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A Survey of Current Music Therapy Practices for Clients with Substance Abuse and Eating Disorders

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FLORIDA STATE UNIVERSITY
COLLEGE OF MUSIC

A SURVEY OF CURRENT MUSIC THERAPY PRACTICES FOR
CLIENTS WITH SUBSTANCE ABUSE AND EATING DISORDERS

By

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I wish to dedicate this thesis to those bound by the thoughts of others.
Believe in yourself and extraordinary things will happen.

“I’m nothing great. But I’m a rose... I’m a rose whether I’m admired or not. I’m a rose whether anyone’s crazy about me or not... Like I said, nothing great. Just a rose... But, do you know what it means to be a rose, my friend? Being a rose means ‘freedom.’ It means not existing by the praises of others or not ceasing to exist by their disapproval.”

- Serdar Özkan

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ABSTRACT

The application of music therapy with individuals with eating disorders and substance abuse disorders is existent, though there is a limited amount of research that exists in the current literature. Symptoms that are addressed in individual and group sessions for both populations are presented in this study. The purpose of this study was to examine goals and interventions implemented by music therapists working with these populations. This study is also aimed at examining the transition from the DSM-IV-TR to the DSM-5 and whether this has created any changes in music therapy sessions. Data for this study was collected in the form of an online survey. The American Music Therapy Association (AMTA) provided contact information for music therapists who work with individuals with eating disorders and substance abuse ($N = 128$); however, one contact information provided was marked undeliverable. The researcher also asked professionals not registered with the AMTA who were known to have worked with the populations ($N=11$). Forty-seven individuals responded to the survey, creating a response rate of 34%. Of the 47 individuals who responded to this survey, 95.74% held the MT-BC certification; however only 63.89% held a job with a title of “Music Therapist.” Only 11.63% of respondents ($n = 5$) reported working in a facility that specializes in eating disorders, while 34.88% of respondents ($n = 15$) indicate working in a facility specializing in substance abuse. Fourteen individuals (32.56%) indicated working with individuals diagnosed with eating and substance abuse disorders. Suggestions for future research are made, as well as limitations of the study are presented.

CHAPTER 1

INTRODUCTION

Historical Views of Disordered Eating and Substance Abuse

Eating disorder behaviors have been documented throughout history (Keel, 2005; Brown, 1981; Siegel, 2005; FDA, 2014; Miles, 1995; Morgan, Marsden, & Lacey, 1999, Costin, 2007; Kirkpatrick & Caldwell, 2004). In history where religion played a significant role in individual's lives, religious aspects tried to explain some of the disordered eating behaviors that were seen. Historians have speculated that some 12th century accounts of individuals believed to be victims of demonic possession are actually early depictions of individuals with anorexia nervosa (AN) (Keel, 2005). In addition, while Bulimia Nervosa (BN) was not officially termed until the later 20th century, specific regurgitation behaviors that are part of the diagnostic criteria can be seen as far back as the 1st century (Keel, 2005).

Historically, religious asceticism is one of the most common ways in which eating disorders have been explained. Many different ideas on the theory of "spiritual anorexia" are used to justify some of the first recordings of disordered eating (Keel, 2005; Miles, 1995; Morgan, Marsden, and Lacy, 2000). Individuals during this time believed that by monitoring their intake and decreasing the amount they ate, that they could minimize or even reverse their own sin (Miles, 1995).

Individuals who cite asceticism as rationale for the restriction of food have been found in multiple religions of the world. Morgan, et al. (2000) provides one example involving a catholic woman who "displayed punitive religious devotions involving self-starvation, ingestion of rotting food, and eventually anorexia nervosa, while feeding vagrants with her fresh food." The stringent eating behaviors exhibited may try to explain the same restriction that was exhibited by the Christian deity. In another example presented by Morgan, et al. (2000), a young female exhibited signs of disordered eating after her conversion with a Jehovah's Witness. The individual's case arose "from a history of chaotic parenting, with a strong family history of substance abuse... her religious beliefs providing internal restraint." This case illustrates a restraint of tendencies occurring after her conversion, but it can also lead to a host of other inappropriate behaviors including shoplifting and self-harm.

Examples of binge-purging have been documented as far back as the Roman Empire when Claudius (A.D. 41 – 54) and Vitellius (A.D. 69) practiced vomiting in order to continue to eat more (Keel, 2005; Costin, 2007; Kirkpatrick & Caldwell, 2004). While this was common practice at the time, it may be considered one of the beginnings of Bulimia Nervosa or Binge-Eating Disorder (BED).

In addition to eating disorders, substance abuse is also documented in historical research. Over past decades, popularly used substances, as well as reasons for using them have changed. Historians suggest that alcohol and tobacco were consistently used, a trend that has continued (Brown, 1981; Siegel, 2005). Other substances, Brown suggests, have appeared within the last two centuries. These include: opiates, cocaine, marijuana, cannabis, over-the-counter prescriptions, chloral hydrate, nicotine, heroin, and LSD (1981). As American society has progressed, new drugs have been introduced, leading individuals to sample these new drugs. While some drugs are not specifically made for abuse, some individuals may attempt to use them as such. New laws after the initial drug-control law of 1915 were implemented in an attempt to monitor inappropriate use of these substances (FDA, 2014).

In the last century, drug abuse has become popular among societies. Some examples of drugs that have seen much abuse in the more recent past include alcohol, cocaine, and LSD. Though one of these substances spans further back in time than 100 years, all of these substances, and others, have at one point or another created problems for individuals in society. Depending on the specific drug that may be popular in history, individuals see that these substances are able to influence their actions (Fachner, 2010).

One drug in particular has reached popularity in the United States within the last century, moreso than any other country. According to Controlled Substances (2009), LSD was widely accessible during the 1960s. The authors speculate that part of the reason for the use of this drug is due to the involvement during the Vietnam War. While the majority of use of LSD was during this era, reports of it are still seen in recent years. In 2000, Controlled Substances reports over 4,000 admissions that were related to LSD (2009).

LSD is only one example of drugs that have shown abuse in the past. Other drugs, like those mentioned above, despite their age, may be abused. The time they are most prevalent may be in the past, however, as is seen with LSD, they are still able to be abused today.

DSM Criteria of the Disorders: Previous and Current

Since the earliest years of human civilization, humans have had standards for proper behavior. When individuals behave in a manner that is contradictory to the rest of their society, it is deemed inappropriate. It is from these inappropriate behaviors that stems the idea of disordered behavior. Researchers are constantly trying to understand the causes and effects of these behaviors on the individuals who exhibit them and those around them. While new research is continuously being added to the literature over time, one area that has constantly changed over the last few decades is the understanding of the pathology of eating and substance abuse disorders, as well as their causes, symptoms, and possible treatments. As a result of the most up-to-date research into the area of mental disorders, the Diagnostic and Statistical Manual of Mental Disorders (DSM) was created as a diagnostic tool for clinicians to use when diagnosing and treating disordered behavior. Since its introduction in 1952, the DSM has undergone several revisions.

Eating Disorders

Though many different types of eating disorders exist, three are of notable importance to this study: anorexia nervosa, bulimia nervosa, and binge-eating disorder. The DSM-IV-TR, published by the APA in 2000, contained up-to-date criteria for mental disorders until the DSM-5, published in 2013. In the previous edition of the DSM, eating disorders included specific criteria for AN and BN only. The DSM-IV-TR has four criteria for a diagnosis of anorexia nervosa. The individual's body is 85% less than an average weight for their body type, the individual exhibits an immense fear of gaining weight, despite being underweight, as well as a lack of concern of their low body weight. Individuals diagnosed with AN using this DSM also present with amenorrhea (the absence of at least three consecutive menstrual cycles) (APA, 2000). After an individual has received a diagnosis of anorexia nervosa, they are further classified into two different subtypes: restricting type and binge-eating/purging type. Individuals who have anorexia nervosa-restricting type (ANR) will limit food and restrict intake to achieve weight loss, while individuals who have binge-eating/purging type (ANBP) will engage in compensatory behaviors, such as excessive exercising or self-induced vomiting, to make up for a binge episode.

In the DSM-IV-TR, the APA provided five criteria for a bulimia nervosa diagnosis. The individual must exhibit recurrent episodes of binge eating, and show recurrent compensatory behaviors, with both of these behaviors occurring on average, twice a week for a minimum of three months. The individual bases their self-image on their size and weight, and the disturbance for BN does not occur during the episodes of AN (2000). Like individuals with AN, those with bulimia nervosa are also classified into two subtypes: purging and non-purging types. Individuals with bulimia nervosa-purging type engage in self-induced vomiting to compensate for a binge episode. Those diagnosed with non-purging bulimia nervosa will engage in compensatory behaviors, such as excessive exercising and fasting to make up for the intake of calories (2000).

The year 2013 brought about the most current edition of the DSM, the DSM-5. The DSM-5 is the first in the set to introduce a section on feeding and eating disorders, rather than including these disorders under another category. Other changes include the addition of Binge-Eating Disorder as an official eating disorder. In the previous edition of the DSM, BED was not classified as its own eating disorder; rather it was classified as an eating disorder, not otherwise specified (EDNOS). This section represents disorders that do not meet all of the listed criteria for AN or BN. Also, not unexpectedly, there were changes to the criteria of eating disorders.

In order for an individual to be diagnosed with Anorexia Nervosa according to the DSM-5, they should exhibit the following symptoms:

- A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even through at a significantly low weight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

(APA, 2013; pp. 338-339)

Like the previous DSM, if an individual meets these criteria, they are further classified into one of two sub-types: restricting (controlling intake of food) or binge-eating/purging (intake of large quantities, followed by regurgitation). The removal of the amenorrhea criterion is a major change in the new version. As a result, men can now be diagnosed with AN with the removal of this criterion.

According to the new DSM-5, individuals may be diagnosed with Bulimia Nervosa if they meet the following 5 criteria:

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
 - 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
 - B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
 - C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
 - D. Self-evaluation is unduly influenced by body shape and weight.
 - E. The disturbance does not occur exclusively during episodes of anorexia nervosa.
- (APA, 2013; p. 345)

According to the DSM-5, Binge-Eating Disorder is characterized by the presence of recurrent binge-eating episodes. The criteria associated with Binge-Eating Disorder include:

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
 - 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- B. The binge eating episodes are associated with three (or more) of the following:
 - 1. Eating much more rapidly than normal.
 - 2. Eating until feeling uncomfortably full.
 - 3. Eating large amounts of food when not feeling physically hungry.
 - 4. Eating alone because of feeling embarrassed by how much one is eating.
 - 5. Feeling disgusted with oneself, depressed, or very guilty afterward.
- C. Marked distress regarding binge eating is present.
- D. The binge eating occurs, on average, at least once a week for 3 months.
- E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

(APA, 2013; p. 350)

Substance Abuse

Disorders related to substance abuse are categorized by how an individual uses a substance. The DSM-IV-TR classifies substance abuse disorders as: Substance Dependency,

Substance Abuse, and the Substance-Induced Disorders. For a full diagnosis of substance dependency, manifestation of three of the following must occur: tolerance of a substance, withdrawal of a substance, larger doses or over a longer period of time than intended, unsuccessful efforts to control the use of a substance, much time spent in activities to obtain the substance, use the substance, or recover from the substance, decrease in recreational activities, and continued usage of the substance despite having knowledge of problems caused by it. For a full diagnosis of substance abuse to be given, two of the following must manifest within a 12-month period: recurrent substance use that results in failure of fulfilling job obligations, recurrent substance use in situations in which it is physically hazardous, legal problems caused by recurrent substance use, and continued usage of the substance despite having knowledge of problems caused by it. (APA, 2000)

Major changes were made to the diagnostic criteria for Substance-Related and Addictive Disorders in the DSM-5. The APA kept the DSM-IV-TR's criteria for substance abuse and substance dependency and combined them into one list for the DSM-5. The DSM-5 also included a new list of substance classes relevant to the Substance-Related and Addictive Disorders section: alcohol, caffeine, cannabis, hallucinogens / phencyclidine / other hallucinogens, inhalants, opioids, sedatives / hypnotics / anxiolytics, stimulants, tobacco, and other, which then was created into its own disorder (APA, 2013). The following example is the diagnostic criteria for Alcohol Use Disorder, one of the Alcohol-Related Disorders:

- A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
 1. Alcohol is often taken in larger amounts over a longer period than was intended.
 2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
 3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
 4. Craving, or a strong desire or urge to use alcohol.
 5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
 6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
 7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
 8. Recurrent alcohol use in situations in which it is physically hazardous.

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for alcohol
 - b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

(APA, 2013; pp. 490-491)

The new formation of the Substance-Related and Addictive Disorders in the DSM-5 adjusts the criteria that was seen in the DSM-IV-TR (Substance dependence and substance abuse) to fit each of the substances provided.

Facilities

Many facilities and programs offer assistance to those who are diagnosed with eating and substance abuse disorders (Barnett & Swindle, 1997; Keel, 2005; Calderon, Stoep, Collett, Garrison, & Toth, 2007; Schaffner & Buchanan, 2008; Brown, Vartivarian, & Alderks, 2011; Nowoweiski, Arthey, & Bosanac, 2011; Grewal, Jasper, Steinegger, Yu, & Boachie, 2013; Bégin, Gagnon-Girouard, Aimé, & Ratté, 2013; NIH, 2012). The way that inpatient and outpatient facilities operate is different, but the overall goal is the same. According to the NIH (2012), over 14,500 facilities offer services for substance abuse and other mental disorders, to include eating disorders.

Inpatient facilities provide live – in treatment for substance abuse and eating disorders. According to Keel (2005), inpatient treatment is 24 hour a day treatment. In these facilities, individuals are under constant watch for any relapse of inappropriate behaviors. These residential treatment facilities offer traditional services to their clients, such as therapies, support systems, and counseling to help clients reach their goals.

In a study of inpatient facilities for pediatric patients with an eating disorder diagnosis, Calderon, et al. (2007) reports that of the total number of admissions was 1,713 over a three year period. Of these individuals, 1,208 were diagnosed with anorexia nervosa, 255 individuals were diagnosed with bulimia nervosa, and 250 individual were diagnosed with an eating disorder, not

otherwise specified (Calderon, et al., 2007). While this study shows a higher prevalence of AN, individuals with any type of eating disorder diagnosis can seek help at an inpatient facility.

The length that a patient stays in this type of facility is different for each person. Barnett and Swindle (1997) suggest that length of stay improves the outcomes of treatment. Increased length of stay would offer increased benefits to these individuals, due to increased time with therapists and support groups. Remaining in a program for less time will be less beneficial for the client, while remaining in the program longer will be more beneficial, but at a monetary loss to the client. Specifically, this study found the most cost-effective length of stay is maintained at 21 days

Outpatient programs and facilities are a much cheaper option for the client, as housing is not included in the cost of treatment (Keel, 2005). Individuals in out-patient facilities still receive the benefits of therapies, support systems, and counseling that inpatient clients do. According to Nowoweiski, et al. (2011) day programs allow clients to experience a sense of independency and allows them to re-acclimate to society-approved behaviors, which decrease inappropriate behaviors. This is because in these programs, individuals are not under constant supervision, allowing them to control their own behaviors.

Prevalence and Symptoms

Eating Disorders

According to the National Eating Disorder Association (2014), 20 million women and 10 million men are diagnosed with an eating disorder at some point in their lives. Resulting symptoms can be psychological, physical, and behavioral (Allan & Goss, 2013; Cooper, Todd, & Wells, 2009; Dowling, Weiss, & Condon, 2007; GMHF, 2006; Goldstein, Dechant, & Beresin, 2014; Martín, Nieto, Jiménez, Gómez, & Fernández, 1999; Keel, 2005; Strother, Lemberg, Stanford & Turberville, 2012; Tozzi, Thornton, Klump, Fichter, Halmi, Kaplan, Strober, Woodside, Crow, Mitchell, Rotondo, Mauri, Cassano, Keel, Plotnicov, Pollice, Lilenfeld, Berrettini, Bulik, & Kaye, 2005). Many of the symptoms patients exhibit are seen as cross-over symptoms, meaning that they may also appear in other diagnoses (Tozzi, et al., 2005) such as personality or other psychological disorders (depression, antisocial disorder, etc.). Individuals do not always exhibit the same symptoms as other individuals with the same disorder.

Behavioral symptoms are the most reliable indicators of eating and substance abuse disorders. Individuals who exhibit a change in their typical behaviors may be exhibiting symptoms of a disorder. Abnormal behaviors may be one of the easiest ways to identify a disorder prior to diagnosis. People typically identify changes in eating patterns as the only way to identify a possible eating disorder, but it is not the only. Other indicators might include constant attention to diets (Allen and Goss; 2013). Individuals with AN may also exhibit a propensity toward perfectionism (Keel, 2005; Goldstein, et al. 2014), striving for their ideal body image, but never seeing themselves as having achieved it. This may explain why individuals attempt diets, to achieve these preconceived notions of what their idea of ideal image is, and working toward that goal. These individuals may not realize, however, that their perception of the ideal body is illogical and irrational. According to Keel (2005), it has been recorded that individuals who experience some eating disorders exhibit symptoms that are similar to other personality disorders, such as depression, social anxiety, OCD, and lack of social engagement. Martín, et al. (1999) suggest that one of the most important characteristics of an eating disorder is the individual's negative change of self-perception. Negative self-image is one quality that begins thought processes leading to disordered eating.

Vomiting is a physical sign of BN, though, it is not always a sign, and may instead be the result of other gastrointestinal problems. Self-induced vomiting, according to Cooper et al. (2009), can bring about other physical signs such as tooth damage, swelling of salivary glands, damage to the throat and esophagus, and possibly Russell's sign (rawness of hand as it continuously rubs the inside of the mouth to stimulate the gag reflex, usually along the knuckles). Other symptoms that with which a client may present might include excessive exercising (Keel, 2005; Cooper, et al., 2009; Strother, et al., 2012) or laxative/diuretic abuse (Keel, 2005; Costin 2007). According to Cooper et al., individuals diagnosed with eating disorders may also experience depression symptoms and severe mood swings (2009). Other symptoms relate to risks of obesity, such as high blood pressure and heart disease (NEDA, 2014).

Substance Abuse

Many individuals who abuse substances will exhibit different symptoms based on the substance used (GMHF, 2006; Dowling, Weiss, & Condon, 2007; NIH, 2011; Davis, 1999). The

substance, if overused, can interfere with bodily functions and alter the way one behaves and interacts with others. Clients who suffer from a substance abuse disorder may exhibit cross-over symptoms with other disorders (such as loss of weight, depression, loss of bodily function control, disorientation, etc.). While individuals may engage in substance abuse recreationally, Davis (1999) suggests that individuals who engage in the abuse of drugs or alcohol do so as a coping mechanism for other issues, such as depression or lack of social interaction.

According to a national survey administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2009, “23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3 percent of persons aged 12 or older)” (NIH, 2011). The survey reports that the top three drug abuse admissions were alcohol (23.1%), alcohol in combination with another drug (18.3%), and marijuana (17%). The survey also says 60% of those admitted for treatment of Substance-Abuse Disorder were Caucasian, with the second highest rate of admittance being African-American at 20.9% (NIH, 2011). While adolescents and young adults are mostly associated with the idea of substance abuse, the National Institute of Health reports that all ages are susceptible. In fact, out of 1.8 million admissions, 14.8% of the admissions are of ages 25 – 29, 14.4% are of ages 20 – 24, and 12.6% are of ages 40 – 44. While the idea of substance abuse is typically associated with younger individuals (Dowling, et al., 2007), geriatric populations (ages 60 and higher) also make the list at 1.8%. (NIH, 2011)

Some cases of substance abuse may be unintentional. This may be the case seen with elderly adults, who depend on caregivers to manage their prescriptions. These individuals may depend on these caregivers due to a loss in brain function and memory loss. According to the Geriatric Mental Health Foundation (GMHF), as individuals grow older, the way they are affected by substances changes (2006). This makes taking prescriptions or drinking alcohol risky. Davis, et al. (1999) suggests that if an individual receives an incorrect dosage of a substance for a prolonged period of time, the individuals may experience a higher risk of developing a substance abuse. The GMHF reports that these changes in the body can make one more sensitive to the affects of a substance, such as delirium and disorientation.

Influences Leading to Eating and Substance Abuse Disorders

There are many different factors that may influence an individual to engage in substance abuse and abnormal eating behaviors, including: media and self-thought (Becker, Burwell, Herzog, Hamburg, & Gilman, 2002; Thompson and Stice, 2001), family and friends (Eneli, Crum, & Tylka, 2008; Salk and Engeln-Maddox, 2011; Adewuyi & Akinsola, 2013), and “drunkorexia” (Barry, Piazza-Gardner, 2012).

Much of what we see and hear in the media influences how we think of our self-image. If an individual does not look like the image on the TV, they may feel socially unacceptable. In response, an individual may engage in disordered behaviors to control it. One study by Becker, et al. (2002) examined how the introduction of media (TV) in a previously non-westernized civilization affects the prevalence eating disorders. The researchers presented Fijian girls ($n = 63$) with televisions, and studied the population at 1 month after presentation and again at 3 years. The results of this study showed an increase in self-induced vomiting and more individuals were engaged in dieting practices. Individuals who experience this sensation of not looking like the people on TV may experience a disturbance in body image. The thin-ideal internalization as defined by Thompson and Stice is “the extent to which an individual cognitively ‘buys into’ socially defined ideals of attractiveness and engages in behaviors designed to produce an approximation of these ideals” (2001).

Family and friends also have a major influence on prevalence rates of disorders, and these influences may range back to the time of childhood (Eneli, et al. 2008). Examining how an individual grows in an environment will give insight into their eating styles and patterns. When individuals are young, parents supervise behaviors and dictate aspects of a child’s life, such as food and exercise. Children who grow up with this type of parenting may experience a lack of self-esteem, as they are unable to make their own choices in what to eat or how much (Eneli, et al., 2008). This interaction demonstrates restricting and controlling behaviors, which may eventually mutate into an eating disorder.

Friends also play an important role in the formation of self-image. Many individuals engage in a process called “fat-talk,” referring to conversational dialogue where the target topic is body shape and size (Salk & Engeln-Maddox, 2011). The researchers of the fat-talk study recruited undergraduate women ($N = 186$) and asked them to fill out a survey regarding body size and conversational dialogue. Results show that 93% of friends engaged in fat talk. The

purpose of these conversations was to gain reassurance, denial (“You aren’t fat.”), and emotional support from their friends. (2011)

In a study performed by Adewui & Akinsola, the researchers examined age and peer influences on substance abuse (2013). The researchers recruited undergraduates ($N = 513$) from Nigeria, and presented them with the APISAI (Age and Peer Influence on Substance Abuse Inventory). Their findings indicated that individuals engaged in these relationship-based behaviors for many reasons: social pathologies, emotional and psychological stresses, and peer group pressure. The results of this descriptive study showed that there is a significant relationship between peer influence and substance abuse (2013), suggesting that individuals will engage in these behaviors as a coping mechanism or to create a sense of belonging.

Other trends such as “Drunkorexia” (Barry, et al., 2012) may influence disordered behaviors. Drunkorexia is a coined term for a phenomenon wherein individuals restrict their eating (anorexia) and compensate by an increase of alcohol drinking (substance abuse). The researchers took a national survey of college students ($N = 22,488$). Results showed a high level of excessive exercising to make up for a binge-drinking episode. The abuse of alcohol is highest among the most active of students (Barry, et al., 2012), typically those belonging to a college fraternity or sorority.

Individuals may engage in disordered behaviors because they are victims of unfortunate events, or because they are influenced in some way by friends or family. Like the symptoms that are exhibited, the influences and reasons for these behaviors are different for everyone. Based on presented symptoms, clients quality of life and how they are able to live may be affected.

Quality of Life

Because individuals with eating disorders tend to suffer from a variety of comorbid conditions, it is difficult to distinguish between symptoms that are related to eating disorders alone and those related to their comorbidities. Many studies have been executed in which the goal was to examine the quality of life of an individual who has an eating disorder or substance abuse (Mond, Hay, Rodgers, Owen, & Beumont, 2005; Padierna, Quintana, Arostegui, Gonzalez, & Horcajo, 2000; Rie, Noordenbos, & van Furth, 2005). Due to the overlapping of comorbidities of eating and substance abuse disorders, research focusing on quality of life is typically geared toward the entire spectrum of mental disorders.

One such study, performed by Mond et al. (2005), recruited participants from an eating disorder day program to examine their quality of life. Participants ($N = 87$) who were diagnosed with an eating disorder (AN, BN, or BED) were given questionnaires (SF-12, WHOQOL-BREF, K-10) which pertained to different affected areas of eating disorders, including: general distress, social and demographic information, and pathological. They found that the 87 participants, when compared to a control group ($N = 495$), showed lower mean results in the domains of (Patients : Control): mental component scale (30.01 : 47.40), psychological component scale (46.96 : 50.73), psychological quality of life (2.39 : 371), and social quality of life (3.01 : 3.70).

In another descriptive study, by Padierna, et al. (2000), participants ($N = 197$) between the ages of 14 and 65 who received a diagnosis of AN, BN, or BED were given multiple questionnaires (SF-36, EAT-40, and the HAD) to assess their quality of life (physical function, physical role, bodily pain, general health, vitality, social function, emotional role, and mental health). The results illustrated that AN was the most represented disorder in this study. While the majority of the evaluated areas were affected by the eating disorder (exception of physical functioning), results show that the greatest areas of deterioration were from the psychosocial categories: vitality, emotional role, social functioning, and mental health. (Padierna, et al., 2000)

Results from another descriptive study by de la Rie, et al. (2005) offered similar findings as Padierna, et al.'s research. The participants recruited for this study included individuals with eating disorders ($n = 156$), individuals who formerly had eating disorders ($n = 148$), normal individuals ($n = 767$), and individuals with mood disorders ($n = 591$). The focus of this study was to examine factors that contributed to the participants' quality of life, by using several questionnaires (Eating Disorder Examination Questionnaire, SF-36, and Rosenberg's Self Esteem Questionnaire). Of the participants that exhibited current symptoms and diagnoses, anorexia nervosa was the most common eating disorder. These results show that participants who have an eating disorder, whether currently or in the past, exhibited lower quality of life values compared to those without eating disorders.

Individuals who suffer from substance abuse disorders also may experience a decrease in quality of life (Rudolf & Watts, 2002; Singh, Mattoo, Sharan, & Basu, 2004; Benaiges, Prat, & Adan, 2012; Schmitz, Kruse, & Kugler, 2003). Like individuals with eating disorders, individuals who have substance abuse disorders may suffer from an array of comorbidities. Substance abuse and dependency can be associated with other disorders, such as bipolar and

other mental disorders (Rudolf & Watts, 2002; Singh et al., 2004; Schmitz et al., 2003). According to Rudolf & Watts (2002), dual diagnosis data shows that individuals who experience dual diagnoses exhibit “faster relapse, higher rates of rehospitalization and incarceration, poor participation in aftercare services, loss of social support and more financial problems.”

In a study to compare the quality of life in individuals with substance abuse disorder and individuals with bipolar disorder to individuals who have a dual diagnosis of substance abuse and bipolar disorders, Singh et al. (2004) sought to find out if there were differences between the quality of life of people with a single diagnosis versus a dual diagnosis. The researchers administered several surveys (ICD-10, HDRS, MRS, SADQ, and WHO-QOL – BREF) to four groups of participants and a control group. Areas of that were examined include: general well-being, physical health, psychological health, environment, and social relationships. The results of this study show that while quality of life in individuals with substance dependency is not as low as individuals with dual diagnosis, their quality of life remains lower than individuals with bipolar disorder or individuals with no disorders.

Results from Benaiges, et al’s (2012) study, are similar to the findings of Singh et al (2004). The results from Singh, et al’s (2004) study are also able to be seen in the results reproduced by Benaiges, et al’s (2012) study. Benaiges, et al. recruited individuals (N = 105) and split them into 3 different groups: dual diagnosis (substance abuse and mental disorders), severe mental illness, and substance use dependence. This study offered the Short Form -36 Item Health Survey to the participants and reproduced similar results to Singh, et al., showing that individuals with dual diagnoses scored very low in quality of life measures. While people with substance abuse disorders score higher than individuals with mental illnesses and individuals with dual diagnoses, in terms of general health and vitality, they score lower in functional abilities.

In another study, quality of life associated with smoking and nicotine dependence was examined. Schmitz, et al. (2003) recruited individuals to take part in a two-step descriptive study. Out of the total respondents for the first study (N = 7,124), only 61.5% returned for the completion of the study (N = 4,181). The authors used several tests to examine health-related quality of life (physical functioning, physical role functioning, bodily pain, general health, vitality, social functioning, role emotional functioning, and mental health), including the German National Health Interview and Examination Survey. This study found that, with the exception of

one area, physical functioning, nicotine-dependent smokers reported significantly lower quality of life than nonsmokers and current smokers.

CHAPTER 2

REVIEW OF LITERATURE

The Treatment Team

When an individual is diagnosed with an eating or substance abuse disorder, they may choose to be placed in a facility where they undergo treatment and therapies. All individuals who need assistance for substance abuse or eating disorders are eligible to receive the help of a treatment team. According to the report *Treatment Improvement Protocols*, “multidisciplinary teams can be composed of credentialed specialists as well as self-help and grassroots organizations” (Center for Substance Abuse Treatment, 2000). A team can be comprised of any professional that will help to treat the whole patient in a holistic way. (Hazelden, 2014; Walden Behavioral Care, 2014; Schaffner & Buchanan, 2008; Nowoweiski, et al., 2011).

The diagnosis and the goals of each individual will help determine the clinicians who will be on their team. Because each team is made up of professionals that will most benefit the individual, treatment teams can be large or small. Clinicians on an individual’s team may include: nutritionists, psychologists, social workers, psychiatrists, a multitude of therapists, specialists, physicians, occupational therapists, expressive arts therapists, licensed drug and alcohol counselors, nutritionists, case managers, spiritual care counselors, licensed recovery coaches, and counselors (Schaffner & Buchanan, 2008; Walden Behavioral Care, 2014; Hazelden, 2014) as well as other clinicians employed by the treatment facility. (Nowoweiski, et al., 2011).

Therapies

Clients with eating or substance abuse disorders may undergo multiple types of therapy during the course of their treatment (Wilson, Grilo, & Vitousek, 2007; Fairburn & Harrison, 2003; Corsini & Wedding, 2008; Keel, 2005; Kirkpatrick & Caldwell, 2004; Costin, 2007; Sperry, Roehrig, & Thompson, 2009; Kratina, 2003; Van Dyke & Drinkwater, 2013; Taylor, 2010; Wilson, 2008; Bobilin, 2008). While therapies based on behavioral techniques such as Cognitive-Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT), are most common in working with those diagnosed with a substance abuse or an eating disorders, others do exist, such as family therapy and contemplative therapies.

According to Keel (2005), “cognitive-behavioral therapies are directive therapies focused on the present (versus relational features of the rearing environment).” Therapies that make their foundations on CBT principles will use exhibited behaviors through the use of multiple “techniques to modify automatic thoughts and assumptions” to create a new way of learning (Corsini & Wedding, 2008). “The individual with anorexia has a need for control and views the eating disorder as the aspect in life that can be controlled” (Bobilin, 2008). Within a session, a music therapist is able to give the client choices regarding the structure of the session. This is thought to elicit a sense of control that the client had previously been seeking through weight loss or substance abuse. The overall goal of these therapies is for the client to recognize an inappropriate behavior and learn how to adapt it into an appropriate behavior.

The Dialectical-Behavior Therapy model utilizes the techniques of CBT and interpersonal therapy. DBT is a “focus on balancing the traditional emphasis on behavior change with the value of acceptance, and the importance of the relationship between the two” (Wilson, 2008). There are some slight differences in the goals of DBT, when compared to CBT. Costin (2007) suggests that there are four goals to DBT: mindfulness, distress tolerance, interpersonal effectiveness, and emotional regulation. Mindfulness refers to an awareness of internal and external stimuli and how it affects oneself. Distress tolerance is “the ability to develop safe ways of coping with painful emotions without resorting to impulsive (and often self-destructive) behaviors that ultimately increase emotional pain” (Keel, 2005). Interpersonal effectiveness is a sense of providing the body with needs in regards to social relationships. Finally, emotional regulation refers to a experience emotions without having an fluctuation in the overall experience of life. Though the original use of DBT was for individuals with personality disorders, it became adaptable for those with eating disorders as understanding of these disorders and their comorbidities increased (Keel, 2005).

The most researched type of therapy with clients diagnosed with anorexia nervosa is family therapy (Wilson, et al., 2007). Family therapy focuses on interaction between a client with a diagnosis and their family members. According to Sperry, et al. (2009), this form of therapy uses the client’s family as the prime facilitators of change. Costin (2007) explains that the parents become the “boss” of the child’s habits, making any sacrifices needed to monitor them. This form of treatment has become known as the Maudsley Model.

“Control Reversal Therapy” is a technique that was coined in the treatment of eating disorders, specifically Anorexia Nervosa. When this type of therapy is used with clients with anorexia nervosa, they have displayed a regression in anorexic behaviors and an increase in appropriate eating patterns (Taylor, 2010). Control Reversal Therapy has a main goal of retraining the individual’s brain as to what is the actual cause of lack of control and regaining it. When administered effectively, Taylor suggests that clients will feel less need to experience a sense of control through eating, but rather another action (2010).

There are also many forms of non-psychotherapy methods for working with individuals with substance abuse and eating disorders. Support groups, counseling, and specialized programs are the most common form of these methods. Group therapy and support groups work in similar fashions. Group therapy invites individuals into groups to work on their goals (McGilley, 2006). Group therapy, like support groups, focuses the sessions to elicit healing. Support groups and specialized programs are also types of methods of treating disorders. An example of this is a rapidly growing movement called Health at Every Size (HAES). This movement is founded in the idea that “a focus on approaches that can produce health benefits independently of weight loss may be the best way to improve the physical and psychological health of Americans seeking to lose weight” (NIH, 1992; as cited in Kratina, 2003). Non-dieting (the main method of weight loss condoned by HAES) in an attempt to listen to what your body says it wants and when it is or is not hungry are some of the foci of this group. This can also be referred to as “intuitive eating,” based on the belief that the body “knows” the exact type and amount of food needed to maintain appropriate nutritional health” (Van Dyke & Drinkwater, 2013). Programs such as Weight Watchers or Alcoholics Anonymous are groups that practice this method.

Complementary and alternative therapies are relatively new to the treatment of eating and substance abuse disorders. Kirkpatrick & Caldwell (2004) provides a list of some different types of therapies that fall under this category, including: physiotherapy, occupational therapy, massage therapy, drug therapy, art, and music therapy. Many of these therapies practice from the foundations of the previously mentioned therapies, but offer more hands on experiences. These experiences are usually in the form of physical manipulation of objects (paintbrushes or instruments).

Music Therapy

According to the American Music Therapy Association (AMTA), “music therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program” (2014). A music therapist works by using music to address non-music related goals. According to the AMTA Member Survey Workforce Analysis (2013), 21% of music therapists serve the mental health populations under which substance abuse and eating disorders fall.

While an expansive amount of literature about substance abuse and eating disorders currently exists within the literature of other disciplines, there is a lack of current research examining music therapy practices with eating disorders and substance abuse. As these disorders become more prevalent, it can be speculated that this gap in the literature will begin to close.

Eating Disorders

Some music therapists have begun to publish their research results from studies with clients diagnosed with eating disorders (Heiderscheit, 2008; Parente, 1989; Siegel, 2007; Trondalen, 2004; Justice, 1994). “Music therapy can provide support, experiences in which the patient has control, new ways of expressing herself and coping with emotions, and connections with other people” (Justice, 1994). Music therapy is able to address many of the different goals that are addressed when working with those diagnosed with eating disorders. While music therapy can work with these individuals, Siegel (2007) reports that there is no standard assessment tool with regards of music therapy.

Justice’s early article focuses on helping professionals identify some of the different techniques that may help with individuals with eating disorders, including: movement to music, music-reinforced relaxation, guided imagery techniques, and breathing techniques. By using these four different relaxation techniques, Justice prepares a patient in the ability to cope with the ideas of weight gain/loss and working to relieve stress and anxiety that might accompany these thoughts. Music and movement is used as a way to help the client become active without focusing on the idea of exercise and/or calorie burning. Justice suggests that singing in a group allows the patient to build up a sense of self-esteem and confidence in ones own skills. While the previous article is older, Justice’s techniques continue to be used in current treatment (1994).

Process Theatre, another technique used with those diagnosed with an eating disorder, shows effective results. While process theatre has been primarily used to work with developmentally disabled clients, Parente (1998) writes about the incorporation of music therapy with individuals with eating disorders. This study, which eventually became known as *Companions*, and later *Companions & Company*, worked with women who were diagnosed with anorexia ($N = 8$). During this experiment, individuals had music therapy once a week, and sessions were meant to focus on the irrational fears of the clients and to create songs about anorexia and the challenges they faced. This experiment ran for over a year before the show was performed for audiences. The performers expressed joy, cleansing, master of fears, and gain of self-esteem regarding the therapeutic process. (Parente, 1998)

Music therapy is able to address many complications in a single medium. Heiderscheit (2008) provides several examples of music therapeutic interventions that are utilized with clients diagnosed with eating disorders. In one instance, song communication was used with a 31-year-old woman. Identification of songs that are examples of what one feels is helpful for some in understanding and acknowledging one's feelings and learning to reclaim one's life. In another example, Heiderscheit discusses song analysis. While similar to song communication, song analysis is able to create a moment where clients are able to understand their condition on a level that was never considered (ex. realization that song lyrics are exactly like their lives or how the client feels), and allows for regression in the symptoms by learning how to cope with the symptoms in a positive way. Heiderscheit also talks about group songwriting. Individuals in these groups create their own lyrics and combine all of them into a song. "The therapeutic process of songwriting is not about producing an end result" (Heiderscheit, 2008). The objective of songwriting is about allowing a safe and creative outlet for client's feelings that create the song. The completion of the song is a highlight for the clients, but it is not the overarching goal of the treatments. These techniques are helpful in allowing clients to express feelings in a nonjudgmental environment.

Trondalen (2004) also utilizes improvisation with these clients. Trondalen writes that some individuals are referred to music therapy when they become exhausted from traditional "talk therapy" techniques. Trondalen goes on to explain that "significant moments," or those that "signify some clear and evident signs in a limited period of time," exist between the client and therapist. Trondalen's study lasted one year, during which she examined musical

improvisations and the way significant moments presented. Participants ($N = 2$) experienced these experiences during the finalizations of improvisations. One participant expressed what one of these experiences was like:

“It is as if an empty space is filled inside of me... memories are coming forward... I am a bigger part of the music when I’ve made it myself... this really gives me something... the finest part was the last part where you played the piano and I sung and played the drum, which I never do. It was that combination that contributed the most to a sort of... quietness and peace... It is strange... it is as if everything is opening without doing anything for it.”

(Trondalen, 2004; p.410)

These experiences help the clients diagnosed with eating disorders by allowing them to reconnect to a calm and tranquil reality, without focusing on the demands of the life with anorexia nervosa.

Substance Abuse

Music therapy research with those diagnosed with substance abuse disorders has been expanding (Winkelman, 2003; Jones, 2005; Soshensky, 2007; Silverman, 2011; Gardstrom, Carlini, Josefczyk, & Love, 2013; Heiderscheit, 2009). According to Gardstrom, et al. (2013), of the music therapists that are registered with the AMTA, only a small amount (4%) are listed as having worked with individuals with substance abuse, despite the fact that 15% have reported working with such clients.

Like individuals with eating disorders, those that suffer from substance abuse disorders may experience benefits through music therapy. According to Heiderscheit (2009), music allows the feelings and emotions of one’s subconscious to be expressed. In 2007, Soshensky posited a list of possible interventions that can be used with those that have substance abuse disorders, including: improvisation, drumming and rhythm, singing, songwriting, and performance. Many of these interventions will allow individuals to express their feelings and emotions nonverbally. Being able to express things through these activities is a creative outlet that encourages positive interaction between the therapist and client.

According to Winkelman (2003), “drumming enhances hypnotic susceptibility, increases relaxation, and induces shamanic experiences.” Drumming and rhythm have been used as interventions that can engage individuals in nonverbal conversation, nonverbal yet pleasurable and self-expressive. Soshensky (2007) wrote a case study of music therapy focusing on

drumming and rhythm. In this study, an individual (former heroin addict) was abusing the psychiatric antidepressant, Elavil. Upon first assessment, he was not focused on any important details in his everyday life, other than how he was going to get his Elavil. One session allowed the client to close a traumatic event in his past, and become verbally engaged in an environment that was non-threatening. Soshensky writes, “The music established a driving urgency that took on a life of its own” (2007).

Songwriting and lyric analysis are techniques that are frequently used by music therapists working with a variety of populations. Songwriting is able to help a client, safely express feelings and emotions, facilitate communication, stimulate one’s own self-awareness, and encourage group cohesion (Soshensky, 2007). In an article that examines and compares the effects of songwriting and lyric analysis, Jones (2005) provided music therapy sessions as part of the 12-Step Work program. Both the songwriting group and the lyric analysis group consisted of 13 individuals. Using a Visual Analog Scale, as well as a pre- and post-test analysis, individuals were asked to do the scales and answer a questionnaire. After analysis, the researcher found that no significant difference was found between the two styles of intervention during the pre-test or post-test. This is important because it shows that individuals benefit from the two types of interventions, despite the difference in how these interventions address goals.

Silverman (2011) published a study that examined the effect of music therapy interventions that was focused with a “rockumentary” base, which means “lyric analysis coupled with a detailed history of the band and their substance abuse”. This study incorporated three groups of forty-seven individuals ($N = 141$), with each group receiving a different form of therapy: music therapy, verbal therapy, or recreational music therapy. With the music therapy group, the researcher had the clients do introductions, followed by lyric analysis, and question focus. The second group (verbal therapy) experienced the same as the first group, only without musical aspects. The recreational music therapy group utilized musical games and discussion based on songs. The results of this study show no significant difference between the two different music therapy groups; however, both music therapy groups were rated as more effective than the verbal therapy group.

Purpose

This research study aims to focus on patient demographic information, therapeutic goals, and approaches and interventions music therapists use when working with individuals that have eating and substance abuse disorders. Because the amount of current literature for this field is limited, a goal of this project is to increase the amount of information that is available to music therapists for treatment of such clients. The results of this study may be beneficial to other music therapists in development of their clients' goals and session plans.

CHAPTER 3

METHOD

Study Participants

E-mail address (N = 129) were obtained for music therapists that work with these clients from the American Music Therapy Association. The researcher also asked other professionals known to work with individuals with eating disorders and substance abuse. This study was sent to eligible participants that work in settings that offer music therapy services to clients with eating disorders and substance abuse issues. These participants are located throughout the United States. Informed consent was obtained from each participant before continuing to the survey.

Study Device

This study was post-test only and used an electronic survey (See Appendix A) hosted through SurveyMonkey.com. Before sending this survey to any participants, the web link to the survey was sent to field testers (personal acquaintances of the researcher). By using a web-based survey, a greater pool of eligible individuals was able to be reached. Participants that took part in this survey were able to complete the questionnaire on their own time. By allowing them this freedom, there was a greater chance of participation.

After the initial test of the survey, questionnaires were sent to the eligible participants. This survey included questions that examine demographic information (19), behaviors and symptoms (2), music therapy practices (18), effects of the DSM-IV to DSM-5 transition (3), and employment conditions (4).

Procedure

Upon approval from the FSU IRB and the AMTA (See Appendices B and C, respectively), e-mail information was available to the researcher for a fee of \$0.15 per contact. The researcher requested information for music therapists that currently work specifically with individuals with eating disorders and with substance abuse issues, without regard to facility type.

Upon receipt of contact information, the researcher sent a cover letter to all participants explaining the purpose of the study (See Appendix D). This letter contained a link to the survey,

as well as a link to opt out of the survey. As participants opened the survey, they were shown an informed consent form, reminding them that personal identities would remain anonymous. Data was recorded via the host site, and became available to the researcher after the survey was completed. The researcher sent reminder e-mails to participants who had not responded after 14 days and again at 18 days after receiving notice of the study. The survey was closed after 21 days.

Scoring of the Survey

Short answer boxes were provided for any questions marked “Other” by participants. These responses, as well as those requiring short answers (not multiple choice), were grouped together based on similarity of responses.

CHAPTER 4

RESULTS

Of the 129 emails sent, 128 were confirmed to be received by participants. Of these, 47 participated in the survey, for a response rate of 34%.

Participants were asked a series of multiple-choice and short answer questions. Of the music therapists surveyed, 76.60% of respondents were female, while 23.40% were males. The largest percentage of respondents (34.04%) indicate their age was 25 – 29 years, followed by 25.53% of respondents at 30 – 34 years, and 14.89% were ages 20 – 24. Table 1 shows a complete representation of respondents' ages, as well as other demographic information.

With regard to degree level, 95.65% individuals indicated holding a bachelor's degree, 71.74% of respondents hold a master's degree, and 6.52% hold a doctoral degree. Forty-five respondents (95.74%) are certified with the Music Therapist – Board Certified credential and 1 respondent identified as a Certified Music Therapist (2.13%). No respondents indicated certification as an Advanced Certified Music Therapist or a Registered Music Therapist. Of those with credentials, 23 respondents indicated holding specialized training certificates (50.00%), include the NMT, or Neurologic Music Therapist (6 respondents), the GIM, or Guided Imagery and Music (4 respondents), and the NICU-MT, or Neonatal Intensive Care Unit – Music Therapist (10 respondents). Other respondents also indicated holding certifications in Certified Drum Circle Facilitator ($n = 1$), Registered Yoga Teacher ($n = 1$), Austin Vocal Psychotherapist Certification ($n = 1$), Licensed Baccalaureate Social Worker ($n = 1$), Mandala Assessment Research Instrument ($n = 1$), and Certified Alcohol Drug Counselor 1 ($n = 1$). Two respondents indicated holding the Licensed Creative Arts Therapist (LCAT) license. One respondent also indicated holding the designation FAMI, or Fellow of the Association of Music and Imagery.

Regarding employment, the most represented job title was Music Therapist (66.67%). Among the 6 respondents who indicated "Other," 2 respondents were classified as "Rehabilitation Therapist," one respondent was a "Registered Therapist," one was an "Adjunctive therapist," 1 identified as a "Clinical Director" and 1 was a "Community Programs Manager." Only 16 respondents (48.48%) indicated working full-time; however, 20 respondents (58.82%) indicated working 40 or more hours per week at their facility. The majority of

respondents ($n = 20$) indicated that their annual salary was either below \$20,000 or above \$50,000 (64.52%). Table 1 also presents data regarding employment conditions.

TABLE 1
Music Therapist Demographic Questions and Responses

Questions	n responses	Σ responses	Percentage
Gender	47		
Female		36	76.60%
Male		11	23.40%
Music Therapist Age Range	47		
Under 20		0	0.00%
20 - 24		7	14.89%
25 - 29		16	34.04%
30 - 34		12	25.53%
35 - 39		0	0.00%
40 - 44		3	6.38%
45 - 49		4	8.51%
50 and Above		5	10.64%
Professional Credential or Designation	47		
MT-BC		45	95.74%
ACMT		0	0.00%
CMT		1	2.13%
RMT		0	0.00%
Other		1	2.13%
Specialized Trainings	46		
Yes		23	50.00%
No		23	50.00%
Degrees Held*	45		
Bachelors		44	95.65%
Masters		33	71.74%
Doctoral		3	6.52%
Employment Classification	33		
Full-Time		16	48.48%
Part-Time		4	12.12%
Contracted		7	21.21%
Other		6	18.18%
Job Title	45		
Music Therapist		30	66.67%
Recreational Therapist		2	4.44%
Activity Therapist		2	4.44%
Creative Arts Therapist		6	13.33%
Other		5	11.11%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

TABLE 1 - CONTINUED

Questions	<i>n</i> responses	Σ responses	Percentage
Average Hours Per Week	34		
0 - 4 Hours		2	5.88%
5 - 9 Hours		1	2.94%
10 - 14 Hours		5	14.71%
15 - 19 Hours		3	8.82%
20 - 24 Hours		0	0.00%
25 - 29 Hours		1	2.94%
30 - 34 Hours		2	5.88%
35 - 39 Hours		0	0.00%
40 Hours and Above		20	58.82%
Annual Salary	31		
Below \$20,000		10	32.26%
\$20,000 - \$29,999		2	6.45%
\$30,000 - \$39,999		3	9.68%
\$40,000 - \$49,999		6	19.35%
\$50,000 and Above		10	32.26%
Specific Training	34		
Yes		25	73.53%
No		9	26.47%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

Respondents were asked to give information regarding facility locale and employment conditions. These responses can be found in Table 2. The greatest response rate comes from music therapists working in facilities located in the Southeastern region (32.61%). The Mid-Atlantic and Great Lakes regions also show high representation (21.74% and 15.22%, respectively).

Most respondents indicated that their facility was not specialized for either eating disorder or substance abuse clients (61.36%, $n = 27$). Nineteen respondents indicate that their facility is an inpatient facility (43.18%), while only 9.09% classified their facility solely as outpatient. Also of note is that 31.82% of respondents indicated that their facility has both inpatient and outpatient units, while 15.91% indicate their facility is neither inpatient or outpatient.

Among the 43 respondents who answered questions about the populations served, only 11.63% indicate they serve individuals with eating disorders only, while 34.88% serve only individuals with substance abuse. Only 72.73% ($n = 24$) of the respondent facilities offer admittance on the diagnosis alone, despite the increasing rate of these disorders. These results

indicate that while the number of cases involving eating and substance abuse disorders continues to rise, there are still facilities that do not accept these clients on that disorder alone, and require at least one comorbidity.

TABLE 2
Facility Types, Locations, and Populations Served

Questions	<i>n</i> responses	Σ responses	Percentage
Facility Region	46		
Great Lakes Region		7	15.22%
Mid-Atlantic Region		10	21.74%
Midwest Region		2	4.35%
New England Region		1	2.17%
Southeastern Region		15	32.61%
Southwestern Region		5	10.87%
Western Region		6	13.04%
Facility Specialization	44		
Eating Disorders		4	9.09%
Substance Abuse		10	22.73%
Both		3	6.82%
Not Specialized		27	61.36%
Facility Type	44		
Inpatient		19	43.18%
Outpatient		4	9.09%
Both		14	31.82%
Neither		7	15.91%
Populations Served	43		
Eating Disorders		5	11.63%
Substance Abuse		15	34.88%
Both		14	32.56%
Other		9	20.93%
Primary Diagnosis Admittance	33		
Yes		24	72.73%
No		9	27.27%

Respondents were asked to provide information regarding how long they have worked with this population, which can be found in Table 3. Of the 46 respondents, 71.74% ($n = 33$) responded as having only worked at the current facility for 4 years or less. Information regarding respondent's previous work with these populations can also be found in Table 3. Many respondents indicated no experience with individuals with eating disorders ($n = 17$,

38.64%). The largest amount of respondents (45.45%, $n = 20$) indicate working with this population. No respondents indicated being very experienced, with 15 years or more.

The majority of respondents ($n = 46$) indicated working with individuals with substance abuse. Twenty-seven respondents (58.70%) indicated having worked with this population for 1 – 4 years, three respondents indicated no experience with this population (6.52%), and three individuals (6.52%) have worked extensively with this population (over 15 years).

TABLE 3
Music Therapist Experience by Population

Questions	n responses	Σ responses	Percentage
Years in Current Facility	46		
0 - 4		33	71.74 %
5 - 9		10	21.74%
10 - 14		2	4.35%
15 or More		1	2.17%
Years Working with Eating Disorder Clients	44		
No Experience		17	38.64%
1 - 4		20	45.45%
5 - 9		3	6.82%
10 - 14		4	9.09%
15 - 19		0	0.00%
20 or More		0	0.00%
Years Working with Substance Abuse Clients	46		
No Experience		3	6.52%
1 - 4		27	58.70%
5 - 9		7	15.22%
10 - 14		5	10.87%
15 - 19		1	2.17%
20 or More		3	6.52%

Table 4 shows data relating to clients' ages, as well as music therapist/client interactions outside of the therapy session. Respondents indicate that most clients in the eating disorder and substance abuse populations fall within the ages of 16 – 25 (48.89%) and 31 or above (45.24%), respectively. Majority of respondents ($n = 20$, 62.50%) indicated working with an average of 1 - 5 clients with eating disorders on a weekly basis, while the number of clients seen per week for a substance abuse was more evenly dispersed. The majority of respondents ($n = 10$) see 1 – 5 clients per week.

Participants were also asked to answer questions about how interactions occurred with the clients outside of sessions, if at all. 55.81% respondents ($n = 24$) indicated that there was some interaction with clients outside of the session, in the form of client field trips (13.04%), lunch supervision (21.74%), relocation of clients (17.39%), transportation of clients (21.74%), and “Other” (69.57%). Individuals who provided examples of other interactions indicated special events ($n = 5$), patient assessments ($n = 5$), and hallway conversations ($n = 6$) as some other ways of interacting with the clients.

TABLE 4
Client Ages and Therapeutic Interactions

Questions	<i>n</i> responses	Σ responses	Percentage
Age Range of Clients with Eating Disorders	45		
0 - 4		1	27.78%
5 - 10		2	19.44%
11 - 15		7	13.89%
16 - 20		13	16.67%
21 - 25		9	
26 - 30		6	
31 or Above		7	22.22%
Age Range of Clients with Substance Abuse	42		
0 - 4		1	2.38%
5 - 10		0	0.00%
11 - 15		2	4.76%
16 - 20		8	19.05%
21 - 25		6	14.29%
26 - 30		6	14.29%
31 or Above		19	45.24%
Clients per Week with Eating Disorders	32		
1 - 5		20	62.50%
6 - 10		4	12.50%
11 - 15		3	9.38%
16 - 20		2	6.25%
21 or Above		3	9.38%
Clients per Week with Substance Abuse	36		
1 - 5		10	27.78%
6 - 10		7	19.44%
11 - 15		5	13.89%
16 - 20		6	16.67%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

TABLE 4 – CONTINUED

Questions	<i>n</i> responses	Σ responses	Percentage
Clients per Week with Substance Abuse	36		
21 or Above		8	22.22%
Interaction Outside of Sessions	43		
Yes		24	55.81%
No		29	44.19%
Outside of Session Interaction Type*	23		
Client Field Trips		3	13.04%
Lunch Supervision		5	21.74%
Relocation of Clients		4	17.39%
Transportation of Clients		5	21.74%
Other		16	69.57%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

In addition, respondents were also asked to identify the types of sessions they provide to individuals with eating disorders and substance abuse (See Table 5). Of the 43 respondents who answered this question, 65.12% ($n = 28$) of them offered individual one-on-one sessions to the clients, 95.35% ($n = 41$) offered group sessions, and only 18.60% ($n = 8$) offered family therapy sessions. Due to the benefits of familial support with these clients, the researcher asked participants if they offered, with the clients' consent, to allow family members or significant others to be involved in the session. Of the 39 individuals that responded, 53.85% ($n = 21$) did offer this opportunity to their clients.

Table 5 also displays data regarding referrals to music therapy services. Twenty-six respondents indicate receiving referrals for clients with eating disorders per week. Twenty-one of respondents (80.77%) indicated receiving between 0 and 4 referrals each week. Of the 30 individuals who indicated receiving referrals for substance abuse clients, 21 (80.77) of the individuals indicated receiving 0 to 4 referrals per week. One individual (3.33%) indicated receiving 20 or more referrals per week.

The final set of data in Table 5 indicates who made referrals. Thirty-two individuals answered this question. Many of the respondents who list a specific professional (46.88%, $n = 15$) indicated that referrals came from the doctors, followed closely by nurses (43.75%, $n = 14$). Sixteen individuals (50.00%) suggested a number of other individuals who offer referrals for music therapy, including: the Behavioral Division ($n = 1$), a Qualified Mental Health Professional, or QMHP ($n = 2$), Self-Referrals ($n = 3$), Other Therapeutic Staff ($n = 4$),

Physicians Assistant ($n = 1$), Nurse Practitioner ($n = 1$), Social Worker ($n = 2$), Chaplain ($n = 1$), Child Life Specialist ($n = 1$), Case Manager ($n = 1$), and the Treatment Team ($n = 1$).

TABLE 5
Session Types and Referrals

Questions	n responses	Σ responses	Percentage
Music Therapy Session Services*	43		
Individual		28	65.12%
Group		41	95.35%
Family		8	18.60%
Other		0	0.00%
Participation of Family Members/Significant Others (if no family session provided)	39		
Yes		21	53.85%
No		18	46.15%
Referrals for Eating Disorders Per Week	26		
0 - 4 Referrals		21	80.77%
5 - 9 Referrals		4	15.38%
10 - 14 Referrals		1	3.85%
15 - 19 Referrals		0	0.00%
20 or More Referrals		0	0.00%
Referrals for Substance Abuse Per Week	30		
0 - 4 Referrals		23	76.67%
5 - 9 Referrals		3	10.00%
10 - 14 Referrals		3	10.00%
15 - 19 Referrals		0	0.00%
20 or More Referrals		1	3.33%
Referrals Received From*	32		
Doctors		15	46.88%
Nurses		14	43.75%
Family Members		5	15.63%
Psychologist		13	40.63%
Other		16	50.00%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

Respondents were asked multiple choice and short answer questions regarding session structure (See Table 6). In regards to eating disorder groups, 59.09% of respondents ($n = 13$) held groups of 1 – 5 clients. Respondents also held groups ranging from 6 to 10 clients, as well as 21 clients or more (both at 9.09%, $n = 2$). Of participants offering group sessions to clients

for substance abuse (N = 34), many offer group sizes of 1 to 5 clients per group (29.41%, $n = 10$).

Table 6 also offers data regarding specialized services during sessions, such as interdisciplinary services (ex. art therapy and music therapy) and technological services. Of the 33 respondents who answered the questions for interdisciplinary services, 60.61% ($n = 20$) of the participants responded that other services co-treat during sessions. Many of the respondents indicated that art therapy ($n = 11$) and recreational therapy ($n = 6$) were the most common, while others mentioned included: aromatherapy ($n = 1$), dance therapy ($n = 1$), yoga ($n = 1$), massage ($n = 1$), and pet therapy ($n = 2$). For a listing of how these therapies can be utilized, see Appendix E. Of the 34 individuals that answered the question focusing on whether application based technology is used during sessions, only 35.29% ($n = 12$) indicated that they use mobile devices in sessions. For a complete list of commonly used applications by respondents, see Appendix F. Similarly, individuals were given an opportunity to provide commonly used songs and artists that are requested by their clients. For a complete listing of offered songs and artists, see Appendix G (eating disorders) and Appendix H (substance abuse).

TABLE 6
Session Structure

Questions	n responses	Σ responses	Percentage
Group Size Average for Eating Disorders	22		
1 - 5 Clients		13	59.09%
6 - 10 Clients		5	22.73%
11 - 15 Clients		2	9.09%
16 - 20 Clients		0	0.00%
21 or More Clients		2	9.09%
Group Size Average for Substance Abuse	34		
1 - 5 Clients		10	29.41%
6 - 10 Clients		9	26.47%
11 - 15 Clients		7	20.59%
16 - 20 Clients		3	8.82%
21 or More Clients		5	14.71%
Interdisciplinary Services During Sessions	33		
Yes		20	60.61%
No		13	39.39%

TABLE 6 – CONTINUED

Application Based Technology Used During Sessions	34	
Yes	12	35.29%
No	22	

The following tables represent symptoms and behaviors that are addressed during sessions. Table 7 notes the symptoms of eating disorders. Of the 36 individuals who responded to this question, 41.67% ($n = 15$) expressed anxiety as the most common, followed by social withdrawal, depression, distortion of self-image, and social withdrawal, all of which were indicated by 14 respondents (38.89%). In group sessions, the most common symptoms to be addressed were anxiety and inflexible thinking (55.56%, $n = 20$). The next highest symptom addressed was depression at 52.78%, indicated by 19 respondents.

Table 8 shows the symptoms of substance abuse that are addressed during individual and group sessions. Of the respondents that answered this question ($N = 38$), social withdrawal was the top addressed symptom (55.26%, $n = 21$). Anxiety followed closely, indicated by 20 respondents (52.63%). In group sessions, the most indicated symptom was anxiety (78.95%, $n = 30$). Social withdrawal and depression follow at a rate of 76.32% ($n = 29$). Several participants marked “Other” and noted self confidence ($n = 3$), boundaries ($n = 2$), coping skills ($n = 4$), post-traumatic issues ($n = 1$) and social re-acclimation ($n = 1$) as symptoms they address in sessions.

TABLE 7
*Symptoms and Behaviors of Eating Disorders**

Eating Disorder Symptoms / Behaviors	n responses	Σ responses	Percentage	n responses	Σ responses	Percentage
	(Individual)			(Group)		
	36			36		
Does Not Apply		16	44.44%		13	27.78%
Abdominal Pain		6	16.67%		3	8.31%
Amenorrhea		6	16.67%		2	5.56%
Anxiety		15	41.67%		20	55.56%
Chronic Food Refusal		7	19.44%		5	13.89%
Dehydration		36	16.67%		2	5.56%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

TABLE 7 – CONTINUED*

	<i>n</i> responses		<i>n</i> responses	
	(Individual)	Σ responses Percentage	(Group)	Σ responses Percentage
Eating Disorder Symptoms / Behaviors	36		36	
Delusional Beliefs		9 25.00%		12 33.33%
Depression		14 38.89%		19 52.78%
Distortion of Self-Image		14 38.89%		15 41.67%
Excessive Exercising		6 16.67%		7 19.44%
Extreme Weight Loss / Gain		6 16.67%		6 16.67%
Extreme Fear of Weight Loss / Gain		9 25.00%		9 25.00%
Frequent Methods of Evaluation of Body		10 27.78%		8 22.22%
High / Low Blood Pressure		5 13.89%		5 13.88%
Inflexible Thinking		12 33.33%		20 55.56%
Irregular Heart Rhythms		3 8.33%		2 5.56%
Lethargy		6 16.67%		9 25.00%
Misuse of Laxatives, Diuretics, or Enemas		2 5.56%		2 5.56%
Nausea		4 11.11%		3 8.33%
Nutritional Deficiency		7 19.44%		6 16.67%
Obsessive-Compulsive Behaviors		11 30.56%		17 47.22%
Oral / Dental Complications		2 5.56%		1 2.78%
Regurgitation		4 11.11%		1 2.78%
Selective Eating		7 19.44%		4 11.11%
Self-Induced Vomiting		6 16.67%		3 8.33%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

TABLE 7 – CONTINUED*

	Σ		n	
	n responses (Individual)	response s Percentage	responses (Group)	Σ responses Percentage
Eating Disorder Symptoms / Behaviors	36		36	
Sensitivity to Appearance, Color, Smell, Texture, Temperature, Taste		6 16.67%		6 16.67%
Social Withdrawal		14 38.98%		6 16.67%
Spit Out Food		2 5.56%		1 2.78%
Suicidal Tendencies		10 27.78%		13 36.11%
Uncontrollable Eating		6 16.67%		4 11.11%
Other		3 8.33%		4 11.11%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

TABLE 8

*Symptoms and Behaviors of Substance Abuse**

	Σ		n	
	n responses (Individual)	responses Percentage	responses (Group)	Σ responses Percentage
Substance Abuse Symptoms / Behaviors	38		38	
Does Not Apply		12 31.58%		5 13.16%
Anxiety		20 52.63%		30 78.95%
Delusional Beliefs		16 42.10%		24 63.16%
Depression		19 48.72%		29 76.32%
Extreme Change in Weight		2 5.26%		1 2.63%
Hallucinations		12 31.58%		13 34.21%
Headaches / Migraines		8 21.05%		8 21.05%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

TABLE 8 – CONTINUED*

	<i>n</i> responses		<i>n</i> responses	
	(Individual)	Σ responses Percentage	(Group)	Σ responses Percentage
Substance Abuse Symptoms / Behaviors	38		38	
High / Low Blood Pressure		6 15.79%		6 15.79%
Hyper Attention		7 18.42%		7 18.42%
Impaired Memory		13 34.21%		16 42.11%
Impaired Vision		2 5.26%		1 2.63%
Irregular Heart Rhythms		3 7.89%		1 2.63%
Irregular Social Behaviors (Stealing, Declining Grades, etc.)		18 47.47%		25 65.79%
Irritability		18 47.47%		25 65.79%
Lethargy		14 36.84%		23 60.52%
Mood Swings		16 42.11%		24 63.16%
Nausea		6 15.79%		3 7.89%
Nutritional Imbalance		4 10.53%		3 7.89%
Obsessive-Compulsive Behaviors		10 26.32%		15 39.47%
Paranoia		14 36.84%		18 47.37%
Regurgitation		0 0.00%		0 0.00%
Sensitivity to Appearance, Color, Smell, Texture, Temperature, Taste		2 5.26%		3 7.89%
Shaking / Sweating		7 18.42%		6 15.79%
Sleeping Problems		13 34.10%		18 47.37%
Social Withdrawal		21 55.26%		29 76.32%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

TABLE 8 – CONTINUED*

	<i>n</i> responses	Σ	Percentage	<i>n</i>	Σ	Percentage
	(Individual)	responses		(Group)	responses	
Substance Abuse Symptoms / Behaviors	38			38		
Suicidal Tendencies		15	39.47%		22	57.89%
Other		1	2.63%		2	5.26%

*Indicates respondents were able to make multiple selections; therefore, total percentage may equal more than 100%.

Participants were given an opportunity to provide specific interventions that they use when working with individuals with eating disorders and substance abuse. The top suggested interventions can be found in Tables 9 and 10.

TABLE 9
Top Three Eating Disorder Interventions

Ranking	Intervention for Individuals	<i>n</i>	Interventions for Groups	<i>n</i>
1	Song Writing / Lyric Re-Write	12	Lyric Analysis	12
2	Lyric Analysis	8	Song Writing / Lyric Re-Write	11
3	Improvisation	6	Improvisation	5
			Drumming	5

TABLE 10
Top Three Substance Abuse Interventions

Ranking	Interventions for Individuals	<i>n</i>	Interventions for Groups	<i>n</i>
1	Lyric Analysis	11	Lyric Analysis	22
	Song Writing / Lyric Re-Write	11		
2	Relaxation	5	Song Writing / Lyric Re-Write	19
3	Music Listening	4	Improvisation	10

Respondents were asked about typical client’s length of treatment in their facilities. In Table 11, the data shows that of the 21 individuals who answered the question, 7 participants noted that the length of stay was 1 week or less (33.33%). Another set of respondents, and the

majority ($n = 8$) indicate that the length of stay is between 1 and 5 months. No individuals indicated a length of stay from 6 months to 1 year. Twenty-nine respondents answered the question regarding length of treatment in their facilities in regards to substance abuse. The majority of respondents ($n = 11$) indicated that the length of stay was 1 week or less (37.93%).

Table 11 also presents the data focusing on relapse seen in clients. Twenty-five respondents answered the question in regards to eating disorders. 24.00% ($n = 6$) of these respondents indicated that they see a relapse in their clients' symptoms and behaviors 0% - 20% of the time, while another five individuals (20.00%) see relapse in 21% to 40% of their clients. Only one individual indicated seeing a relapse in their clients 41% - 60% of the time. No respondents indicated seeing relapse more than 60% of the time in an eating disorder treatment.

Twenty-nine participants answered a similar question regarding substance abuse. Six participants (20.69%) indicated seeing a relapse in their clients 0% - 20% of the time, while another six individuals (20.69%) indicated seeing a relapse in 21% - 40% of their clients. Two respondents indicated that they see a relapse 41% - 60% of the time. Two respondents indicated that relapses can be seen in 61% - 80% of the clients. One participant indicated relapse frequency of 81% - 100% of the time.

TABLE 11
Treatment Length and Relapse

Questions	n responses	Σ responses	Percentage
Length of Treatment for Eating Disorders	21		
Less than 7 Days		7	33.33%
7 Days to 1 Month		4	19.05%
1 Month to 5 Months		8	38.10%
6 Months to 1 Year		0	0.00%
1 Year or Longer		2	9.52%
Length of Treatment for Substance Abuse	29		
Less than 7 Days		11	37.93%
7 Days to 1 Month		3	10.34%
1 Month to 5 Months		7	24.14%
6 Months to 1 Year		3	10.34%
1 Year or Longer		5	17.24%
Relapse in Clients' Eating Disorder Behaviors After Treatment Completion	25		
Does Not Apply		11	52.00%
0 - 20%		2	24.00%
21 - 40%		2	20.00%

TABLE 11 – CONTINUED

Questions	<i>n</i> responses	Σ responses	Percentage
Relapse in Clients' Eating Disorder Behaviors After Treatment Completion	25		
41 - 60%		1	4.00%
61 - 80%		0	0.00%
81 - 100%		0	0.00%
Relapse in Clients' Substance Abuse Behaviors After Treatment Completion	29		
Does Not Apply		12	41.38%
0 - 20%		6	20.69%
21 - 40%		6	20.69%
41 - 60%		2	6.90%
61 - 80%		2	6.90%
81 - 100%		1	3.45%

Due to the recent transition from the DSM-IV-TR to the DSM-V, questions were asked regarding this transition and how it affected session structure, goals, documentation, and diagnosis (See Table 12). Of the 33 respondents who answered the question regarding changes in the session structure, goals, and documentation, no respondents indicated any alterations in the form of session structure or goals. However, one participant did indicate a slight change in documentation. No respondents expressed any increase or decrease in the number of referrals for eating disorders or for substance abuse. Twenty-eight participants answered questions based on changes in diagnosis. 85.71% of participants ($n = 24$) saw 0% -20% change in diagnosis. Two individuals (7.14%) saw a 21% to 40% change in client diagnosis, and another two respondents (7.14%) saw a 41% to 60% change in the diagnosis of their clients.

TABLE 12
Transition from DSM-IV-TR to the DSM-5

Questions	<i>n</i> responses	Σ responses	Percentage
Transition from DSM-IV-TR to DSM-V			
Changes in:	33		
Session Structure		0	0.00%
Goals		0	0.00%
Documentation		1	3.03%
Increase / Decrease of Referrals	26		
Eating Disorders (Increase)		0	0.00%
Eating Disorders (Decrease)		0	0.00%
Increase / Decrease of Referrals	29		
Substance Abuse (Increase)		0	0.00%

TABLE 12 – CONTINUED

Questions	<i>n</i> responses	Σ responses	Percentage
Increase / Decrease of Referrals	29		
Substance Abuse (Decrease)		0	0.00%
Change in Diagnosis	28		
0 - 20%		24	85.71%
21 - 40%		2	7.14%
41 - 60%		2	7.14%
61 - 80%		0	0.00%
81 - 100%		0	0.00%

CHAPTER 5

DISCUSSION

This study aimed to focus on music therapy practices with individuals with eating and substance abuse disorders. The structure of the survey included 47 questions regarding demographics (music therapist and client), music therapist experience, behaviors and symptoms of substance abuse and eating disorders, the practices of music therapists, as well as the transition into the current DSM. It is uncommon for music therapists to work with eating disorders, and only slightly more common for substance abuse. The need for music therapists with these populations will continue to grow.

The survey was deferred to potential participants who were registered with the American Music Therapy Association as working with clients that have eating disorders or substance abuse disorders. People with the job title “Music Therapist” were highly represented in this study (66.67%). The majority of participants in this study currently hold the certification MT-BC ($n = 45$). Because of this, some eligible participants may have not been included in this survey, as many music therapists do not notify the AMTA of the populations with which they work. Also, in accordance with the Survey Monkey privacy policy, individuals may have chosen to “opt-out” of future surveys, which would cause problems, as Survey Monkey would not deliver the survey to that individual.

Several individuals did not complete the entire survey. This could have been due to several reasons; the survey did ask numerous questions, so the length may have deterred them from finishing the survey. In addition, questions that required a typed response from the participant received the lowest amount of answers, compared to the multiple choice questions. Another reason might be the nature of the disorders because both eating disorders and substance abuse disorders commonly present with comorbidities. It is impossible to describe 100% of behaviors.

The majority of respondents indicated their location to be the in the Southeastern region (32.61%), followed by the Mid-Atlantic and Great Lakes regions (21.74% and 15.22%, respectively). This data corresponds with the data presented by the AMTA in their “Descriptive Statistical Profile of the AMTA Membership” (2013), which suggests the majority of membership is held by individuals in those three regions. While a small percentage of the

represented facilities offer specialization in eating disorders (11.63%), substance abuse (9.09%), or both (31.82%), there are still many facilities that are capable of offering services to the individuals despite a lack of specialization. This is extremely important to note as it means that individual facilities are able to see that there is a need for services with substance abuse and eating disorders. This may lead to music therapists specializing in work with these populations in the future.

Of the 20 respondents who indicated interdisciplinary services are offered during music therapy sessions, 55.00% of the participants ($n = 11$) said that art therapy was often utilized. Other therapies such as pet therapy and aromatherapy emerged as interdisciplinary services that have been offered. This is important to note, because it means that professionals are starting to see that complimentary therapies, such as these, are able to offer healing effects, sometimes more than pharmaceutical means.

The application of art therapy and music therapy in one session is only one way that offers suggestions as to how these disorders are similar. Participants indicated that the top three interventions for eating disorders and substance abuse, whether in an individual or group session, all were the same (lyric analysis, song writing, and improvisation). Both sets of disorders are typically accompanied by comorbidities, which can also influence session structure. 60.61% of individuals indicated that application-based technology were utilized during sessions. Though this study presents a low rate of technological use in sessions, it is important to note that technology is continuously improving and progressing, so more applications may become available for professionals to use with these populations. Despite what may seem like unrelated disorders, eating disorders and substance abuse disorders may be more closely linked than believed. The interventions for both disorders (both individual and group sessions) utilize the same interventions.

Limitations of the Study

Electronic surveys have common limitations. This survey was distributed solely through the internet. Individuals who lack knowledge of technology or the concept of the internet may have been eligible for the survey, but due to inexperience, they may not have had an opportunity to take the survey. Another limitation may have occurred if participants did not have access to a

computer with internet capabilities during the duration of this study. While the internet is almost an unavoidable aspect in this era, it must be included as a limitation.

Due to the lack of research and music therapists working with these populations compared to other populations (AMTA, 2013), lack of resources is also a limitation of this study. Because there is crossover of eating disorders and substance abuse symptoms into other areas, such as personality disorders and social disorders, that are better classified as other disorders, there may be some music therapists who are working with these disorders, but have not received the diagnosis of eating or substance abuse disorders.

The low response rate of this survey also presents itself as a limitation. Because many individuals do not have an adequate amount of time in working with individuals of these populations, the amount of data that can be collected currently is not as much as other populations. This may create some complications in analyzing a small amount of data, as well as in the creation of possible lists (applications and songs).

Further Research

The prevalence of eating disorders and substance abuse is on the rise in today's society. Due to this significant increase in cases, there is an increased need for research to support the professionals that treat these individuals.

One area that requires further analysis is work that specifically relates to males with eating disorders. Because eating disorders have historically been considered a "female disorder," research has been focused on treatment of females; however, in today's society, we see an increasing rate of men that present with eating disorder symptoms. According to Jones & Morgan, "men represent 10 – 20% of cases of anorexia nervosa and bulimia nervosa and up to 40% of cases of binge eating disorder" (2010). These men may be more prone to using dangerous means to get desired results, such as overuse of steroids (Pope Jr., Phillips, & Olivardia, 2005). Despite research that shows men are also at risk for these types of disorders, much of the literature still shows a consistent focus on females.

Gender is not the only aspect of an individual that should be taken into consideration when looking at criteria for study participants. The age of an individual is also important. While there are some published studies that have been completed in this area, more should be considered to establish validity. According to the Geriatric Mental Health Foundation, "almost one in every

five older Americans drink alcohol or use medications unsafely” (2006). As individuals grow older, the way their bodies accept substances changes, therefore creating a different affect than what individuals may have expected.

Due to the constant growth of medications and drugs in today’s society, this survey can also be expanded. New chemicals are always being made, both medically and experimentally, which can alter an individuals behavior and thought patterns. Future studies would be able to look at these new substances or new disorders to examine whether individuals experience symptoms differently than those in this study.

Conclusion

This study aimed to survey professionals in the music therapy field to create a general overview of demographics, background, and music therapy practices used when working with individuals with eating disorders and substance abuse disorders. Future employers of music therapists or music therapists working in mental hospitals who have clients that have these diagnoses may utilize the results of this study. The researcher aimed to create a foundation for these growing disorders, in hopes of encouraging future studies in an area where literature and resources are lacking.

APPENDIX A

SURVEY

Consent Form

*** 1. By marking "Give Consent" you indicate acknowledgement that all personal identities will be kept confidential and no publications will indicate that your facility was involved in this study. Should you select "Do Not Give Consent," you understand that none of your answers will be recorded for use in this research study, and you just need to close the web browser to exit.**

- Give Consent
- Do Not Give Consent

Demographics

2. What is your gender?

- Female
- Male
- Prefer Not to Answer

3. What is your age?

- Under 20
- 20 - 24
- 25 - 29
- 30 - 34
- 35 - 39
- 40 - 44
- 45 - 49
- 50 and Above

4. What professional credential or designation do you currently hold?

- MT-BC
- ACMT (Advanced Certified Music Therapist)
- CMT (Certified Music Therapist)
- RMT (Registered Music Therapist)
- Other

If Other, Please Specify:

5. Do you currently have any certificates in specialized trainings? (i.e., NICU-MT, NMT, GIM, etc.)

- Yes
- No

If Yes, Please Specify:

6. Please indicate the degree(s) that you currently hold.

Bachelor's:

Master's:

Doctoral:

7. Please indicate the number of years you have worked in your current facility.

8. Please indicate the total number of years that you have worked with clients who have eating disorders and substance abuse, disregarding the number of facilities.

	Have Not Worked With	1 - 4	5 - 9	10 - 14	15 - 19	20 Years or More
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. What is your job title?

- Music Therapist
- Recreational Therapist
- Activity Therapist
- Creative Arts Therapist
- Other

If Other, Please Specify:

10. Please indicate in which region your facility is located.

- Great Lakes Region (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)
- Mid-Atlantic Region (Delaware, Maryland, New Jersey, Pennsylvania, Virginia, Washington DC, West Virginia)
- Midwest Region (Colorado, Kansas, Montana, Nebraska, North Dakota, South Dakota, Wyoming)
- New England Region (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)
- Southeastern Region (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee)
- Southwestern Region (New Mexico, Oklahoma, Texas)
- Western Region (Alaska, Arizona, California, Hawaii, Nevada, Oregon, Utah, Washington)

11. Do you work in a facility where the speciality is eating disorders or substance abuse?

- Eating Disorders
- Substance Abuse
- Both
- Not Specialized

12. Please indicate the populations music therapy services are provided to in your facility.

- Substance Abuse
- Eating Disorders
- Both
- Other

If Other, Please Specify:

13. Is your facility an inpatient facility or outpatient facility?

- Inpatient Facility
- Outpatient Facility
- Both
- Neither

If Neither, Please Specify:

14. Does your facility admit clients on primary diagnoses (eating disorder or substance abuse)?

- Yes
- No

15. What is the average age range for clients who are seen that have been diagnosed with an eating disorder or substance abuse?

	0 - 4	5 - 10	11 - 15	16 - 20	21 - 25	26 - 30	31 or Above
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. On average, how many clients do you work with during a week who have a substance abuse problem or an eating disorder diagnosis?

	1 - 5	6 - 10	11 - 15	16 - 20	21 or Above
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Do you see or interact with your clients outside of the music therapy sessions?

- Yes
- No

18. Please select how this interaction occurs.

- Client Field Trips
- Lunch Supervision
- Relocation of Clients
- Transportation of Clients
- Other

If Other, Please Specify:

19. Please indicate the type(s) of Music Therapy services provided at your facility. Please check all that apply.

Individual

Group

Family

Other

If Other, Please Specify:

20. Do you allow family members and significant others to participate during individual sessions, with the client's consent, if family sessions are not provided?

Yes

No

Behaviors and Symptoms

21. Please select the symptoms that are addressed during Music Therapy sessions for individuals with eating disorders.

	INDIVIDUAL	GROUP
Does Not Apply	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Amenorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Food Refusal	<input type="checkbox"/>	<input type="checkbox"/>
Dehydration	<input type="checkbox"/>	<input type="checkbox"/>
Delusional Beliefs	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Distortion of Self-Image	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Exercising	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Fear of Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Methods of Evaluation of Body	<input type="checkbox"/>	<input type="checkbox"/>
High / Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Inflexible Thinking	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Rhythms	<input type="checkbox"/>	<input type="checkbox"/>
Lethargy	<input type="checkbox"/>	<input type="checkbox"/>
Misuse of Laxatives, Diuretics, or Enemas	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Nutritional Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Oral/Dental Complications	<input type="checkbox"/>	<input type="checkbox"/>
Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>
Selective Eating	<input type="checkbox"/>	<input type="checkbox"/>
Self-Induced Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Appearance, Color, Smell, Texture, Temperature, Taste	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>
Social Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>
Spit Out Food	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Tendencies	<input type="checkbox"/>	<input type="checkbox"/>
Uncontrollable Eating	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
If Other, Please Specify:		

22. Please select the symptoms that are addressed during Music Therapy sessions for individuals with substance abuse.

	INDIVIDUAL	GROUP
Does Not Apply	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Delusional Beliefs	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Change in Weight	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>
High / Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Hyper Attention	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Memory	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Rhythms	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Social Behaviors (Stealing, Declining Grades, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Lethargy	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Nutritional Imbalance	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>
Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Appearance, Color, Smell, Texture, Temperature, Taste	<input type="checkbox"/>	<input type="checkbox"/>
Shaking / Sweating	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>
Social Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Tendencies	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

If Other, Please Specify:

Music Therapy Practices

23. Please rank the top 3 interventions that you use during INDIVIDUAL Music Therapy sessions for individuals with EATING DISORDERS.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

24. Please rank the top 3 interventions that you use during GROUP Music Therapy sessions for individuals with EATING DISORDERS.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

25. Please rank the top 3 interventions that you use during INDIVIDUAL Music Therapy sessions for individuals with SUBSTANCE ABUSE.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

26. Please rank the top 3 interventions that you use during GROUP Music Therapy sessions for individuals with SUBSTANCE ABUSE.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

27. Please rank the top 3 songs (and respective artists) that you use during Music Therapy sessions for individuals with EATING DISORDERS.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

28. Please rank the top 3 songs (and respective artists) that you use during Music Therapy sessions for individuals with SUBSTANCE ABUSE.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

29. On average, how many referrals for Music Therapy services do you receive in a week?

	0 - 4	5 - 9	10 - 14	15 - 19	20 or More
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. On average, how many clients participate in group Music Therapy sessions?

	1 - 5	6 - 10	11 - 15	16 - 20	21 or More
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Who do you receive referrals from for Music Therapy services?

- Doctors
- Nurses
- Family Members
- Psychologist
- Other

If Other, Please Specify:

32. Are interdisciplinary services offered during Music Therapy sessions? (i.e., art therapy, pet therapy, aromatherapy, etc.)

- Yes
- No

If Yes, Please Specify:

33. Please give a short description of how non-music therapy specialists are used to create interdisciplinary sessions.

34. Do you incorporate the use of application-based technology with your clients?

Yes

No

35. Please indicate the most utilized MUSIC apps during Music Therapy sessions for EATING DISORDERS.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

36. Please indicate the most utilized NON-MUSIC apps during Music Therapy sessions for EATING DISORDERS.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

37. Please indicate the most utilized MUSIC apps during Music Therapy sessions for SUBSTANCE ABUSE.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

38. Please indicate the most utilized NON-MUSIC apps during Music Therapy sessions for SUBSTANCE ABUSE.

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

39. What is the average length of treatment time for individuals with eating disorders or substance abuse?

Eating Disorders	<input type="text"/>
Substance Abuse	<input type="text"/>

40. What percentage of time do you see a relapse in your clients' behaviors after their Music Therapy sessions have been completed / terminated?

	Does Not Apply	0 - 20%	21 - 40%	41 - 60%	61 - 80%	81 - 100%
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Changes to the DSM

41. Did the changes from the DSM-IV-TR to the DSM-5 result in changes within your session structure, goals, and documentation?

- Yes
- No

If Yes, Please Explain:

42. Please approximate the percentage of increase / decrease that was seen in client referrals. (i.e., 52% increase, 10% decrease, etc.) If there was no change, please write "None."

Eating Disorders

Substance Abuse

43. Based on the changes from from the DSM-IV-TR to the DSM-5, what percentage of your current clients' diagnoses were altered?

- 0 - 20%
- 21 - 40%
- 41 - 60%
- 61 - 80%
- 81 - 100%

Employment Conditions

44. Please specify your current employment classification.

- Full-Time Employee
- Part-Time Employee
- Contracted
- Other

If Other, Please Specify:

45. How many hours, on average, do you work per week?

46. What is your annual salary?

- Below \$20,000
- \$20,000 - \$29,999
- \$30,000 - \$39,999
- \$40,000 - \$49,999
- \$50,000 and Above

47. Does your facility require any specific training? (i.e., CPI, CPR, etc.)

- Yes
- No

If Yes, Please Specify:

APPENDIX B

APPROVAL FROM AMERICAN MUSIC THERAPY ASSOCIATION



American Music Therapy Association®

8455 Colesville Rd., Ste. 1000 • Silver Spring, Maryland 20910
Tel. (301) 589-3300 • Fax (301) 589-5175 • www.musictherapy.org

March 28, 2014

Dear Christopher,

Thank you for your request for the use of AMTA mailing labels. We have reviewed your materials and I am pleased to inform you that your study has been approved. Once the IRB approves your study, please notify Angie Elkins so she can process the labels.

We wish you the best of luck with your response rate and data collection. Please send us a summary of your results.

Best regards,



Dr. Andi Farbman
Executive Director
American Music Therapy Association
www.musictherapy.org

APPENDIX C

APPROVAL FROM FSU HUMAN SUBJECTS COMMITTEE



Office of the Vice President for Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8673 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 04/07/2014

To: Christopher Beach [REDACTED]

Address: [REDACTED]

Dept.: MUSIC SCHOOL

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
A Survey Of Current Music Therapy Practices for Clients with Substance Abuse and Eating Disorders

The application that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human Subjects Committee. Your project is determined to be Expedited per 45 CFR § 46.110(7) and has been approved by an expedited review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If you submitted a proposed consent form with your application, the approved stamped consent form is attached to this approval notice. Only the stamped version of the consent form may be used in recruiting research subjects.

If the project has not been completed by 04/03/2015 you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the Committee.

You are advised that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report, in writing any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Human Research Protection. The Assurance Number is IRB00000446.

Cc: Jayne Standley <jstandley@fsu.edu>, Advisor
HSC No. 2014.12074


APPENDIX D
COVER LETTER

Dear Music Therapists,

My name is Christopher Beach and I am a master's student in the Music Therapy Program through the College of Music at Florida State University, under the direction of Dr. Jayne Standley. I am conducting a survey examining the therapeutic practices with clients that have an eating disorder or substance abuse problems, including the areas of demographics, therapeutic practices, working conditions, etc.

You are cordially invited to participate in this study. Your name is being used with the permission of the American Music Therapy Association who has reviewed this study. You were listed in the AMTA database as working with clients who have eating disorders and/or substance abuse. The questionnaire contains a confidentiality/consent agreement, followed by 46 questions and will take approximately 15 to 20 minutes to complete. Your answers will only be recorded once consent to participation is granted. You will submit your answers by clicking "Submit" at the end of the survey. By consenting to participate, you confirm understanding that your answers will be used only for analysis in this study and that you are free to withdraw your participation at any time during the survey. You also acknowledge that all personal identities will be kept confidential and no publications will indicate that your facility was involved in this study. Your participation is optional and, therefore, are not required to answer every question, but are encouraged to answer any questions as comfortably as you are able.

There are no known risks or benefits associated with this research study. Should you have any questions regarding the process or this study, please feel free to contact myself or Dr. Jayne Standley. You may also contact the Florida State University Institutional Review Board should you have further questions regarding policies and rights as a study participant.

Should you choose to participate in this study, please click on the individually unique web link located here: 

Thank you for your consideration in the participation of this research study. By participating, you will help increase the understanding of music therapy practices with individuals with eating disorders and/or substance abuse.

Sincerely,

Christopher Beach

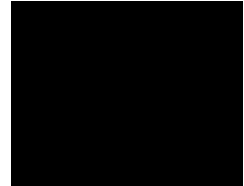

Jayne Standley



Florida State University
College of Music



FSU IRB



APPENDIX E

INTERDISCIPLINARY MODALITIES

Modalities	Utilization
<ul style="list-style-type: none"> • Aromatherapy 	<ul style="list-style-type: none"> • Relaxation
<ul style="list-style-type: none"> • Art Therapy 	<ul style="list-style-type: none"> • Creation of Mandalas • Resource Sharing • Self-Expression
<ul style="list-style-type: none"> • Dance / Movement Therapy 	<ul style="list-style-type: none"> • Beginning Movement towards Physicality • Stretching with Preferred Music
<ul style="list-style-type: none"> • Dietician 	<ul style="list-style-type: none"> • Distract from Eating and Intrusive Thoughts
<ul style="list-style-type: none"> • Family Therapy 	<ul style="list-style-type: none"> • Decrease Trauma
<ul style="list-style-type: none"> • Massage Therapy 	<ul style="list-style-type: none"> • Relaxation • Assisted Muscle Movement towards Physicality
<ul style="list-style-type: none"> • Occupational Therapist 	<ul style="list-style-type: none"> • Relaxation • Resource Sharing
<ul style="list-style-type: none"> • Pet Therapy 	<ul style="list-style-type: none"> • Relaxation • Social Behaviors
<ul style="list-style-type: none"> • Recreational Therapy 	<ul style="list-style-type: none"> • Coping Skills • Self- Expression • Social Interactions • Turn Taking
<ul style="list-style-type: none"> • Therapeutic Mall Program (6 patients to 7 groups provided simultaneously, and patient selects group of therapy to join) 	<ul style="list-style-type: none"> • Decision Making
<ul style="list-style-type: none"> • Yoga Therapy 	<ul style="list-style-type: none"> • Movement towards Physicality • Relaxation • Stretching with Preferred Music

APPENDIX F

TECHNOLOGY APPS

UTILIZED TECHNOLOGICAL APPLICATIONS (MUSIC)

Eating Disorders	Substance Abuse
iTunes	Amazon MP3 Cloud
GarageBand	Garage Band
Piano	Guitar JamTracks
Relax HD	OnSong
Voice Memos	Spotify
YouTube	Ultimate Guitar
	Voice Record Pro
	YouTube

UTILIZED TECHNOLOGICAL APPLICATIONS (NON-MUSIC)

Eating Disorders	Substance Abuse
Notes	Evernote
	Notes

APPENDIX G

SONG LIBRARY COMPILATION CHART FOR EATING DISORDERS

SONG	ARTIST
A Thousand Years	Twilight Soundtrack
Bad Day	Daniel Powder
Be Ok	Ingrid Michaelson
Beautiful	Christina Aguilera
Brave	Jana Stanfield
Breathe	Anna Nalick
Count on Me	Bruno Mars
Courage	Superchick
Firework	Katy Perry
Happy	Pharrell Williams
Human	Christina Perri
I Choose	India Arie
Let It Be	The Beatles
Let It Go	Idina Menzel
Let That Be Enough	Switchfoot
Mary Jane	Alanis Morissette
My Life	Kid Cudi
Pearl	Katy Perry
Perfect	Pink
Roar	Katy Perry
Say (John Mayer)	John Mayer
Say Something	Christina Aguilera
Sophie	Eleanor Mcevoy
Stand in the Rain	Superchick
That's Who I Am	Jessica Andrews
Three Little Birds	Bob Marley
Unwell	Matchbox 20
Warrior	Demi Levato
Who You Are	Jessie Jackson

APPENDIX H

SONG LIBRARY COMPILATION CHART FOR SUBSTANCE ABUSE

SONG	ARTIST
A Change is Gonna Come	Sam Cooke
Amsterdam	Coldplay
At This Point in My Life	Tracey Chapman
Bad Bad Leroy Brown	Jim Croce
Beautiful	Christina Aguilera
Brave	Sara Bareilles
Breakers	Local Natives
Center Stage	Indigo Cash
Count on Me	Bruno Mars
Desperado	The Eagles
Don't Stop Believin'	Journey
Don't Let Me Be Misunderstood	Nina Simone
Don't Worry, Be Happy	Bobby McFerrin
Fire and Rain	James Taylor
Fix You	Coldplay
Going Through Changes / Not Afraid	Eminem
Good Riddance	Green Day
The Greatest	Kenny Rogers
How to Save a Life	The Fray
Hurt	Johnny Cash
I Can See Clearly Now	Johnny Nash
I Choose	India Arie
I Won't Give Up	Jason Mraz
King of the Road	Roger Miller
Lean on Me	Bill Withers
Let it Go	Idina Menzel
Life Starts Now	Three Days Grace
Man in the Mirror	Michael Jackson
My Stupid Mouth	John Mayer
Peace Like a River	Religious
The Reason	Hoobastank
Right Where It Belongs	Nine Inch Nails
River of Dreams	Billy Joel
Roll Away Your Stone	Mumford & Sons
Safe and Sound	Taylor Swift
Scotch and Soda	The Kingston Trio

Substance Abuse Song List Continued.

SONG	ARTIST
Sentimental Journey	Les Brown
She's a Butterfly	Martina McBride
Sitting on the Dock of the Bay	Otis Redding
Sober	Pink
Stand by Me	Ben E King
Stardust	Hoagy Carmichael
That's Who I Am	Jessica Andrews
Things That Matter	Rascal Flatts
Thrive	Switchfoot
Under the Bridge	Rod Hot Chili Peppers
Watching the Wheels	John Lennon

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