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Effects of active music therapy interventions on attendance in people with severe mental illnesses: Two pilot studies

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ABSTRACT

The purpose of these brief pilot studies was to determine if there were differences between active music therapy and passive music listening in attendance rates, durational attendance, and treatment perceptions in people with severe mental illnesses. In both studies, the researchers conducted a series of active group music therapy interventions (lyric analysis, songwriting, music game, facilitated percussion interventions, and singalong) and passive group music listening sessions (recorded music via iPod) each for five days. During the first study, a higher percentage (15.53%) of patients on the unit attended the active music therapy sessions than the passive music listening sessions. Concerning treatment perceptions, participants in the active music therapy condition tended to have slightly higher mean perceptions of enjoyment and comfort than participants in the passive music listening condition. During the second study, participants spent more time in active music therapy sessions than in passive music listening sessions. Participants in the active music therapy condition also tended to have higher perceptions of helpfulness and amount learned concerning managing their mental illnesses than participants in the passive music listening condition. Results may have implications for funding psychiatric music therapy. Limitations and suggestions for future research are provided.

Introduction

While mental illness affects from 20 to 30% of American adults, severe mental illness (SMI) affects approximately 5.4% of the population (Kessler et al., 1998). Other estimators have noted that SMI can affect more than five million adults and seven million children in the United States each year (National Alliance for the Mentally Ill, 1999). Despite advances in treatment, the number of Americans with SMI has remained constant (Frank & Glied, 2006). People with SMI typically require longer inpatient hospitalizations, higher degrees of supervision, and are usually considered chronic (as opposed to acute). Moreover, upon discharge from a psychiatric inpatient facility, people with SMI often require a great deal more follow-up care: They typically spend time in a group home or another type of supervised care while acute care patients often return to their home living environments (Thomas, 2007).

Because of their unique set of symptoms and the way psychiatric facilities provide treatment, it can be difficult to systematically study the effects of a specific psychosocial intervention on people with SMI in an inpatient setting. Additionally, as multiple simultaneous strategies have been found to work best in the treatment of SMI (Kempe, 2005), it can be challenging to isolate the effects of a particular variable on a singular outcome. This can further complicate designing and conducting systematic and objective research with an already intricate population to study.

Music therapy is a psychosocial intervention commonly utilized to treat people with SMI. Researchers who conducted a pilot project found that patients both attended and participated in recently implemented group music therapy sessions (Bunt, Pike, & Wren, 1987). This study was consequential as recruiting people with SMI to attend therapy sessions can be especially difficult due to their symptomologies, idiosyncratic behaviors and cognitions, and the way psychiatric facilities provide treatment. Perhaps studying attendance is a practical and realistic method for increasing the size of the literature base concerning music therapy and people diagnosed with SMI. To date, there are no other psychiatric music therapy studies wherein the primary dependent variable was attendance.

Scholars in the field of psychosocial treatments for psychiatric consumers have continually noted the importance of treatment perceptions. Psychiatric consumers, despite various social functioning levels, should be considered experts in their own care and have the authority and expertise to identify treatments they find effective and ineffective (Dickey, 2005; Kitcher, 2001; Leff, 2005;

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Table 1
Participant demographic data (experiment 1).

Patient#	Sessions attended	Ethnic background	Gender	Number of previous psychiatric admissions	Age	MT in past?	Admission type
1	1, 3	Caucasian	Female	≤5	65	Yes	Voluntary
2	1	Caucasian	Male	2–4	27	No	Voluntary
3	1, 2, 4	Caucasian	Male	1	20	Yes	Voluntary
4	2, 3, 4	Caucasian	Female	2–4	43	No	Involuntary
5	2, 4, 5	Other	Female	1	31	No	Voluntary
6	2, 5	Caucasian	Female	1	57	No	Involuntary
7	5	Caucasian	Male	≤5	51	No	Voluntary
8	6, 7, 8, 9, 10	Hispanic	Female	≤5	22	Yes	Voluntary
9	6, 7, 8	African American	Female	1	51	No	Voluntary
10	6, 7, 8, 9	Other	Female	1	27	No	Voluntary
11	6, 7, 8	Caucasian	Female	1	53	Yes	Involuntary
12	7, 10	Caucasian	Male	≤5	25	Yes	Voluntary
13	7	Caucasian	Male	≤5	18	Yes	Voluntary
14	9	Caucasian	Female	1	36	No	Voluntary
15	10	Caucasian	Female	≤5	38	No	Involuntary
16	10	Caucasian	Female	2–4	44	No	Voluntary

National Association of State Mental Health Program Directors, 1989). Specific to music therapy research, psychiatric consumers' perceptions of this psychosocial treatment have been high in descriptive (Heaney, 1992; Silverman, 2006) and experimental studies (Silverman, 2009). As treatment perceptions remain a consequential dependent measure, additional music therapy research is warranted before generalizations can occur.

The psychiatric music therapy literature base is expanding as researchers identify and implement innovative ways to measure treatment effects. Researchers have found music therapy can have positive effects for people with schizophrenia (Ulrich, Houghtmans, & Gold, 2007) and for people having an acute psychotic episode (Morgan, Bartrop, Telfer, & Tennant, 2011). Grocke, Bloch, and Castle (2009) found that music therapy improved quality of life in patients with severe and enduring mental illness. Silverman (2010) utilized a mixed-methods approach and found that participants diagnosed with SMI (1) were able to articulate what they had done in a group music therapy intervention, (2) were able to explain the purpose and general group objective of their music therapy session, and (3) supported the use of music therapy on the unit.

Researchers who conducted a systematic review of music therapy for patients with schizophrenia and schizophrenia-like illnesses found positive results: Music therapy combined with standard care can help people with schizophrenia improve their global state (Gold, Heldal, Dahle, & Wigram, 2005). However, as only four studies met inclusion criteria, there remained a dire need for additional quantitative studies documenting how music therapy might affect people with SMI. In a meta-analysis concerning the effects of music on the symptoms of psychosis, Silverman (2003) did not find significant differences between (1) recorded music versus live music or (2) active music therapy interventions versus passive listening. Thus, future music research using comparison conditions is warranted for inclusion in eventual systematic reviews and meta-analyses.

Research demonstrating the unique effects of interactive music therapy (i.e., active music therapy) versus listening to recorded music (i.e., passive music listening) is warranted in an attempt to further differentiate music therapy from other types of treatment utilizing music. In an attempt to categorize and distinguish these interventions, music therapy scholars noted active music therapy interventions might be considered *Insight Music Therapy with Reeducative Goals* (Wheeler, 1983) or *Music in Psychotherapy* (Bruscia, 1998) while passive music listening might be considered *Music Therapy as an Activity Therapy* (Wheeler, 1983) or *Music as Psychotherapy* (Bruscia, 1998). Additionally, with increasing interest in *Music Medicine*, wherein medical populations receive passive music listening interventions from a non-music therapist, it has become vital to differentiate active music therapy from passive music listening. Therefore, the purpose of these brief pilot studies was to compare active music therapy interventions to passive music listening in patients with SMI. Specific research questions included:

1. Will a greater percentage of patients on the unit attend active music therapy sessions than passive music listening sessions? (Experiment 1)
2. Will patients remain in the therapy sessions longer during active music therapy than during passive music listening? (Experiment 2)
3. Do patients with SMI perceive active music therapy as more therapeutic than passive music listening? (Experiments 1 and 2)

General method

Research participants

Participants were inpatients with SMI on an intermediate-care psychiatric unit of a large university teaching hospital in the Midwestern part of the United States. Upon admission, these patients had severe psychotic symptoms and were unable to be placed on a short-term acute care unit. Participants were diagnosed with bipolar disorder, schizophrenia, schizoaffective disorder, psychosis, or major depressive disorder. Emblematic of most institutions, patients' lengths of stay varied, but typically ranged from a minimum of two weeks to a few months depending upon symptom severity, response to medications, treatment progress, and follow-up care. Due to the high degree of supervision and care they typically required, patients were normally discharged to a group home or similar type of facility. Patients received a variety of other programming, such as group and individual therapy, psychoeducation, leisure activities, a movement-based group, along with community meetings each day. Participant demographic information is depicted in Table 1 (experiment 1) and 5 (experiment 2).

Design

The principal investigator (PI), a Board Certified Music Therapist with over nine years of clinical experience with psychiatric populations at the onset of experiment 1, facilitated a series of five different active music therapy interventions that are commonly