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Women’s Perceptions of the Usefulness of Group Music Therapy in Addictions Recovery

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Accepted manuscript of article published in the *Nordic Journal of Music Therapy*, Volume 26, Issue 4 (2017)

Published online Oct. 17, 2016
Version of record available at http://doi.org/10.1080/08098131.2016.1239649
Abstract

This study represents our attempt to uncover aspects of group music therapy that women with addictions perceive as useful toward recovery—factors that have yet to be clearly identified in existing literature. Women in residential treatment for addictions to heroin and other substances were surveyed following group music therapy sessions involving vocal and instrumental re-creation, listening, and improvisation. Qualitative content analysis of data revealed four major findings. We learned that treatment is, in fact, seen as useful by these particular women and that Yalom’s theory provides a meaningful framework for identifying, understanding, and fostering mechanisms within the group music therapy experience that contribute to improved well-being, such as Catharsis, Self-Understanding, Group Cohesiveness, and Instillation of Hope. We also learned that certain intrapersonal aspects of therapy are thought to be helpful, such as those leading to desired changes in mood state, energy, sense of self, and level of enjoyment. Finally, we learned that aspects of therapy appearing in the women’s responses tended to be those emphasized in the therapists’ session planning and facilitation.

Keywords: women, addictions, heroin, group music therapy, Yalom
Women’s Perceptions of the Usefulness of Group Music Therapy

In Addictions Recovery

Introduction

Music therapy is a reflexive process wherein a credentialed therapist helps a client to optimize health using various facets of music experience (Bruscia, 2014). In health and mental health care settings, music therapy is used for a variety of musical, physical, emotional, social, cognitive, and spiritual benefits (Bruscia, 2014; Wheeler, 2015). As a primary or additive treatment modality, music therapy has been purported to assist in the biophysical, psychoemotional, and psychospiritual healing that is thought to be a necessary aspect of recovery from addictions\(^1\) to alcohol and drugs (Borling, 2011; Murphy, 2013, 2015).

A 2008 systematic exploration of English language, peer-reviewed publications about music therapy and addictions yielded just 19 program descriptions and 5 studies involving actual clients (Mays, Clark, & Gordon, 2008). In spite of certain limitations of this review and the fact that it occurred nearly 10 years ago, the authors’ fundamental claim appears to hold: There is a paucity of and need for more research to support broad acceptance of music therapy as a viable treatment modality for persons with addictions.

\(^1\) NIDA (2014a) defines addiction as “a chronic relapsing disease that goes beyond physical dependence and is characterized by uncontrollable drug-seeking no matter the consequences.” (http://www.drugabuse.gov/publications/research-reports/heroin/what-are-long-term-effects-heroin-use)
Publications that target group-based, women-centered music therapy practices are negligible (Gardstrom, Carlini, Josefczyk, & Love, 2013; Gardstrom & Diestelkamp, 2013; Miller, 2014) but consistently offer claims of efficacy. Gardstrom, Carlini, Josefczyk, and Love (2013) purport that music therapy is uniquely positioned to address issues of particular relevance to women in recovery, such as supporting their unique needs for safety, helping them to feel included and make meaningful connections with others, enabling emotional expression and validation, and encouraging self-respect and self-empowerment. Whereas it is tempting to trust the assertions of experienced clinicians who have worked with women in recovery, the present authors maintain the view that clinicians’ claims can never inform as deeply and truthfully as the voices of the clients themselves.

Although there is a burgeoning body of music therapy literature that reflects perspectives of clients in recovery from mental illnesses (Ansdell & Meehan, 2010; MacDonald, 2015; Rolvsjord, 2010; Solli, 2014; Solli & Rolvsjord, 2014; Stige, 2012), publications that target the personal perspectives of women in addictions recovery are slight. Research that captures the unique narratives of these women is warranted as a way for music therapists to understand more completely their needs in order to improve service delivery. The present authors espouse this belief, even though such inquiry may disrupt or contradict prevailing discourse about music therapy’s import and effectiveness.
The overarching purpose of this study was to expand our understanding of women’s perspectives on the usefulness of group music therapy in order to improve clinical services. All women involved in the study met the DSM-5 criteria for substance use disorders related to their drug of choice, which was predominantly heroin.

The specific research question that we set out to answer was this: What aspects of group music therapy sessions, if any, did the research participants perceive as useful in their ongoing recovery?

**Review of Literature**

Illegal drugs constitute a serious public health problem in communities throughout this country. Of particular concern recently is the use of and addiction to *opiates* (aka *narcotics*), such as oxycodone (e.g., Oxycontin, Percocet) and morphine and its notorious semi-synthetic derivative, heroin. Perhaps the most accurate, comprehensive, and up-to-date information about heroin use, dependence, addiction, and related treatment in this country comes from two sources, frequently cited below: (1) a website maintained by the National Institutes of Health/National Institute of Drug Abuse (NIH/NIDA) and (2) The National Survey on Drug Use and Health (NSDUH), conducted annually in the US by the Substance Abuse and Mental Health Services Agency (SAMHSA, 2011, 2014).
Short- and Long-Term Effects of Heroin Use

Once in the body, heroin immediately activates receptors in the brain, which cause the release of dopamine, a naturally produced chemical that blocks pain messages from the spinal cord to the brain. With intravenous injection, the user feels a surge of pleasure (the “rush”) that has been likened to a sexual orgasm, followed by a period of euphoria characterized by a heavy feeling in the arms and legs and clouded mental functioning. This is followed by a longer-lasting period of alternating wakefulness and drowsiness (“on the nod”). The immediacy and desirability of heroin’s effects afford it a greater potential for abuse, addiction, and overdose than many other drugs, as well as a high rate of relapse among users (NIDA, 2014b). The effects of chronic heroin use include myriad physical and psychiatric complications and diseases.

Statistics reported in the NSDUH 2013 report are discouraging, if not frightening. In spite of widespread anti-drug campaigns in the USA, approximately 681,000 people over the age of 12 reportedly used heroin in 2013. Although this figure comprises a relatively small percentage of the total USA population (especially as compared to users of alcohol and marijuana, for instance), it represents a statistically significant increase from 2007 (SAMSHA, 2014). Moreover, in 2013, approximately 517,000 people were thought to have abused or developed a dependence on heroin, which represents an increase over numbers from the years 2002 to 2008 (SAMSHA, 2014). Finally, an estimated
526,000 people received treatment for heroin addiction in 2013 (SAMSHA, 2014). It is unknown how many women were among them.

Because heroin users eventually develop a tolerance to the drug (thus requiring increasing amounts to obtain the desired effect), they are at high risk for overdose and overdose-related death. The US Center for Disease Control (2014) reports that the rate of narcotic-related deaths in the US quadrupled between 2000 and 2013, from .7 to 2.7 per 100,000. Because women need a smaller quantity of a drug to experience the same effects as men, they develop tolerance and become addicted more rapidly and are thus thought to be at higher risk for overdose (NIDA, 2014d).

It is somewhat difficult to discern how women are represented in statistics related to heroin use, dependence, addiction, and treatment because survey responses of women and men surrounding heroin are merged in the NSDUH 2013 report. The report does reveal that the rate of illicit drug use (i.e., marijuana/hashish, cocaine [including crack], heroin, hallucinogens, inhalants, and certain prescription drugs used non-medically) among women in that year was 7.3% and that 5.3% of women met the criteria for substance abuse or dependence. The same survey found that 58.3% of new illicit drug users were female, which has moved upward from previous years. Clearly, some effort must be made to address this disturbing trend.
Treatment for Addictions

Narrative on the NIDA website (2014c) underscores the need for comprehensive and robust treatment in order to address the complexities of addiction and recovery. Treatment settings can be broadly categorized as inpatient or outpatient. Inpatient programs may be further described as long-term residential (6 to 24 months) and short-term residential (28-day stay). Outpatient treatment programs typically involve both individual and group services, offered on a daily basis or less frequently, depending on program philosophy, need, funding, and other factors.

Whatever the focus of treatment for heroin addiction—whether on promoting specific behavioral outcomes, uncovering and “working through” the underlying causes of addiction, or some combination of these aims—, programs often involve pharmacological intervention, individual counseling, didactic and “process” groups, and voluntary or required participation in 12-step support groups such as Alcoholics/Narcotics Anonymous. Pharmacological interventions for opiate addictions include the use of drugs that suppress withdrawal symptoms and relieve cravings for the user and thus potentially decrease the likelihood of relapse (NIDA, 2014c).

Women with heroin addictions can be found in both mixed-gender and gender-specific treatment programs, although some governmental agencies
advocate for gender-sensitive settings (NIDA, 2015) to accommodate for the prevalence of trauma, child-care needs, and pregnancy.

There is a growing body of research to support the use of music therapy in addictions treatment. However, the majority of these papers report on the use of music therapy in mixed-gender programs, rather than women-only programs. An extensive search of the literature reveals that only a handful of published papers appear to target individual and group music therapy with women in recovery.

**Clinical descriptions.** Pickett (1991) describes her work with a woman dually diagnosed with depression and multiple addictions (food, drugs, and alcohol). Through a series of weekly Bonny Method of Guided Imagery and Music sessions, the client was able to identify and work through important issues necessary for her recovery as well as “…touch the deeper stronghold that the addictive process had on her” (p. 66).

Gardstrom, Carlini, Josefczyk, and Love (2013) describe clinical postures and music experiences based on their work with women with various addictions. In their seminal paper, they identify four interrelated needs thought to be relevant for women in recovery: (1) safety; (2) inclusion and connectedness; (3) emotional expression and validation; and (4) self-respect and empowerment. They further recommend several music therapy methods and their variations for addressing these needs. Their proposed postures and methods, which are grounded in the
literature and practice wisdom of the authors and those with whom they consulted, warrants further exploration and development.

Miller (2014) describes a 13-week music therapy program that she designed for and implemented with women in a residential treatment program. The goal of this program was to help the women become more familiar with and gain a deeper understanding of the 12 Steps and slogans of Alcoholics Anonymous (AA). Additional goals included stress management, increased self-awareness and emotional expression, and identification of the effects of addiction and personal qualities that would contribute to recovery. Each session involved active music making, song discussion, or mindfulness and music. Based on assessment data and session notes, Miller suggests that the women grew in their personal relationship with the 12 steps and became more familiar with the AA slogans. She advocates for additional research on music therapy and mindfulness in gender-based treatment.

**Research studies.** As with clinical reports, the research literature on gender-specific music therapy treatment for women with addictions is limited. Silverman (2003) surveyed eight women who participated in group music therapy while in residential treatment. His pilot study results suggest that they enjoyed music therapy and found it to be effective. These results must be interpreted with caution due to methodological concerns, as noted by Gardstrom et al. (2013).
Cevasco, Kennedy, and Generally (2005) compared movement-to-music, rhythm activities, and competitive games on depression, anxiety, stress, and anger of women in substance abuse treatment. The various interventions yielded no statistically significant differences in dependent measures. However, participants’ self-reports indicated a decrease in feelings of depression, stress, anxiety, and anger immediately following the sessions. In interpreting these results, one must consider the small sample size, use of non-standardized measurement tools, and lack of clarity in the description of the data analysis process.

Gardstrom and Diestelkamp (2013) conducted a survey of women with addictive disorders in a gender-specific residential program in order to gain information about their anxiety levels before and after group music therapy. Sessions were held twice weekly for nine weeks. First session pre-session surveys indicated self-perceived anxiety in 39 of 53 cases. Of these 39, 33 (nearly 85%) indicated a palpable decrease in anxiety post-session. It is unclear whether this desired change was related to participation in the music therapy experiences, group dynamics, or a combination of these and other factors. Moreover, the authors caution against suppositions of causality in that the survey was not standardized, and no control group was available for comparison. Findings were nonetheless encouraging.

At least one non music therapy study on the impact of music on the well-being of women with substance dependence has been published. Yun and Gallant
(2010) examined the effectiveness of music-based interventions used as part of individual grief counseling sessions with women with alcohol and drug dependence. Participants attended 12 bi-weekly individual counseling sessions over a 6-month period. In each session, the women listened to either a pre-recorded or live version of a therapist-selected song that was based on the issues raised by the participant. Participants’ posttest scores on the Forgiveness Grief Perspectives Scale and the Beck Depression Inventory were significantly lower than pretest scores. Again, no control group was employed, so causality cannot be assumed.

Taken together, the literature related to substance dependence rehabilitation acknowledges the need for gender-specific treatment. Although one article offers clinical recommendations for music therapists practicing in women-only treatment programs (Gardstrom et al., 2013), the fact remains that more information is needed to support effective and ethical clinical practice in this area. Furthermore, the voices of women in recovery have been given scarce direct expression in the literature. With this in mind, the purpose of this study was to illuminate what women addicts themselves perceive to be the benefits of music therapy in their recovery.

**Method**

**Participants**

Participants in the study were women in residence in a 20-bed, gender-
specific unit of a treatment facility for individuals with drug and alcohol addictions. All women were assigned to the Women’s Residential (WR) unit, one of many components of a continuum of residential and outpatient behavioral health services. Length of stay in the program was typically 28 days but varied depending on insurance coverage, aftercare arrangements, and legal mandates.

The women were predominantly Caucasian (75%) and African-American (25%). Ages ranged from 18 to 60 years. All were diagnosed with a substance-related disorder. Most self-identified as “an addict” and many claimed multiple substance dependences. The overwhelming majority disclosed a history of opioid use, with heroin noted most frequently as the drug of choice. Staff estimated that 9 out of 10 women on the WR unit were heroin addicts. Interestingly, a resident’s age was not found to be a reliable predictor of duration of use. One woman in the study, a college student who appeared to be 18 or 19 years old, had begun using prescription opiates at age 8. Another woman in her 50’s disclosed that she had started using heroin just two years prior in response to a family trauma. Still another resident in her 40’s had begun using at age 12. She had been an addict for 27 years—that is, apart from the five years she spent in prison. She claimed, “those years were the best of my life. I was clean, I knew myself, and I loved myself.”

Although all women had completed a supervised detoxification period prior to admission, many experienced symptoms associated with Post-Acute
Withdrawal (PAWS). Symptoms typical of opioid withdrawal (racing thoughts, insomnia, muscle and bone pain, “goose flesh”, gastro-intestinal distress, and psychological anxiety) were often reported; psychomotor agitation, distractibility, impulsivity, emotional lability, hypo-activity, and drowsiness were commonly observed conditions. Buprenorphine and methadone were administered at the facility to reduce cravings and thus support the women’s recovery process, but it is unknown how many study participants were taking these medications. Some of the women disclosed secondary psychiatric diagnoses, such as bi-polar disorder and post-traumatic stress disorder. It was presumed, but again unconfirmed, that many were taking anti-anxiety and anti-depression medications for these co-morbid disorders.

Approximately 25% of the residents were court-ordered to the facility and 75% were voluntary admits. According to staff estimates, more than half of the women had been in prior addictions treatment programs, and some participants had previously attended the WR program. Only one woman mentioned that she had participated in music therapy during a prior stay.

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2 Post-Acute Withdrawal (PAWS), also known as protracted withdrawal is defined as “the presence of substance–specific signs and symptoms common to acute withdrawal but persisting beyond the generally expected acute withdrawal timeframe” which in the instance of heroin dependence would be 4 to 10 days (Center for Substance Abuse Treatment, 2010, n.p.)
Procedures

The researchers obtained IRB approval to conduct the study. Data were collected between February 2015 and April 2015 during group music therapy sessions facilitated by a certified music therapist and two student music therapists. Session attendees were routinely screened for participation by facility staff based on length of stay. Priority was given to women who had been in residence at the facility for at least two weeks. There was no additional staff screening or recruitment. Participants attended two 50-minute group music therapy sessions per week. On average, 10 women comprised each session, and each woman attended one to five sessions before departing from the facility. Rolling admission meant that the configuration of the group changed regularly as residents came and went.

Overarching treatment aims were to: (1) increase the women’s knowledge about and comfort with group music therapy processes; (2) showcase their musical knowledge and skills; (3) help them to develop emotional self-awareness and expressive abilities; (4) promote group cohesion; (5) teach them about ways to use music in recovery; and (6) help them to reclaim a sense of personal agency. Sessions involved a variety of music experiences based on the women’s stated and perceived needs.

As shown in Table 1, three of the four music therapy methods (Bruscia,
WOMEN IN RECOVERY

2014) were regularly employed. Re-creation experiences took the form of instrumental and vocal performance. A variety of listening experiences were introduced. The women improvised on instruments and with their voices, and improvisations were both referential (theme-based) and nonreferential (free).

Table 1. Methods and variations used in group music therapy.

<table>
<thead>
<tr>
<th>RE-CREATION</th>
<th>LISTENING</th>
<th>IMPROVISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vocal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Song choice: Singing client-selected songs</td>
<td>“Keep Breathing” (Ingrid Michaelson)</td>
<td>Musical check-in with tubano (Individual)</td>
</tr>
<tr>
<td>Chant: “I Have Everything I Need”</td>
<td>“Let the Rain” (Sara Bareilles)</td>
<td><strong>Instrumental Nonreferential</strong></td>
</tr>
<tr>
<td>Chant: “The Ocean Refuses No River”</td>
<td>“Sober” (Pink)</td>
<td>Conducted and non-conducted</td>
</tr>
<tr>
<td>Chant: “Step Into the Flow”</td>
<td>“The Climb” (Miley Cyrus)</td>
<td>Chromatic Bells (individual and group)</td>
</tr>
<tr>
<td>Chant: “Standing Like a Tree”</td>
<td>“Merry” (Dave Matthews)</td>
<td>Metallophones (group)</td>
</tr>
<tr>
<td>Chant: “Be Yourself”</td>
<td>“Little Girl” (John Michael Montgomery)</td>
<td><strong>Vocal Nonreferential</strong></td>
</tr>
<tr>
<td><strong>Instrumental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Lean on Me” with tone chimes</td>
<td>“I Can Do Bad All By Myself” (Mary J. Blige)</td>
<td></td>
</tr>
<tr>
<td>“Here Comes the Sun” with tone chimes</td>
<td>“Below My Feet” (Mumford and Sons)</td>
<td></td>
</tr>
<tr>
<td>“Ode to Joy” using chromatic bells</td>
<td><strong>Imaginal Listening</strong></td>
<td></td>
</tr>
<tr>
<td>Rhythmic imitation with assorted drums</td>
<td>“Intermezzo” from Carmen</td>
<td></td>
</tr>
<tr>
<td><strong>Vocal and Instrumental</strong></td>
<td><strong>Imaginal Listening and Mandalas</strong></td>
<td></td>
</tr>
<tr>
<td>“Appalachian Spring” (Aaron Copland)</td>
<td><strong>Progressive Muscle Relaxation</strong></td>
<td>Various recorded selections</td>
</tr>
<tr>
<td><strong>Song Communication</strong></td>
<td></td>
<td>Various recorded selections</td>
</tr>
</tbody>
</table>
Session structure was flexible, allowing for attention to the immediate and emergent needs of the attendees. Murphy (2015) writes, “When planning music therapy experiences, the music therapist should always ask: ‘What does the client need from the music today?’” (p. 355) and suggests that clients’ needs align with certain stages of recovery—*detoxification, rehabilitation,* and *relapse prevention*. As such, each session began with a brief description of music therapy and a verbal or musical check-in (e.g., introducing one’s emotional state with a frame drum) so that the therapists and clients could together ascertain salient needs. The sessions continued with a brief musical “warm-up” and a longer “core” music experience based on one of the three music therapy methods, as stated above. Approximately 10 minutes before departure, the therapists provided a verbal summary or led the participants in a musical closure of some kind (e.g., singing a chant with an empowering message).

In the last five minutes of the session, the women were invited to share their perceptions of the usefulness of music therapy with a single prompt: “Before we adjourn, I invite each of you to share out loud or in writing what, if anything, was useful about today’s session toward your ongoing recovery.” Such open-ended prompts are a well-established means of data collection in qualitative investigations that aim to elucidate personal thoughts and opinions of study respondents (Giorgi, 1975). The written “invitation to participate” (see Appendix A) and one index card was then circulated to each group member who chose to
provide anonymous, written feedback (see Appendix B).

Women who elected to share non-anonymous feedback verbally did so while the therapist scribed their words on a blank index card. Names were not included on any cards. All cards were collected before the women left the room and subsequently were given to Author B (a non-participant in the sessions) who entered feedback into a data spreadsheet, along with information about the session content and other potentially meaningful details.

**Data Analysis**

We approached this study from interpretivist orientation, which acknowledges the subjective nature of human experience and the need for interpretation of this experience. Thus, the data from the spreadsheet were subjected to qualitative content analysis (Hsieh & Shannon, 2005; Mayring, 2000) in an attempt to both make sense of manifest content and interpret latent content (Elo & Kyngäs, 2008).

In all, data were collected for 15 sessions. As noted above, each woman attended between one and five sessions and had an opportunity to respond to the research question after each session. In addition, each woman had the freedom to write or say as much or as little as she desired in the allotted time. One hundred and thirty-eight data sets were advanced into content analysis. This analytic process involved the following steps, as recommended by Mayring (2000):

1. Authors A and C independently a) read the first 50% of the data sets to
get a sense of the whole, b) read these data sets again to cull text that was deemed irrelevant to the research question (e.g., “Keep coming back, please”), and c) reviewed the remaining data sets, highlighting what appeared to be meaning units and assigning preliminary codes to each unit (e.g., “preferred activities are calming and soothing”).

2. Authors A and C compared what had derived from their independent coding processes, made adjustments, and then assigned all codes to overarching themes (e.g., Calms/Relaxes).

3. Authors A and C sent the themes for the first 50% of the data to Author B as a form of “reliability checking” (Mayring, 2000, n.p.). Author B conducted an independent review, suggesting alternative themes to more accurately reflect meaning and adding, deleting, and merging themes as she saw fit.

4. Once all three authors were in agreement about the themes for the first half of the data, Authors A and C returned to the balance of the text, applying the agreed-upon themes as they continued to analyze. This portion of the analysis was again confirmed with Author B, in a repetition of Step 3. A few new themes emerged at this stage, and certain themes were merged with others if they were thought to represent the same or similar concept. This negotiation process continued until all authors agreed upon a list of 32 thematic groupings.

5. Author A placed each of the themes in alpha order with all meaning units (verbatim) listed under each theme. This enabled all three authors to confirm
that meaning units had been assigned according to the authors’ collective understanding of what each thematic grouping was to represent. At this point, more data were culled as it became evident that they did not relate directly to the research question. Other data were reassigned and six themes were deleted, leaving 26 thematic groupings. Certain themes took on new names to better communicate the essence of the narrative data within.

6. At this point in the analysis, although the authors did not intend to treat the data according to any particular clinical or theoretical constructs, five thematic labels strongly invoked Yalom’s notions about therapeutic factors in group psychotherapy (Yalom, 1995; Yalom & Lesczc, 2005), defined as the “actual mechanisms of effecting change in the patient” (1995, p. xi). The authors thus decided to re-consider all of the raw data in light of Yalom’s complete list of factors. This necessitated a re-assignment of certain meaning units, while others remained in their original thematic groupings.

**Results**

The final thematic groupings appear in Table 2. The number in parentheses next to each theme signifies the number of discrete meaning units within that theme. The incidence of units is offered here as a way to indicate response trends; however, we espouse the belief that all relevant responses can contribute something of value to our understanding of the women’s perspectives, no matter how frequently represented.
Table 2. Yalom’s therapeutic factors and incidence of occurrence.

| YALOM’S THERAPEUTIC FACTORS | DATA aligned with the following seven therapeutic factors: Altruism, Group Cohesiveness, Universality, Catharsis, Self-Understanding, Instillation of Hope, and Existential Factors. Of these, meaning units related to Catharsis appeared most frequently (26), followed by Self-Understanding (13), Group Cohesiveness (9), and Instillation of Hope (8). The remaining three factors had one or two meaning units each. Therapeutic group factors that were not apparent in the data were Development of Socializing Techniques, Interpersonal Learning, Guidance, Identification, and Family Reenactment. Data evidenced seven additional themes that did not connect to group-based mechanisms but rather were representative of individual, intrapersonal processes related to physical, |
emotional, and musical experiences, which we labeled as follows: Alters
Feelings/Mood in a Desired Direction, Impacts Present Energy Level
(Calms/Relaxes and Energizes), Aids in Strengthening Sense of Self, Offers
Pause/Diversion, Provides Enjoyment, and Fosters Musical Connections. All
therapeutic factors are described in turn in the following section, with
representative examples from the raw data.

**Discussion**

**Therapeutic Factors**

*Altruism.* Altruism relates to finding intrinsic value in the act of helping
others, feeling useful, and acting selflessly. We witnessed numerous examples of
altruistic behaviors, such as one woman forfeiting her song choice so that another
woman could hear her preferred song before being discharged. Some women gave
advice about meetings, future placements, and the like or directed comments at
someone in a vulnerable state, such as, “If you ever want to talk, just come and
find me!” Yet, just one respondent identified opportunities to help others as a
useful aspect of group therapy, writing about “teaching songs to the youngguns.”
She was referencing a session in which she helped another, much younger
resident learn a specific instrumental part. In that session, the respondent spoke
about how good it felt to be of assistance to someone else, if only in a small way.
That more women did not identify helping others as a useful aspect of music
therapy may mean that 1) they did not recognize when this was, in fact, occurring,
2) they were self-focused as addicts tend to be, especially in the early stages of recovery, or 3) there were not as many opportunities for altruism within the emerging session structures.

*Group Cohesiveness*. This factor pertains to feeling a sense of belonging to a group and of having the acceptance and approval of group members. As noted above, promoting group cohesion was a primary aim of treatment. That cohesion was useful was evidenced in the following representative comments:

- *Singing and playing as a group!*
- *The feeling of camaraderie with the sisterhood was therapeutic*
- *Common love of music and what it stands for brought us together in a unique and beautiful [rhythm].*
- *Working as a team, meaning working with my sponsor & people in recovery*

*Universality*. Perhaps the best way to describe universality in this clinical setting is, “I am not alone in my addiction; we’re all in the same boat.” The recognition of universality is critical for personal healing in times of emotional hardships characteristic of recovery. A sense of universality helps to minimize feelings of isolation stemming from the women’s perceptions that they are unique in their disease and that no one can understand or help them. Additionally, as women in the group listen to other residents describe “hitting bottom,” they may
experience less shame about the thoughts, feelings, and actions related to their own addictions. One statement pointed undisputedly to this factor:

- *It helps me feel as if I’m not alone.*

We were surprised that only one such response emerged, but we recognize that some of the statements appearing in Group Cohesiveness (e.g., *Bond with the girls*) suggest a similar sentiment.

*Catharsis.* In Yalom’s theory, catharsis refers to any open expression of affect. As noted above, there were more meaning units tethered to this theme than any other. This makes sense, given that many of the music experiences used in the sessions were specifically designed to promote the residents’ emotional awareness and expressive output and were presented as such.

- *Play the instruments and let out your frustrations and bad feelings you are having.*
- *Just to play the drums and let out my Stress.*
- *Got rid of stress by singing*
- *It helped me let go of the negative energy that I was feeling.*
- *It brought out a lot of feelings we got to process*

*Self-Understanding.* Self-understanding pertains to the development of insight into one’s problems and their genesis. Such insight often comes through feedback from others; in this way, there is overlap between this factor and the mechanism of interpersonal learning:
I enjoyed reading the lyrics to the song cause it really brings to mind what I feel.

Seeing so much clarity & seeing how the lyrics relate to my life.

The routine & consistency of the music helps [me]

Learned that a drum is like my recovery, go at my own pace.

that I don't need a mind altering substance to let go & dance.

**Instillation of Hope.** When instillation of hope is present as a therapeutic factor, group members believe that treatment can and will be helpful and feel motivated to make changes. Some such statements of hope, motivation, and inspiration were as follows:

- It really gives me hope!
- I’m seeing the light and the brighter side of my recovery
- Gives me faith in making changes
- It made me feel like things were flowing in the right direction.
- Listening to inspiring music really motivates me to do what’s best for me
- It’s in this class that we feel alive again.

**Existential Factors.** When Existential Factors are operating, group members are taking the opportunity to confront and accept issues related to isolation, meaning, responsibility, life, and death. One woman wrote:
• I hated that song Motherless Child, because that’s too close to home in my situation w/my kids. It made me feel worse, but I know its reality.

Initially, we were tempted to cull this statement, believing that it was irrelevant to the research question. As we interpreted for latent meaning, however, we came to see this woman’s expression as indicative of a noteworthy life experience. Data collection was an anonymous process, yet earlier in the session this respondent had self-identified by referencing the fact that she had lost her own mother to addiction and now was unavailable to her own young children due to having been incarcerated for drug-related charges and subsequently mandated to treatment.

The song itself seemed to serve as a container for her shame and despair, evident in her defeated posture and quiet tears while the therapists and residents sang together mournfully:

\[
\text{Motherless children have a hard time} \\
\text{Motherless children have such a hard time} \\
\text{Motherless children have a really hard time} \\
\text{A long way from home, a long way from home}
\]

Although this woman remained silent during the processing after the song, her written statement suggested that not only had the song allowed her to acknowledge her feelings about her past, but also that she was coming to accept the reality of her life situation.
The second statement representative of this theme was one of the most poignant statements of all:

- Made me think about where I was and how I have crawled out of this dark hole I was in.

**Unrepresented Factors**

Interestingly, none of the women shared perspectives neatly aligned with the *Development of Socializing Techniques and Interpersonal Learning*. When these factors are operating, members learn ways to connect with and relate to others and make discoveries through the processes of giving and receiving feedback about members’ actions and their impact on others. The lack of data supporting these factors may indicate an absence of this type of development or the fact that this kind of learning would have been difficult for the women to capture in words in the few minutes that they had to respond to the research question. Moreover, this aspect was not an explicitly stated expectation of treatment. Had we invited these responses with direct probes (e.g., “Could you share with Sheila how her words impact your feelings?”), we may have drawn the residents’ attention to this potential benefit of treatment.

*Guidance.* Yalom describes Guidance as the instructional, or didactic, aspect of therapy. Group members learn from therapists and other clients who impart information within sessions, such as the purpose of treatment, how to find
a sponsor, and so forth. The music therapy sessions were not particularly didactic, so it makes sense that comments of this nature did not appear.

**Identification.** Identification describes clients who learn vicariously by watching other, more successful individuals or who imitate the behavior of self-selected role models. Although no statements aligned with this theme, one resident, after selecting a song by P!nk as a way to communicate something about herself (song communication), talked at length about her identification with this singer. She voiced deep respect for P!nk because this artist had struggled with multiple addictions and yet had “made something of herself” by accepting professional help. Other women then mentioned celebrities and family members who had served as their role models in recovery. It is unknown whether any of the women consciously identified with the therapists, agency staff, or peers present in the group process.

**Family Reenactment.** Family reenactment, also called “the corrective recapitulation of the primary family group,” refers to the acting out of early family dynamics within the context of a “performing” therapy group. This can help members clarify distortions about self and find redress for emotional damage linked to neglectful, abusive, or “process poor” family systems. That no statements referred to this therapeutic factor might simply confirm that this was not a particular focus of the music therapy sessions. However, it bears mentioning that the women’s occasional interactions with others in the sessions—
nonsexual physical intimacy (e.g., hugging, holding hands, caressing each other’s hair), statements implicating feelings of friendship and sisterhood, and expressions of gratitude toward staff—might have been evidence that some women were looking for (or had found) sibling or parental surrogates within the group.

**Themes Related to Intrapersonal Processes**

*Alters Feelings/Mood in a Desired Direction.* It is not uncommon for women in recovery to experience long-term stress, situational anxiety, and minor to severe depression (Brady & Hartwell, 2009; Pettinati & Plebani, 2009). Several of the responses confirm that participation in the music therapy group brought about an awareness of a positive shift in feelings or mood:

- *However you feel if you listen to that kind of music it will pass.*
- *I feel better after this class*
- *Singing & listening to uplifting music aides in boosting my emotions*
- *Makes me feel good throughout the day.*
- *I really had a good time, I was sad but I am not now*

*Impacts Present Energy Level.* Engagement in music, whether one is quietly listening to a favorite song or more physically involved in playing an instrument or singing, is known for its ability to impact energy levels. This was indeed the case with the study participants. Many women noted palpable and desirable decreases in energy:
- I felt relaxed sitting here listening to music.
- It helped me to be able to calm myself after a very stressful morning.
- Relaxing my muscles and breathing with music gave me soothing imagery and calmness.

At other times, a welcomed increase in energy was discerned:
- It will help to know that I can always listen to music to bring me energy!
- I think the drums gave us fun positive energy.
- Dancing in Music therapy today was exhilarating.

Aids in Strengthening Sense of Self. The majority of the women on the WR unit had survived significant and sustained abuse. Such life experiences—not to mention the pervasive shame that accompanies heroin use and failed attempts at recovery—had damaged their self-esteem. Moreover, incarceration and prior residence in “cookie cutter” treatment programs had further eroded their sense of individuality and independence. As noted above, reclamation of personal agency was a treatment focus of music therapy. The following comments pointed to a strengthening of self, brought about through engagement in the sessions:

- Music makes me feel so much better about myself.
- Amazing [especially] being sober when they played the song Climb it makes me feel stronger, more confidence.
- I feel confident in my uniqueness.
I can do anything I put my mind to.

I'm able to be who I want to be and feel amazing about it at the same time

Offers Pause/Diversion. Racing thoughts and obsessive preoccupations are symptoms related to PAWS and are particularly common during opiate withdrawal. Additionally, the effort expended in learning a new way of being contributes considerable stress to the women’s daily lives. Participation in the music therapy group seemed to allow these women to “take a break” and temporarily step away from their day-to-day stressors:

- It helps me forget my troubles even for just a moment
- Just to breathe
- It took my mind off treatment work, which I needed desperately
- I can put everything else on hold—my negativity can be "over there" for just a moment

One woman identified a potential long-term benefit of involvement in music therapy:

- Music Therapy will help keep my mind off Drugs and Alcohol

Produce Enjoyment. Eight comments referenced how enjoyable the sessions had been, with statements such as these:

- [I] enjoyed singing along. I love the sound of the instruments and playing the drums!

- Playing music w/the group was fun
• *Gives me pleasure*

When asked, most of the residents could not recall the last time they had had “good, clean, sober fun.” A lack of true pleasure had significantly diminished their quality of life. Caught in the desperate and self-destructive “high” of heroin addiction, the women experienced dysphoria and, in turn, could not mobilize their inner resources to make a change. And so, it seems reasonable that the women would identify those music experiences that were “fun” or “enjoyable” as aiding in their recovery. With enjoyment came elevated mood, which agency staff confirmed continued well beyond the sessions and improved the women’s overall receptivity to subsequent treatment activities.

*Fosters Musical Connections.* A few respondents identified the benefits of intramusical connections. In some comments, music was personified as having the ability help one “through” a particularly trying emotional state:

• *There were some painful emotions, but the music was there to carry us through*

• *Any kind of mood I’m feeling, music helps me through*

These comments suggest the kind of intimacy, benevolence, and trust associated with a positive transference, with music cast as a parental object, or what Winnicott (1960) refers to as the “good enough” mother. From a psychodynamic perspective, then, it could be said that these women perceived music as being
appropriately attentive to and patient with their painful emotions (i.e., anger, frustration, loneliness, etc.) and strong enough to contain their expression.

**Conclusion**

There were four primary findings from our investigation:

1. *The respondents did indeed find group music therapy to be a useful treatment modality.* As we consider all of the data, in fact, we note that all but two meaning units reflected the perception that group music therapy was useful in the recovery process. Moreover, comments such as “everything was awesome,” and “please come back!”—culled early in analysis because they did not answer the research question—demonstrate the women’s positive feelings about and attitudes toward the sessions.

   In regard to the outliers, one woman wrote:

   - *It made me feel good, brought back memories and mostly good ones but also bad triggers partying and dancing*

   This response and similar comments during the sessions led the therapists to include opportunities for discussion about music as a trigger for relapse and strategies for healthy listening, which some of the women volunteered was helpful information.

2. *Certain aspects of music therapy valued by the respondents aligned with Yalom’s therapeutic factors.* Seven mechanisms of change were noted, with
Catharsis, Self-Understanding, Group Cohesiveness, and Instillation of Hope most frequently identified.

3. **Other aspects identified as useful were intrapersonal in nature.** These did not neatly correlate with Yalom’s group factors but are associated with benefits of treatment referenced in addictions literature (Baker, Gleadhill, & Dingle, 2007; Gardstrom et al., 2013; Hwang & Oh, 2013; Jones, 2005).

4. **The findings helped to illuminate themes and processes that were both emphasized and de-emphasized by the therapists, whether consciously or unconsciously.** As we engaged in planning and facilitation, we undoubtedly interjected our own predispositions regarding which particular aspects of treatment might be useful, and these biases likely impacted both the women’s responses and our data analysis. Case in point: As we introduced music therapy briefly at the start of each session, we almost always described music therapy as a means to connect more deeply with personal emotions and give them outward expression. In stating this, we gave credence to the value of self-understanding and catharsis as curative factors and offered “permission” for the women’s exploration in these intrapersonal areas. In contrast, we did not explicitly talk with the women about how music therapy might provide opportunities for helping others (altruism) and the therapeutic benefits of this interpersonal process.

We hold the core belief that each woman is the “expert” when it comes to her own life experiences and perspectives. With this in mind, we sought the
perceptions of heroin addicts as a way to reveal what, if anything, was useful to them in their ongoing recovery. We learned that treatment is, in fact, seen as useful by these particular women and that Yalom’s theory provides a meaningful framework for identifying, understanding, and fostering mechanisms within the group music therapy experience that contribute to improved well-being. We also learned that certain intrapersonal aspects of therapy are thought to be helpful, such as those leading to desired changes in mood state, energy, sense of self, and level of enjoyment. Finally, we learned that aspects of therapy appearing in the women’s responses tended to be those emphasized in the therapist’s session planning and facilitation. These findings will serve as a guide for our future encounters with women in recovery and may serve as a foundation for further inquiry into a clinical topic that, in our opinion, has yet to garner the attention it deserves.
References


Center for Substance Abuse Treatment (2010). Protracted withdrawal. *Substance*


Appendix A

INVITATION TO PARTICIPATE IN RESEARCH

Research Project Title: “Women’s Perceptions of the Usefulness of Group Music Therapy in Recovery From Addictions”

As a faculty member at the XX, I am conducting a study to learn what women with addictions find most useful about music therapy. My hope is that this will improve services for women with addictions.

To gain this information, I will be asking a single question at the end of each music therapy session.

- Your participation is entirely voluntary and you may stop your participation at any time with no negative consequences.
- You may answer the question out loud or in writing on the index card that I provide.
- If you answer out loud, I will write the main ideas of what you say; I will not include your name or other identifying information in my notes.
- If you answer in writing, please do not include your name or other identifying information on the card.
- You will not be paid for your participation.

If you have any questions or concerns, please contact:

XX, Principle Investigator
Coordinator of Music Therapy
XX
XX
XX

If you feel you have been treated unfairly, or you have questions regarding your rights as a research participant, you may contact

XX IRB Chair
XX
XX

NOTE: RESEARCH CONTACT INFORMATION IS POSTED IN THE STAFF OFFICE.
Appendix B

What (if anything) about today’s music therapy session will aid in your recovery?

___ Nothing about today’s session will aid in my recovery.

___ The following thing(s) about today’s session will aid in my recovery: