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BRIEF REPORT

Comparing Educational Music Therapy Interventions via Stages of Recovery with Adults in an Acute Care Mental Health Setting: A Cluster-Randomized Pilot Effectiveness Study

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Abstract
The purpose of this cluster-randomized pilot effectiveness study was to compare two different group-based educational music therapy interventions with a control condition as measured by the stage model of recovery in adults on an acute care mental health unit. Participants ($N=69$) were cluster-randomized to one of three single-session conditions: educational lyric analysis (ELA), educational songwriting (ESW), or control. ELA and ESW conditions targeted motivations for and factors contributing to recovery. Results indicated no significant between-group difference. However, ELA and ESW conditions tended to have slightly more favorable stage of recovery mean scores than the control condition. Generally, educational music therapy may be clinically relevant for impacting stage of recovery within the temporal parameters of a single session. As ELA and ESW conditions had similar results, the specific educational music therapy intervention did not affect results. Implications for clinical practice, limitations, and suggestions for future research are provided.

Keywords Mental health condition · Music therapy · Mental health · Recovery · Stage of recovery · Randomized · Songwriting · Lyric analysis

Literature Review

The emphasis of mental health care has shifted from a cure to recovery. Within the recovery concept, the goal is not necessarily the elimination of mental health problems or all symptoms, but the reclamation of a meaningful, purposeful, and valued life. Central to the recovery construct is that the person with a mental health condition decides what constitutes meaning, purpose, and value in their[1] life. Moreover, factors such as deinstitutionalization, the community mental health movement, and improved pharmacological and psychosocial treatments have resulted in a brief model of acute mental health care—comprised of an average of 7.2 days of hospitalization in the United States (Centers for Disease Control and Prevention 2015)—that prioritizes recovery.

Recovery was founded upon the consumer movement and the belief that people with mental health conditions have the potential to recover and maintain productive and satisfying lives according to their own criteria (Bellack 2006). Perhaps reflecting and highlighting the uniquely individualized recovery process (Anthony 1993), there is not a consensus on how to best operationally define recovery (Slade 2009) and authors have articulated that recovery is not comprised of a specific set of techniques (Green et al. 2014). Scholars have conceptualized recovery as more of an attitude, philosophy, vision, movement, or multidimensional construct rather than a model (Green et al. 2014). Recovery is a social movement away from the traditional paternalistic and medically dominated mental health system wherein consumers perceive themselves as survivors not of mental health conditions but of the mental health system (Sowers et al. 2004).

Recovery from mental health conditions is possible. Warner (2010) found that a sizeable number of people who have mental health conditions recover completely or return to an acceptable level of functional capacity. In an attempt to better understand and conceptualize recovery, Andresen

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[1] This word is used to recognize the possibility of multiple genders and identities.

et al. (2003) analyzed published accounts of recovery from people with schizophrenia and other serious mental health conditions. The researchers identified four processes of recovery: Finding hope, re-establishment of identity, finding meaning in life, and taking responsibility for recovery. Within the process of taking responsibility for recovery, the authors classified and operationally defined the stage model of recovery:

1. *Moratorium* In this stage, the person experiences denial, confusion, hopelessness, identity confusion, and self-protective withdrawal.
2. *Awareness* In this stage, the person recognizes that there is hope for a better life and recognizes that recovery is achievable. This recognition can be an internal event or it can be externally influenced by a clinician, significant other, peer, or a role model. It involves a cognizance of a possible identity other than that of a sick person (i.e., a self that is capable of recovery who is not defined by the mental health condition).
3. *Preparation* In this stage, the person resolves to start working toward recovery. This stage involves taking inventory of the self and of one's values, strengths, and weaknesses. It also involves connecting with peers, learning about mental health conditions, potential services and resources available, recovery skills, and becoming involved in psychoeducational programming and therapy.
4. *Rebuilding* In this stage, the person works to forge a positive identity that involves setting and working towards personally valued goals. This stage may also involve the reassessment of old goals and values and taking responsibility for managing the mental health condition, taking control of one's life, taking risks, suffering setbacks, and trying again if goals are not initially achieved.
5. *Growth* In this stage, although the person may not be completely free of symptoms, the person knows how to successfully manage the mental health condition in order to remain well. The person is resilient in the face of setbacks, has faith in their own ability to overcome adversities, and maintains a positive attitude. The person is able to live a meaningful life, looks forward to the future, and has a positive sense of self. The person may even conceptualize that the experience of having a mental health condition has made them a better person. This is considered the final stage of recovery, the terminal objective, or outcome of the recovery process.

Music therapy is a profession wherein credentialed professionals design and implement music-based interventions to accomplish individualized goals within a therapeutic relationship (American Music Therapy Association 2019). Scholars have noted that mental health recovery and music therapy share congruent principles (Bibb and McFerran 2018; Grocke et al. 2008; McCaffrey et al. 2011, 2018; McCaffrey and Edwards 2016; Silverman 2015). Silverman (2016b) found that adults on an acute care mental health unit who received a single music therapy session (either a songwriting or lyric analysis invention, both delivered using an educational[2] approach) targeting hope for recovery tended to have higher state hope for recovery than participants in a control condition. As the Silverman (2016b) study is the only music therapy investigation quantitatively measuring an aspect of recovery (i.e., state hope for recovery) but did not measure recovery itself, additional music therapy and recovery research is warranted. Moreover, as music therapy is a profession and not a specific intervention, additional controlled inquiry is warranted to empirically determine what specific type of educational music therapy intervention might be most effective in targeting recovery.

Educational music therapy shares the collaborative and empowering aspects of resource-oriented music therapy (Rolvsjord 2010) and recovery-oriented music therapy (Solli et al. 2013; Solli and Silverman 2016). However, educational music therapy for recovery differs from resource- and recovery-oriented music therapy as it is more germane to the contextual parameters of group-based music therapy (Silverman 2007; Thomas 2007) specific to acute mental health care within the United States (Solli and Silverman 2016). For example, it can be group-based, time-limited, highly structured, not based on improvisation, and can be focused on expediently teaching adults with mental health conditions management skills to promote recovery. Additional information on educational music therapy targeting recovery can be found in Silverman (2015).

While researchers have articulated that mental health recovery and music therapy can be coupled (Bibb and McFerran 2018; Grocke et al. 2008; McCaffrey et al. 2011, 2018; McCaffrey and Edwards 2016; Silverman 2015), objectivist research is warranted to determine *if* music therapy can impact mental health recovery. Due to the importance and applicability of mental health recovery, there is a need to study if specific types of music therapy interventions can be utilized to impact stage of recovery in people with mental health conditions. Therefore, the purpose of this cluster-randomized pilot effectiveness study was to compare two different group-based educational music therapy

[2] While music therapy is a general term describing the profession, educational music therapy (Silverman, 2015) is a specific treatment approach or philosophy for adults with mental health conditions that emphasizes learning how to manage the mental health condition in order to augment the likelihood of recovery. Music therapy interventions, such as songwriting and lyric analysis, can be implemented for adults with mental health conditions using an educational music therapy approach as the theoretical framework.

interventions with a control condition as measured by the stage model of recovery with adults in an acute care mental health setting. Specific research questions were as follows:

1. Are there differences between stages of recovery scores in adults with mental health conditions on an acute care unit who receive educational music therapy interventions and those in a control condition?
2. Are there between-group differences among educational music therapy interventions (educational lyric analysis versus educational songwriting) in adults with mental health conditions on an acute care unit as measured by stages of recovery?

Method

Participants

Research participants were 69 adults on an acute care/crisis stabilization mental health unit. Adults typically remained on the unit for 3 to 7 days and had varied diagnoses, including bipolar disorder, major depressive disorder, schizoaffective disorder, and schizophrenia. The unit was part of a large university hospital in the Midwestern region of the United States. Adults on the unit volunteered to take part in the study, were not paid, and had the option to receive treatment without being a research participant. Inclusion criteria were all adults admitted to the acute care mental health unit. Exclusion criteria included not being able to read English or attending multiple sessions with the researcher. Criteria were purposely inclusive in order to provide treatment to as many people as possible and accurately represent contemporary acute mental health care. The author's Institutional Review Board (IRB) approved this study (1307S37441).

The unit offered a variety of daily group-based psychosocial and educational sessions. This programming included community meetings, general health, occupational therapy, process group, medication education, spirituality, topics group, reflection/journal sessions, and relaxation group.

Instrument

The Stages of Recovery Instrument (STORI; Andresen et al. 2006) is a 50 item self-report scale. There are five subscales within the STORI: moratorium, awareness, preparation, rebuilding, and growth. Items are rated on a 0 (not true at all) to 5 (completely true now) point Likert-Type Scale and subscale scores can range from 0 to 50. Lower scores on the moratorium subscale indicate a higher stage of recovery while higher scores on the other four subscales indicate higher stages of recovery. The creators of the STORI found that their instrument correlated with psychological health variables, that the STORI measured stage-related variables not present in other measures, and that the five subscales were internally consistent. Although the STORI was designed to measure a person's current stage of recovery (i.e., the highest score indicates the person's current stage of recovery), for the purposes of the current pilot effectiveness study, scores were interpreted using means and standard deviations. Cronbach's coefficient alpha scores were calculated for each of the five subscales and ranged from $\alpha = 0.88$ to $\alpha = 0.94$.

Design

This study was a single-session, cluster-randomized, three-group design. A single-session design was selected because it is more congruent with the rapid ebb and flow of people who are hospitalized in acute care mental health settings than other research designs. The investigator, a board-certified music therapist with over 14 years of clinical mental health experience at the onset of data collection, conducted all sessions and acknowledges this as a limitation.

Randomization and Procedure

Participants were cluster-randomized into conditions by session, with a total of 21 sessions delivered during the study period. Cluster randomization methods have become popular and involve randomizing social units rather than individuals (Guittet et al. 2006; Laupaiboon 2003). In the current study, the investigator randomized the numbers 1–21 into three groups via a computer program (http://www.randomizer.org) and each group was assigned to a condition. The only differences between clusters were the independent variables delivered as participants were on the same acute care mental health unit and all other between-group aspects were similar. People on the unit could voluntarily become research participants in the first session they attended. In an attempt to be as inclusive as possible, participants were allowed to attend multiple sessions but data were only collected before (control) or after (educational lyric analysis and educational songwriting) completion of a participant's first session. Each morning before the session began, the investigator and staff announced "music group" would be starting and encouraged all people on the unit to attend. Thus, potential participants had a choice to attend sessions but did not choose what condition would take place on each day. Regardless of treatment condition, staff members also encouraged all people on the unit to attend sessions. The investigator conducted the study Tuesday mornings from May to November, 2014.

All sessions were approximately 45-min and were based on scripts in an attempt to control the independent variables. Regardless of condition, the investigator described and obtained informed consent from each group at the

immediate onset of each session. During this process, the investigator explained the study including potential risks and benefits of participation, that study participation was voluntary and participants could withdraw from the study at any time without penalty, and what participation would involve. Given the clinical population and setting, the IRB granted a waiver of signatures on informed consent forms. Although consent procedures were group-based, potential participants were able to individually ask the investigator questions. In an attempt to be as inclusive as possible within the contextual parameters of an acute mental health unit, people were also permitted to attend sessions without volunteering to be research participants. Due to the exploratory nature of the study, ethical implications, and issues of confidentiality at the mental health facility, no fidelity measure was taken.

Conceptual Framework and Interventions

While a plethora of frameworks and theories shaped the construction of the interventions, the guiding framework was resultant of the unique contextual and temporal parameters of the acute care crisis stabilization unit. People on the unit required as much information as possible concerning how to manage their mental health conditions, appropriately cope with environmental stressors, and recognize situational risk factors during a single treatment session typical of an acute care mental health unit in the United States. Additionally, the managers of the acute care mental health unit specifically requested that music therapy be used to target aspects of recovery. Therefore, an educational music therapy approach for recovery (Silverman 2015) was utilized. This approach was derived from the psychoeducational and recovery literature so people would better understand, be aware of, and manage their mental health conditions based on their personalized goals and values.

Educational Lyric Analysis (ELA)

In an introductory exercise, the music therapist (MT) first asked participants to state their names and something about themselves (such as favorite food, least favorite vegetable, or favorite sport) within a 12-bar blues progression in the Key of E played on an acoustic guitar (Yamaha FG720S). The MT then distributed small pieces of paper and pens to all group members and asked them to write the title of a song that represented where they were in their mental health recovery. The MT then collected these papers, read each song title, and the group's task was to identify which group member wrote each song. After each song was identified, the MT asked the group member about their recovery and what they could do to facilitate recovery. The MT then distributed lyrics sheets for the song "I won't back down" and played and sang the song, asking group members to circle any lyrics that "jumped out" at them or to which they could relate. After playing the song, the MT facilitated a dialogue concerning group members' identified lyrics and how they related to mental health recovery. At the conclusion of the session, the MT verbally processed the session by asking the group how the session related to their recovery and what specific actions they could take to augment the likelihood of recovery, thanked everyone for participating, asked for questions and comments about the session, and distributed questionnaires to people who volunteered to complete them.

Educational Songwriting (ESW)

In an introductory exercise, the MT first asked participants to state their names and something about themselves (such as favorite food, least favorite vegetable, or favorite sport) within a 12-bar blues progression in the Key of E played on an acoustic guitar. The MT then informed the group they would be writing a song about mental health recovery but they would begin by brainstorming ideas of why they were motivated for recovery in the first verse. The MT wrote down group members' ideas and suggestions in a "lyric bank" on a dry erase board. Common ideas concerned family, friends, health, personalized goals, vocational aspirations, and happiness. The MT then facilitated group songwriting utilizing the group's suggestions. Thus, the first verse of the blues song concerned *why* people were motivated recovery. The MT used a similar procedure for the second verse but focused on *how* group members would recover. Common ideas concerned taking medications as prescribed, adhering to therapy after discharged from the hospital, monitoring the mental health condition, and having a positive attitude. The songs were 12 bar blues songs in the key of E and, due to time constraints of a single therapy session on the acute care unit, the group only had to compose lyrics. Thus, group members thus wrote a two-verse song as a group, with the first verse concerning *why* they were motivated for recovery and the second verse concerning *how* they would recover. At the conclusion of the session, the MT verbally processed the session by asking the group how the session related to their recovery and what specific actions they could take to augment the likelihood of recovery, thanked group members for participating, asked for questions and comments about the session, and distributed questionnaires to people who volunteered to complete them. The MT made copies of the song lyrics for group members to keep.

Control

In order to obtain data uninfluenced by educational music therapy, the control condition initiated with the MT distributing questionnaires to people who volunteered to complete them. The MT asked participants to state their names and something

about themselves (such as favorite food, least favorite vegetable, or favorite sport). The MT then led the group in playing rock and roll bingo. Each person had a separate card with 25 song titles on it. After group members heard a song played from a portable stereo, they placed a small piece of paper on the corresponding song title on their bingo card. At the conclusion of the session, the MT thanked group members for attending the session. Although the group may have learned musical information concerning artists and songs used in the rock and roll bingo game, the MT designed this condition to be non-educational concerning mental health recovery and to serve as a way to obtain control data uninfluenced by the treatment conditions (i.e., pretest only).

Power Analysis

A sample size of 159 would have enabled the researcher to detect a moderate effect size (0.25) when $\alpha = 0.05$ for a power of 0.80 using an ANOVA with fixed effects with three independent treatment groups using a linear mixed model. However, as IRB approval was expiring and participants noted the 50-item STORI was long, the investigator did not apply for an extension from the IRB and discontinued data collection after 21 total sessions.

Analyses

Five separate analyses of variance (ANOVA) were conducted to determine if there were differences between the three treatment groups in (a) ages; (b) the total number of times participants had been admitted to a mental health facility; (c) the number of days participants had been at the hospital; (d) the number of people in each session who volunteered to be research participants; and (e) the total number of people in each session. Chi square tests were conducted to determine if there were between-group differences in the four treatment groups in categories concerning (a) gender, (b) race/ethnicity, and (c) primary mental health diagnosis.

The investigator fit a linear mixed model with group as a fixed effect and cluster as a random effect using the univariate function in SPSS version 19.0. The investigator checked to ensure that assumptions needed for the statistical tests were met. Four of the five Levene's Tests of Equality of Error Variances were not significant (Moratorium $p = 0.705$; Awareness $p = 0.062$; Preparation $p = 0.527$; Rebuilding $p = 0.558$; Growth $F[20, 46] = 4.059$, $p = 0.001$). The investigator reported the overall F test for group differences.

Results

Participants were enrolled in the study from May 2014 to November 2014 resulting in a sample of 69 over 21 sessions. No statistically significant between group difference was found for demographic measures, all $p > 0.05$. No statistically significant between-group difference was found in demographic frequencies (all $p > 0.05$) except for age between the control ($M = 30.04$, $SD = 9.52$, $n = 23$) and ESW ($M = 39.48$, $SD = 12.70$, $n = 29$) groups.

There was no significant between-group difference for any of the STORI subscales. Thus, there was no difference between the educational music therapy and the control conditions (research question 1) and no difference between the ELA and ESW conditions (research question 2). Although not significant, descriptive data indicated that both educational music therapy conditions tended to have slightly more favorable mean STORI scores than the control condition (research question 1) in mortarium (ELA: $M = 15.56$, $SD = 12.46$, $n = 17$; ESW: $M = 20.23$, $SD = 10.36$, $n = 28$; Control: $M = 22.41$, $SD = 11.85$, $n = 22$), awareness (ELA: $M = 27.29$, $SD = 9.37$, $n = 17$; ESW: $M = 28.38$, $SD = 7.92$, $n = 28$; Control: $M = 24.52$, $SD = 10.59$, $n = 22$), preparation (ELA: $M = 32.27$, $SD = 9.66$, $n = 17$; ESW: $M = 30.00$, $SD = 8.78$, $n = 28$; Control: $M = 27.25$, $SD = 11.52$, $n = 22$), rebuilding (ELA: $M = 36.41$, $SD = 10.34$, $n = 17$; ESW: $M = 32.50$ $SD = 9.71$, $n = 28$; Control: $M = 29.09$, $SD = 12.32$, $n = 22$), and growth (ELA: $M = 32.97$, $SD = 14.97$, $n = 17$; ESW: $M = 29.68$, $SD = 11.17$, $n = 28$; Control: $M = 27.23$, $SD = 18.10$, $n = 22$), subscales. While both educational music therapy conditions more favorable means than the control condition, differences between ELA and ESW descriptive data were minimal (research question 2).

Discussion

The purpose of this cluster-randomized pilot effectiveness study was to compare two different group-based educational music therapy interventions with a control condition as measured by the stage model of recovery with adults on an acute care mental health unit. Results indicated that there was no difference between the educational music therapy and control conditions (research question 1) and no difference between the two educational music therapy conditions (research question 2). Although not significant, descriptive data indicated that the ELA and ESW conditions tended to have slightly more favorable mean stage of recovery subscale scores than the control condition. These results are congruent with existing acute care

mental health research indicating that single educational music therapy interventions tend to have more favorable descriptive statistics than control conditions in a variety of measures related to recovery but differences between specific educational music therapy interventions are minimal (Silverman 2014, 2016a, 2016b, 2017, 2018). While no result was significant and the author cautions against generalizations, within the temporal parameters of single-session therapy and contemporary acute mental health care, results may be considered clinically relevant as recovery represents a key goal in mental health care.

Results of this single-session pilot effectiveness study have clinical implications that ELA and ESW can have slight positive impacts upon stage of recovery. As the current effectiveness study was conducted on a secure acute care mental health unit, potential between-group differences may have been minimized due to the setting, which necessitated a single treatment session. More generally, the educational approach to music therapy for mental health recovery (Silverman 2015) may constitute an ideal model for acute mental health care, wherein a music therapy model is needed (Carr et al. 2013).

There are numerous limitations and delimitations of the current study. As maintenance of treatment gains may have dissipated immediately after the session, delimitations of the current study can initiate with the absence of follow-up measures. Due to the high degree of turnover and single-session design applicable for the acute care unit, the investigator did not administer measures beyond immediate posttest. Additionally, the investigator's dual role of researcher and music therapy clinician may have led to biased participant responses. In future studies, research assistants could collect data to minimize bias. However, due to their symptoms, some people on mental health units may be paranoid and researchers should carefully consider the advantages and disadvantages of multiple people interacting with participants in single-session studies. Constituting a limitation, there was a significant between-group difference concerning age between the control and songwriting groups. Additionally, as recovery is highly idiosyncratic (Anthony 1993) and there is not a consensus on how to best operationally define recovery (Slade 2009), the construct of recovery itself represents a limitation. Moreover, the investigator compared between-group descriptive data instead of participants' actual stage of recovery. Finally, the investigator discontinued the study with a small sample of 69 participants as the 50-item instrument took too long for participants to complete within a single 45 to 50-min session.

Suggestions for future research include studying and comparing different music therapy interventions that may have differing degrees of structure, including clinical improvisation. Also, using interpretivist paradigms and mixed-methods investigations to study participants' experiences in educational music therapy interventions could lead to a more holistic understanding of the treatments and potential mechanisms of change. It also may be interesting to compare different music therapy approaches. For example, both music therapy conditions in the current study used an educational approach targeting recovery, although they were different interventions (i.e., ESW and ELA). Future researchers might consider comparing educational music therapy with other types of music therapy approaches, including recreational, resource-oriented, and improvisational. Finally, multiple data collection sites could be used to increase the sample size and future researchers might consider using a shorter psychometric instrument. In the contemporary era of heightened accountability and evidence-based practice, future research concerning other recovery-related constructs using a variety of research paradigms is warranted to provide the best treatment possible for people with mental health conditions.

Compliance with Ethical Standards

Conflict of interest The author reports no conflict of interest.

Ethics Approval The author has read the ethical guidelines for this journal and certifies he is in compliance with all ethical guidelines.

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