after discharged from the unit. Of this population, 88% reported they contributed most of those changes to the combination of medication and all therapy received on the unit including music therapy.

In response to the question “Have the music therapy sessions influenced your way of thinking regarding your drinking habits?”, 40% of the participants reported they had already aware of their drinking problem, though they were more positive and hopeful about changing their behavior after the music therapy sessions. Forty percent of the participants reported increase awareness of alternative coping by using music instead of alcohol. Such statements included “I don’t have to drink to relax”, “I can be with other people and socialize with them without alcohol”, “I didn’t know I can have this much fun without drinking”, “I’ve learned that a little tension in life is okay. I don’t have to run to alcohol all the time” and, “I want to get back to my music again when I leave (the hospital)”. Twenty percent of the participants reported increase awareness of their alcohol use with the statement “I’m more in tuned with what I need to do and what I had done wrong to myself”, and “It (music therapy) made me more aware of when I have urges and what triggers them”. Ten percent of the participants reported feeling supported by peers during music group with the statement “it feels like I can achieve something in this group”
The comments obtained from the participants regarding music therapy were mostly about wanting to have more music therapy sessions because “it helps my time in here go faster”, “it helps me forget about my problem for a while”, and “it helps relaxes me”. One participant reported lack of knowledge about music therapy until he attended one.

**Summary and Discussion**

The result reported in this study provided evidences of an increase in motivation for change in participants with depression and alcohol abuse behaviors after attending five music therapy sessions. However, 88 % of the participants with an increased RCQ scores attributed this change to both a combination of medication and all therapy received on the unit including music therapy. Ninety percent of the participants were willing to comply with treatment of both disorders after being discharged from the hospital.

Although, no significant data suggested the change in motivation came from attending only music therapy sessions, all participants reported positive outcomes, i.e. better mood, better attitudes towards treatment, better coping, more hopeful about future, positive feeling about being supported by peer, and being able to release emotions in music group. Most of the participants verbally reported increased awareness of their alcohol abuse behavior and were able to practice their coping skills through music making. This researcher found a lot more meaningful data observed from the sessions, but is unable to provide or analyze them in this study due to the nature of this quantitative design. For example, some participants reported they were unable to tolerate “tension” or “dissonance” during music making and were ready to walk out of the session. However, they decided to stay until the end. After support and encouragement from peers and after
the music came to a “solution”, the participants reported feeling of relieve and proud that they can “stick it to the end” without walking away from the problem or in some cases they reported “without getting a drink”. Some of the participants reported increased insight into their illness through song/lyrics discussion. They reported they were able to regain control by changing the lyrics of the song and feel the sense of achievement after singing the new version they have created. Some participants were able to relate the experience in music making and music initiation to an increased feeling of confidence in initiating conversation with others without the use of alcohol.

**Recommendations**

Recommendations for future study relate to further analysis of descriptive data, the inclusion of a possible control group comparison and the possibility of expanding the study to a larger sample size.

There were many other significant points of descriptive data of moments observed throughout the sessions that this researcher was unable to report in this study, for example, what participants disclosed verbally about their alcohol use behavior during music making or music listening or how participants interacted with other group members in music therapy sessions etc. It is suggested for the future researcher to explore these data using qualitative analysis or case study in order to capture the participants’ verbal disclosures, thoughts, feelings, and motivation for change in their alcohol use behaviors. In case study, the future researcher can describe participants’ process of change over period of time. The results can be described in more details with case study than with quantitative analysis.
The researcher designed this study to test the data using within subject design to limit the threats to the internal validity i.e. gender, age, religion, education etc. However, to further analyze the effectiveness of music therapy, a control group comparison may be introduced. The future researcher may compare data obtained from participants receiving music therapy with data obtained from participants receiving only verbal therapy to help determine whether or not there is a difference between participants’ motivation for change between these two groups. However, there may be some ethical concerns about a researcher withholding music therapy treatment from clinical control group. This problem may be solved if the researcher chooses to compare data obtained from two different settings, for example from the setting that has a music therapist providing music therapy intervention versus the setting that has no music therapist.

This study has its limitation due to a small sample size (N=10). This researcher, therefore, could not conclude or make significant generalization that the participants’ increase motivation for change occurred due to music therapy treatment. It is suggested that the larger sample size may be used in the future study.

Overall, the study provided data supporting an increase in motivation for change after the participants attended a single music therapy session. Over time, the participants reported an increase in motivation to change their alcohol use behaviors though they contributed those changes to overall treatment including medication and music therapy. The willingness to seek a professional help after discharge has increased. The fact that all participants agreed to be in the study and willingly participated in all music therapy sessions without the researcher’s prompt indicated their degree of commitment or possible degree of enjoyment. The future researchers may also want to explore whether
or not the patients are able to maintain their commitment to changes in their drinking behaviors after discharge from the hospital over period of time.
References


reports, public hearings, and participant acknowledgements. DHHS publication No. (SMA) 00-3479. Rockville, MD: Center for Substance Abuse Treatment.


Woody, G. E., & Blaine, J. (1979). Depression in narcotic addicts: Quite possibly more than a chance association. In Center for Substance Abuse Treatment (Eds.), *Substance abuse treatment for persons with co-occurring disorders. Treatment*
Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992.

Rockville, MD: Substance Abuse and Mental Health Services Administration.

(pp. 65-136).

CONSENT FORM FOR ADULTS

Please read below with care. You can ask questions at any time, now or later.
You can talk to other people before you fill in this form.

Study’s Title:

The Role of Music Therapy in Increasing Motivation for Change in Individuals with Dual Diagnosis: Alcohol Abuse and Depression in an Inpatient Short Term Psychiatric Setting.

Why is this study being done?

This study is being done as a part of this researcher's completion of a Masters of Arts in Music Therapy. The purpose of this study is to determine if music therapy sessions would help increase your motivation to change your alcohol use and decrease your symptom of depression. This study may also help us better understand if music therapy sessions affect your well being while you are receiving medical treatments in this hospital.

What will happen while you are in the study?

We would ask you to fill out a questionnaire before you go to any groups. We would like you to go to five music therapy groups. You do not have to go to all the groups if you do not want to. In the group, you can choose to play instruments, dance, sing along, talk about the songs, make up your own song, listen to music, or just do nothing!

Before and after the first and the last music group, we would ask you to fill out a 12-items questionnaire. There will be another questionnaire asking your opinion about the group after you finish the first and the fifth group. We will not look at your answers.
while you are on the unit. When you are ready to leave the hospital, we will ask you to fill out the survey form about what you think about the music groups. When we are finish with the study, we will destroy all your questionnaires.

**Time:**

It will take you about one to two weeks to finish this study. We would ask you to go to five music therapy groups when you are on the unit. Each group takes about 45-50 minutes. You will have about 3 minutes to fill out each questionnaire.

**Risks:**

The risks in participating in this study are no greater than those in ordinary life. However, you may not feel comfortable being around many people in the group. You are encouraged to consult with your primary care treatment team if you are experiencing stress or emotional discomfort. You are required to meet with your treatment team daily to help monitor your symptoms outside of the music therapy setting. Please know that you can ask to stop participating in this study at anytime.

**Benefits:**

While no medical benefits is reported for the participants, you may like being in the group. You might enjoy listening to your songs, have fun with the instruments, relax, or enjoy singing along with live music.

**Who will know that you are in this study?**

You will not be linked to any presentations. We will keep who you are confidential according to the law.

**Do you have to be in the study?**
You do not have to be in this study. You are a volunteer! It is okay if you want to stop at any time and not be in the study. You do not have to answer any questions you do not want to answer. Nothing will happen to you. You will still get the treatment you deserved.

**Do you have any questions about this study?**

If you have additional questions, please contact the principal investigator, Ann Charoonsathvathana at Acharoon@aol.com or (973) 316-1952.

**Do you have any questions about your rights?**

Phone or email the Interim IRB Chair, Tim Kirby (kirbyt@mail.montclair.edu, 973-655-7534) or the IRB Administrator, Fitzgerald Edwards (edwardsf@mail.montclair.edu, 973-655-7781).”

I would like to get a summary of this study:

Please initial:    _____ Yes    _____ No

The copy of this consent form is for you to keep.

If you choose to be in this study, please fill in your lines below.

________________________  __________________________  _____________
Print your name here     Sign your name here     Date

________________________  ________________  _____________
Name of Principal Investigator     Signature     Date

________________________  ________________  _____________
Name of Faculty Sponsor     Signature     Date
Appendix B

Music Therapy Questionnaire
Please read the sentences below carefully. For each one, please check the answer that best describes how you feel regarding music therapy sessions. Your answer will not effect your treatment you should receive. The answers will be private and will be used for a purpose of the study only.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attending music therapy groups to address my drinking is not helpful because I do not think my drinking is a problem.</td>
<td></td>
<td></td>
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<tr>
<td>2. After music therapy groups, I start to wonder if my drinking is out of control.</td>
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<tr>
<td>3. I have changed my drinking habits, and music therapy groups help me in trying to keep it that way.</td>
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<tr>
<td>4. I have drinking problem, and I will try to use what I have learned in the music therapy groups to help.</td>
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<td></td>
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<tr>
<td>5. I have been using technique learned from music therapy to help cope with my drinking problem</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. The music therapy groups help me weigh up the advantages and disadvantages of my present drinking habits.</td>
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<tr>
<td>7. I think music group should address my other problems, not my alcohol use.</td>
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<tr>
<td>8. Music group help me identify my goal for future, including goal to seek treatment for my alcohol use.</td>
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<tr>
<td>9. When I'm stressed or depressed, I use techniques learned from music therapy sessions.</td>
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</tr>
<tr>
<td>10. I'm able to remain abstinent on the unit and I'm planning to remain this way when I leave by using support experienced from the music therapy sessions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Readiness to Change Questionnaire

Please read the sentence below carefully. For each one, please tick the answer that best describes how you feel. Your answer will be private and will be used for a purpose of the study only.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My drinking is okay as it is.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I am trying to drink less than I used to.</td>
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<td></td>
<td></td>
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<tr>
<td>3. I enjoy my drinking but sometimes I drink too much.</td>
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<td></td>
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<tr>
<td>4. I should cut down on my drinking.</td>
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<tr>
<td>5. It’s a waste of time thinking about my drinking.</td>
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<td></td>
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<tr>
<td>6. I have just recently changed my drinking habits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. Anyone can talk about wanting to do something about drinking, but I am actually doing something about it.</td>
<td></td>
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</tr>
<tr>
<td>8. I am at the stage where I should think about drinking less alcohol.</td>
<td></td>
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</tr>
<tr>
<td>9. My drinking is a problem.</td>
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</tr>
<tr>
<td>10. It's alright for me to keep drinking habits right now.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I am actually changing my drinking habits right now.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. My life would still be the same, even if I drank less.</td>
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<td></td>
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</tr>
</tbody>
</table>
Appendix D

Music Therapy Survey Form

Please take time to fill out the survey form. When you are finished, please drop the form in the locked box provided by the staff. Your answers will be kept confidential. Thank you for your participation in this survey.

1. Could you explain if music therapy has helped you in anyway and how?

2. Do you feel you have changed during your hospital stay? If so, could you describe the change that has taken place?

3. What has contributed most to this change?

4. Have the music therapy sessions influenced your way of thinking regarding your drinking habits?
5. After this hospitalization, do you have any plans for follow up care?

6. Would you please provide any additional comments concerning music therapy sessions?
February 6, 2008

Ann Charoonsathvathana
791 Totowa Road
Totowa NJ 07512

Re: IRB Number 000616: The Role of Music Therapy in Increasing Motivation for Change in Individuals with Dual Diagnosis: Alcohol Abuse and Depression in an Inpatient Short-Term Psychiatric Setting

Dear Ms. Charoonsathvathana:

After a full review, Montclair State University’s Institutional Review Board (IRB) approved this protocol on 1/30/2008. The study is valid for one year and will expire on 1/29/2009.

Before requesting amendments, extensions, or project closure, please reference MSU’s IRB website and download the current forms.

Should you wish to make changes to the IRB-approved procedures, prior to the expiration of your approval, submit your requests using the Amendment form.

For Continuing Review, it is advised that you submit your form 60 days before the month of the expiration date above. If you have not received MSU’s IRB approval by your study’s expiration date, ALL research activities must STOP, including data analysis. If your research continues without MSU’s IRB approval, you will be in violation of Federal and other regulations.

After your study is completed, submit your Project Completion form.

If you have any questions regarding the IRB requirements, please contact me at 973-655-3182, besingj@mail.montclair.edu, or the Institutional Review Board.

Sincerely yours,

Dr. Joan Besing
IRB Chair

cc: Dr. Karen Goodman
The Institutional Review Committee at Saint Clare's Hospital has reviewed the information you have submitted regarding the above application and has granted APPROVAL for the study.

Additional Remarks: Approval Period: 1 year.

This study has been approved effective as of June 28, 2007. Please note that Institutional Review Committee (IRC) approval automatically terminates on June 23, 2008 unless it is re-viewed and re-approved by the IRC. The principal investigator(s) is responsible for timely submission of progress reports and application for re-review. (Please apply to IRC 3 weeks before expiration.)

This approval is contingent upon the investigation being conducted in compliance with the study design/protocol as submitted and approved as well as all requirements and determinations of the IRC. Consent must be obtained and documented in the manner approved by the IRC. Only consent forms bearing a current "IRC Approved" stamp may be used. If the consent form has been modified over the course of the study, the most recently approved version must be used when obtaining consent. Principal Investigators are responsible for maintaining signed consent forms for three years after the research is completed or for a longer term if required by PDA regulations.

The Principal Investigator(s) is responsible for promptly requesting any proposed changes in the above research activity. Such changes may not be initiated without IRC review and approval except when necessary to eliminate apparent immediate hazards to the subject(s) and then a report must be submitted with the change request.

The Principal Investigator(s) is responsible for reporting any unanticipated serious problems involving risks to subjects or others (including unexpected deaths, hospitalizations or serious injuries).

With respect to the use of patient information in the conduct of your research, please see attached information which must be distributed to patients at the time patient informed consent is obtained:

- The policy on the disclosure of personal health information
- Authorization for use and/or disclosure of individually identifiable health information
- The Institutional Review of all Other Nonclinical Values Statement
Also attached is a sample informed consent checklist, which will help you ensure that the informed consent contains all of the necessary elements in developing a research consent.

Upon completion of this study, send a final progress report to the IRC so that we may close the study file.

Aristides Estrada, MD
IRC Chairman