**Music for Recovery Results  
Nilo Fallah-Sohy and John F. Kelly**

**BACKGROUND:** Carr et al. (2013) cite the need for further attention to Music Therapy’s effects in inpatient settings. Drawing a link between the theoretical concepts of group therapy and data specifically evaluating Music Therapy programs seems suited to the incipient status of much of this work. Yalom’s Therapeutic Factors (TFs) are a widely accepted theoretical framework for the aspects of group therapy that serve to effect change in group members (1995). Music Therapy appears to derive its therapeutic effects from an interaction of these factors. Current literature documents Music Therapy’s ability to instill reconnection with previous states, companionship amongst the group, and perceived equality with the therapist unique to the music modality, as well as instillation of hope and positive expression (Ansdell and Meehan, 2010).

“Music for Recovery” (MFR) is one such example of Music Therapy which is available to facilities offering services to patients with substance use disorders. The MFR program, run by a musician in long-term recovery, offers on-site recovery songwriting workshops and performances to explore how creativity can support recovery and enhance treatment experiences. A program evaluation was developed to measure the therapeutic effects of participation in MFR in patients of residential addiction treatment facilities.

**METHOD:** Research staff at the Recovery Research Institute at the Massachusetts General Hospital, Harvard Medical School Psychiatry Department, developed a 10-item questionnaire to assess pre- to post- changes in common therapeutic elements among patients treated for addiction in residential treatment facilities as a function of participating in the Music for Recovery (MFR) program. In order to develop the assessment, we evaluated 164 written narrative self-reports from 107 patients across four residential treatment centers in Massachusetts who previously had participated in MFR. Patients completed these initial brief narrative self-report evaluations following their participation, responding to the question: “Did you find this [performance/workshop] helpful for your recovery journey? If so, how? If not, why not?” These brief narratives were reviewed by members of the research team to help identify common therapeutic themes emerging from them. We used the Grounded Theory Approach to identify common themes centered in Yalom’s group therapeutic factors; these included such factors as catharsis (i.e., MFR enabled patients to express emotion better), cohesion (MFR led patients to feel greater sense of community, trust, bonding, and belonging), existential factors (MFR helped patients boost confidence and empower them to make changes), installation of hope (MFR helped patients believe that positive change and recovery was possible), interpersonal learning (MFR helped patients learn more from one another), and universality (MFR helped patients feel closer to their peers and more a part of the community).

Content from the 164 written narratives fell into one of these 6 therapeutic domains and from these a 10-item scale was constructed based on an established, empirically derived scale known as the Therapeutic Factors Inventory (TFI), which serves to assess the presence of Yalom’s eleven TFs operating in group therapy (Lese and MacNair-Semands, 2000). We created a 10-item Therapeutic Change Scale (TCS), with items rated from 1 (*strongly disagree*) to 6 (*strongly agree*). This served to capture the extent to which patients agreed that a therapeutic element was present in their life and was designed to be sensitive to change in these elements after patients participated in various group therapeutic activities (e.g., the MFR program). The 10-item questionnaire contained 6 domains that captured the TFs found prominent in the qualitative response analysis. These were: Instillation of Hope (3 items), Cohesion and Existential Factors (2 items each), and Catharsis, Interpersonal Learning, and Universality (1 item each).

Patients enrolled at four residential treatment facilities for adults with substance use disorders in Massachusetts were asked to complete the TCS before and after participation in the MFR program. Patients’ pre- and post- questionnaires were stapled together to identify their corresponding responses. Age and gender information were also collected.

**RESULTS:** Individuals who did not complete both the pre- and the post- questionnaire (n=40) were excluded from our analyses, resulting in a completed sample size of 78 individuals. Participants ranged in age from 18 to 74 years (*M* = 36.56, *SD* = 13.45). Of the centers included in the sample, two were mixed gender facilities while two were exclusive to either men or women; participants across the four centers were predominantly male (55%).

The scale was found to be highly reliable, with internal consistency scale alphas very high both before (α = .85) and after (α = .90) participation. Paired-samples t-tests were run on a sample of 78 MFR participants to determine whether there was a statistically significant change in TCS scores before and after MFR participation. Overall, patients reported a significant positive increase in the full scale score of the TCS as a function of participating in MFR, *t*(77) = 4.27, *p* < .001 (see Figure 1). Significant improvements in scores were also found for individual TFs. Specifically, patients reported improved scores for Catharsis (*p* < .001), Cohesion (*p* = .001), Existential Factors (*p* = .002), and Interpersonal Learning (*p* < .001) following participation in MFR.

**CONCLUSION:** Results suggest that the TCS is a reliable measure of therapeutic change. This scale was able to successfully capture changes in important therapeutic domains that are predictive of patient progress during addiction treatment as well as post-treatment outcomes. MFR participation is shown to enhance these therapeutic factors in patients undergoing residential treatment for substance use disorders as measured by the TCS. MFR may be a promising programmatic element that could enhance engagement and retention in treatment by mobilizing common therapeutic mechanisms that ultimately enhance the likelihood of long-term recovery.

**Table 1: Means and SDs Pre- and Post- MFR Participation**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Domain/Scale** | **Items** | **PRE M** | **PRE SD** | **POST M** | **POST SD** | **N** | **95% CI for M diff** | **df** | **T** | **P** | **T statistic** |
| **Overall TF** | [1] +(2+..10) | 48.56 | 6.72 | 50.90 | 7.82 | 78 | 1.25, 3.44 | 77 | 4.271 | .000 | *t*(77) = 4.27, *p* < .001 |
| **Cohesion** | 3 + 10 | 10.00 | 1.81 | 10.54 | 1.86 | 78 | -.85, -.22 | 77 | -3.414 | .001 | *t*(77) = -3.41, *p* = .001 |
| **Existential Factors** | 5 + 7 | 10.36 | 1.55 | 10.74 | 1.69 | 78 | -.63, -.14 | 77 | -3.134 | .002 | *t*(77) = -3.13, *p* = .002 |
| **Catharsis** | 6 | 4.15 | 1.33 | 4.80 | 1.23 | 78 | -.90, -.38 | 77 | -4.920 | .000 | *t*(77) = -4.92, *p* < .001 |
| **Interpersonal** | 9 | 4.88 | .96 | 5.18 | 1.07 | 78 | -.47, -.14 | 77 | -3.639 | .000 | *t*(77) = -3.64, *p* < .001 |
| **Universality** | 8 | 5.31 | .80 | 5.44 | .86 | 77 | -.29, .05 | 76 | -1.438 | .155 | *t*(76) = -1.44, *p* = .155 |
| **Instill of Hope** | [1] + 2 + 4 | 13.85 | 2.11 | 14.22 | 2.38 | 78 | -.80, .07 | 77 | -1.688 | .095 | *t*(77) = -1.69, *p* = .095 |