

THE USE OF DIALECTICAL BEHAVIOR THERAPY (DBT) IN MUSIC THERAPY: A
SURVEY OF CURRENT PRACTICE

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By
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Abstract

THE USE OF DIALECTICAL BEHAVIOR THERAPY (DBT) IN MUSIC THERAPY: A SURVEY OF CURRENT PRACTICE

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This study examined the current uses of DBT in music therapy practice in mental health settings. DBT and music therapy both are well documented in literature for the treatment of individuals with mental health needs, but there are very limited resources on the use of the combination of DBT and music therapy. A mixed methods design was used to survey the current practice of DBT in music therapy. The *DBT in Music Therapy Questionnaire* was constructed and sent to 260 board certified music therapists who are members of the American Music Therapy Association (AMTA) and who indicated working in mental health settings. A total of 48 respondents (response rate of 18.5%) indicated that components of DBT, rather than the entire DBT protocol, are being implemented within music therapy by using music therapy experiences to teach and reinforce DBT skills. Results indicate not only that the respondents value the combination of DBT and music therapy, but also that they feel a lack of competence in implementing it. Two music therapists with experience implementing DBT in music therapy shared their expertise through interviews.

The results of the study indicate the need for future research and suggest the potential need for more training in DBT for music therapists working in mental health settings. In addition, they demonstrate the need for music therapists who implement DBT to publish their work and to create empirical evidence for its use and effectiveness in practice.

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Chapter 1

Introduction

Approximately 26.2% of Americans ages 18 and older—about one in four adults—have a diagnosable mental disorder in a given year (Kessler, Chiu, Demler, & Walters, 2005). Many people experience more than one mental disorder at a given time. About 45% meet criteria for two or more disorders, and there is a strong comorbidity (Kessler et al., 2005). Approximately 1.6% of Americans ages 18 and older have borderline personality disorder (Lenzenweger, Lane, Loranger, & Kessler, 2007); 6.7% have major depressive disorder (Kessler et al., 2005); 3.5% have posttraumatic stress disorder (Kessler et al., 2005); and 3.4% have eating disorders (Hudson, Hiripi, Pope, & Kessler, 2007). Furthermore, a 2006 study determined 11 deaths out of every 100,000 were attributed to suicide (National Center for Injury Prevention and Control, 2010). These statistics show an evident need for effective treatment for individuals with these mental disorders.

DBT is a form of psychotherapy that was developed by Marsha Linehan, a researcher at the University of Washington. DBT was initially created for individuals with self-harm behaviors, suicidal thoughts, urges of suicide, and suicide attempts (Behavioral Tech, 2008). These characteristics are common in individuals with borderline personality disorder (BPD). It is also common for individuals with BPD to have a comorbid disorder such as an eating disorder, substance use disorder, mood disorder, or posttraumatic stress disorder (Behavioral Tech, 2008). This form of therapy developed in reaction to a shortcoming of traditional

Cognitive Behavior Therapy (CBT); which failed to validate the polarities of emotions that this population typically experiences (Linehan, 1993a).

DBT is effective in reducing suicidal behavior, psychiatric hospitalization, treatment dropout, anger, and interpersonal difficulties (Linehan, 1993a). Research also indicates that music therapy is effective in treating mental health populations (American Music Therapy Association, 2013a). The integration of DBT and music therapy could enhance treatment efficacy, and therefore, further inquiry as to the potential benefits is needed. This study assessed the ways in which music therapists are using music therapy experiences to address components of DBT.

Dialectics

Dialectics is grounded in philosophy and science (Feigenbaum, 2007). It is defined as being concerned with or acting through opposing forces simultaneously, holding onto two true but conflicting thoughts at once. Dialectics, as understood in behavior therapy, has two meanings: it applies to the fundamental nature of reality, and it also pertains to the use of acceptance and change that is inherent in the therapeutic relationship (Linehan, 1993a).

DBT emphasizes a dialectical worldview (Linehan, 1993a), which Swales (2000) stated is based on three assumptions on the nature of reality: (a) everything is connected to everything else, (b) reality is a process of continuous change, and (c) reality is comprised of opposing forces. The therapeutic relationship can be used as an example for these assumptions. For example, the therapist and client reciprocally influence each other; the client's constant changing inherently alters the therapeutic dynamic; and the therapist is constantly accepting and validating the client for where they are while simultaneously teaching skills to change behaviors. Individuals are constantly living in a world of opposing

forces, and it can be challenging to see the shades of grey in a seemingly black and white world. This challenge falls upon a DBT therapist to find a balance between acceptance of the client as they presently are, while also facilitating change (Feigenbaum, 2007).

There are three dialectical dilemmas in DBT: (a) emotional vulnerability versus self- invalidation, (b) active passivity versus apparent competence, and (c) unrelenting crisis versus inhibited grieving (Linehan, 1993a). These conflicts, which are ongoing and simultaneous, exemplify the dialectical nature of one's reality from a DBT viewpoint.

One goal of DBT is to find balance between these opposing forces. The need to create this balance was one reason why DBT was developed for individuals with BPD. Such individuals often vacillate between extreme emotional polarities or have emotion dysregulation (Dijk, 2012). They often react emotionally to situations in which most people would not typically react; the reactions are more intense than the situation would typically merit; and recovery after feeling the emotion generally takes more time than for the average person in like circumstances (Dijk, 2012).

DBT can be effective in regulating intense emotions and assisting with “walking the middle path.” “Walking the middle path” means moving away from “either-or” thinking and moving towards “both-and” thinking. It explores the idea that opposing forces can both be valid and embraces duality (Linehan, 1993a). For example, an individual with BPD may want to self-harm. They may see two available choices as “either-or”: to act on the urge or to dissociate to numb the urge. Rather, there is a shade of grey, and there is another option besides feeling the urge very intensely *or* not feeling the urge at all. The “both-and” way of thinking allows wanting to act on the urge *and* wanting to dissociate both be valid simultaneously, by creating a “middle path.” The “middle path” allows one to stabilize in a

place where the client can implement coping skills that bring awareness to the urge and make it more tolerable, while also knowing the urge will pass.

Although it is evident that dialectical dilemmas exist for clients, they also exist for therapists. For example, a therapist must facilitate change in the client while also maintaining empathy and validation of current behaviors and emotions (Linehan, 1993a). Much like the client's struggle with duality, the therapist faces conflict between the need for change and validation. It is therefore vital for the therapist to experience finding balance in duality in conjunction with the client.

Dialectical Behavior Therapy

Three overarching theories—biosocial theory, learning/behavior theory, and dialectical philosophy—guide DBT (Rizvi, 2013). The biosocial theory provides an explanation for the development of BPD. Specifically, the theory holds that individuals with BPD are born with an emotional vulnerability. Due to this vulnerability, individuals confronted with emotional stimuli tend to experience and react to the stimuli more intensely than is typical to the situations (Burckell & McMain, 2011). Further, when others are exposed to an individual's responses they often diminish the situation rather than validate the experience. Such invalidating responses can lead to significant increases in the individual's vulnerability (Burckell & McMain, 2011). Ultimately, this cycle of invalidation and vulnerability renders the individuals with BPD unable to address emotion regulation adequately or effectively (Linehan, 1993a). Therefore, DBT focuses on providing individuals with emotion regulation skills to help mitigate this struggle.

Learning/behavior theory provides an explanation for the development, maintenance, and elimination of behaviors (Burckell & McMain, 2011). One role of the DBT therapist is to

assess stimuli that control behaviors, identify skill deficits, address problematic emotions and dysfunctional cognitions, and determine problematic contingencies that interfere with learning new behaviors (Koerner & Linehan, 1996). This theory explains that individuals are capable of learning new, effective behaviors as alternatives to those behaviors that are less effective.

Dialectical theory provides an explanation for the existence of opposing forces simultaneously and how synthesis can facilitate change (Linehan, 1993a). One dialectic in DBT is acceptance and change. Dialectics explain the “middle path.” This theory also looks at the person holistically. For individuals to be understood, each must be viewed as a whole rather than as parts in isolation.

DBT even incorporates Zen philosophy as a core element of treatment. The acceptance-based strategies in DBT, such as validation and mindfulness, are derived from Zen teachings (Burckell & McMain, 2011). Attaining awareness of one’s thoughts, feelings, and behaviors is necessary before change in behaviors is possible. Practicing mindfulness helps individuals gain awareness, and the validation aspect of Zen encourages acknowledgement and acceptance in a nonjudgmental manner. These strategies aim ultimately to improve emotion regulation and effectuate change in behaviors (Linehan, 1993a).

Traditional DBT protocol is implemented in an outpatient setting and calls for individual therapy, skills training (usually in group form), as-needed phone consultation between client and therapist outside of session, and therapist consultation through team meetings to address and reinforce the skills taught in the four modules (Rizvi, 2013). The protocol aims to increase the client’s motivation to change, enhance the client’s capabilities,

generalize the clients' gains to his or her larger environment, structure the environment to reinforce the client's gains, and increase therapist motivation and competence (Rizvi, 2013).

DBT can provide one with the tools needed to function more effectively and mindfully.

Traditional DBT is organized into four stages and operates within four modules, all of which are grounded in several assumptions pertaining to the client in therapy (Linehan, 1993a). The assumptions guide the stages and modules as the client and therapist navigate through them.

Linehan (1993a) assumes the following about clients in DBT:

1. Clients are doing the best they can;
2. Clients want to improve;
3. Clients need to do better, try harder, and be more motivated to change;
4. Clients may not have caused all of their own problems, but they have to solve them anyway;
5. Individuals with BPD who are suicidal experience their lives as unbearable in their current state;
6. Clients must learn new behaviors in all relevant contexts;
7. Clients cannot fail at therapy; and
8. Therapists treating BPD need support.

The ultimate goal of DBT is to create a life worth living, which can be accomplished through learning new skills, learning to experience emotions, accomplishing ordinary life goals, and feeling connected (Behavioral Tech, 2008). Four stages of DBT treatment have been developed to address these goals. Prior to treatment, there is a pretreatment phase comprised primarily of a client assessment. The assessment gathers information about the

client's history, other relevant disorders, and behaviors. It also consists of identifying goals and providing psychoeducation about BPD and DBT. It is important in this phase for the client to commit to engaging in treatment (Linehan, 1993a).

Upon the pretreatment phase completion, the client begins Stage I (Moving from Being out of Control of One's Behavior to Being in Control). There are four goals in this stage: (a) reducing and eliminating life-threatening behaviors (self-injury and suicide attempts); (b) reducing and eliminating behaviors that interfere with treatment (nonattendance, sporadic or no completion of homework, noncollaboration, not using resources such as on-call therapist, and using the hospital as a way to deal with crises); (c) decreasing behaviors that destroy the quality of life (coexisting diagnoses, medical issues, financial situation, housing) and increasing effective behaviors that make life worth living; (d) learning skills that help with attention, awareness of present moment, building healthy relationships, understanding emotions, and tolerating emotional pain by implementing healthy coping skills and effective behaviors (Behavioral Tech, 2008). This stage creates a greater sense of awareness, understanding, and control over one's emotions. The purpose is to stabilize clients so they can be in a place to work on the core of their deeper issues.

Most clients remain in Stage I throughout their treatment. When DBT clients attain stability in Stage I, they move to Stage II (Moving from Being Emotionally Shut Down to Experiencing Emotions Fully). The main goal of this stage is to help clients experience emotions without using ineffective behaviors as a way to cope. Since clients are stabilized in Stage I, they are able to move on to trauma work in Stage II (Behavioral Tech, 2008).

After working through trauma and allowing the self to feel emotions fully without using ineffective behaviors to cope, DBT clients are ready to move to Stage III (Building an

Ordinary Life, Solving Ordinary Life Problems). In this stage, clients focus on amplifying self-respect, interpersonal relationships, and general functioning (Linehan, 1993a). Rather than focusing on crises situations, this stage explores “ordinary” problems that interfere with happiness (Behavioral Tech, 2008). Although some clients may continue seeing their DBT therapist at this time, some clients choose to work on these goals individually, with a non-DBT psychotherapist or some other type of therapy. This helps clients identify how they want to build their life worth living and what obstacles prevent that from happening.

Although clients may have accomplished their goals in Stage III, it is common for clients still to feel empty and unfulfilled, and to struggle with existential issues (Behavioral Tech, 2008). Stage IV (Moving from Incompleteness to Completeness/Connection) focuses on how clients can create meaning in their life, particularly with their spiritual or religious path. This stage helps clients find meaning and feel connected to a force larger than the self. Behavioral Tech (2008) stated that although treatment is categorized into stages, they are all interconnected.

In addition to the four stages, DBT consists of four modules stemming from cognitive behavioral techniques; specifically, (a) mindfulness, (b) interpersonal effectiveness, (c) emotion regulation, and (d) distress tolerance. These techniques facilitate learning of new skills and inhibit the use of maladaptive behaviors (Feigenbaum, 2007). Skills taught are (a) adaptations from Eastern (Zen) meditation techniques such as mindfulness practice to increase emotional awareness and reduce inhibition; (b) methods to increase interpersonal effectiveness in conflict situations in order ultimately to diminish negative reactivity to environmental stressors; (c) strategies to increase self-regulation of unwanted emotions in the face of actual or perceived negative emotional stimuli; and (d) practices that assist with

tolerating emotional distress until changes are forthcoming. The skills taught in these four modules provide an opportunity to learn coping skills that can be applied in daily situations and lead to a more effective life.

Mindfulness

Overview. One of the four components of DBT is mindfulness, which stems from Eastern spiritual traditions (Linehan, 1993b). In DBT, being mindful means having awareness of the self in the present moment, without trying to change that self. The crux of mindfulness is suspension of judgment (Dijk, 2012). Therefore, being mindful means not worrying about the past or future, but being in the present. To be nonjudgmental, one must view thoughts, feelings, and situations as neutral; there is no “good” or “bad,” they just *are*. A judgment, one's perceived reality, often fails to reflect reality accurately. Being mindful encourages one to become aware of emotions, to experience events as they are in the moment, and to experience events without trying to change or control them.

States of mind. DBT distinguishes three states of mind: (a) reasoning self (b) emotional self; and (c) wise self (Linehan, 1993b). The reasoning self analyzes situations logically and is devoid of emotional reactivity. The emotional self, in contrast, responds to situations based primarily on raw emotion and without consideration for the consequences. This is when emotions are in control. The wise self is a combination of the other selves with neither emotions nor rationality alone controlling. Instead, wise self considers the long-term benefits and consequences. One is choosing how to act in a situation, rather than merely reacting. Although the reasoning and emotional self both serve a function, the wise self is the “ideal self” (Linehan, 1993b).

Goals. The ultimate goal of mindfulness is to practice using the wise mind, preparing an individual to confront difficult situations when they arise (Linehan, 1993b). Other goals are (a) reducing emotional vulnerability; (b) observing and describing the moment; (c) staying present to notice thoughts, feelings, and experiences without reacting to them; (d) putting one's experiences into words to better understand a situation; and (e) increasing the quality of awareness that one brings to activities (Linehan, 1993b).

DBT Mindfulness Skills

What skills. Mindfulness combines “what” skills and “how” skills (Linehan, 1993b). The “what” skills are comprised of observing, describing, and participating (Linehan, 1993b). Observing means bringing awareness to internal experiences without necessarily labeling them. Describing consists of labeling factual observations about the situation without casting judgments. Labeling the internal experience can help integrate the sensations and create a familiarity with them. Participating is the letting go of thoughts to allow for full involvement in the experience. This is the ultimate goal of DBT (Linehan, 1993b).

How skills. The “what” skills describe the goals of mindfulness, whereas the “how” skills describe the qualities to be aware of in order to be able to observe, describe, and participate. The “how” skills are comprised of nonjudgment, one-mindfully, and effectiveness (Linehan, 1993b). Nonjudgment allows one to accept where one is at and what one is experiencing in the moment. This means suspending judgment and allowing oneself to be fully present in the experience. One-mindfully means being fully present and aware in a given experience as it happens (Linehan, 1993b). To accomplish this, one must let go of internal and external distractions. If a distraction arises, the self can give permission to let go and move on rather than judging the distraction. To be effective is to apply relevant DBT

skills to a situation (Linehan, 1993b). It also addresses being aware of a situation objectively while understanding that subjective beliefs of what “should” or “could” happen are not always realistic. Using mindfulness both to distinguish and to embrace internal and external experiences increases the likelihood for effective behaviors. If able to accept the realities, one can be more balanced and present in the situation, thus affording the opportunity to implement skills. The mindfulness skills are necessary for attaining self-awareness and are the core skills to learn before learning the other three modules.

Interpersonal Effectiveness

Overview. Another module of DBT is interpersonal effectiveness (Linehan, 1993b), which focuses on improving and maintaining relationships using effective communication skills. Additionally, interpersonal effectiveness aims to increase awareness and improve assertiveness better to address one’s needs. This means evaluating how relationships function in one’s life and whether or not one’s needs in the relationship are being met. For example, the client learns to address unmet needs before hurt and problems develop. Ending hopeless relationships or resolving and bringing closure to existing conflicts are effective interpersonal techniques. When the client considers a relationship’s overall effectiveness and determines the consequences of each person’s behavior, the client’s thinking may shift from an emotional mind to the wise mind. Relationships are frequently driven by emotional reactions that tend to overlook the larger issues that exist. Using the wise mind instead can allow one to speak up about needs in the relationship beyond the present emotions ultimately to increase the relationship’s effectiveness. In addition, asserting one’s needs may increase confidence.

Interpersonal effectiveness also emphasizes balancing priorities versus demands (Linehan, 1993b). Priorities are those activities or beliefs most important to the self, while demands are others' expectations placed on the individual. Understanding the proportion of priorities and demands in one's life enables an individual consciously to strike a balance between the two, ultimately rendering a person more able to make effective choices. Although both priorities and demands are necessary to be functional, too many or too few demands or priorities can be detrimental and may impede one's behavioral effectiveness.

Interpersonal effectiveness skills assist individuals to make lives worth living and to create meaningful relationships within those lives (Linehan, 1993b). Being in healthy relationships and effectively asserting one's needs can increase confidence and reduce ineffective behaviors in the relationships. Improving or eliminating detrimental relationships also furthers these goals. By implementing interpersonal effectiveness skills, one is able to evaluate relationships and situations through the lens of the wise mind. In the wise mind, many ineffective or emotionally reactive behaviors are reduced, thereby improving the quality of relationships.

Goals. Goals of interpersonal effectiveness are (a) meeting one's objectives or goals in a situation, (b) getting or keeping positive relationships, (c) keeping or improving self-respect and liking for the self, (d) learning effective strategies for asking for what one needs, and (e) coping with interpersonal conflicts. The ability to analyze a situation and to determine goals is crucial for interpersonal effectiveness (Linehan, 1993b).

DBT Interpersonal Effectiveness Skills

When deciding which interpersonal effectiveness skills to use, one must consider personal goals. One then decides whether to use DEAR MAN, GIVE, or FAST skills to achieve them (Linehan, 1993b).

DEAR MAN. This is an acronym for describe, express, assert, reinforce, mindful, appear confident, and negotiate (Linehan, 1993b). This skill is used when attempting to convey one's needs in a relationship. It provides an organized and direct way to make a request, to say no, or to express feelings in a situation.

GIVE. This is an acronym for gentle, interested, validate, and easy manner (Linehan, 1993b). GIVE is used in situations where an objective needs to be met and the client seeks to maintain the relationship.

FAST. This is an acronym for fair, no apologies, stick to values, and be truthful (Linehan, 1993b). FAST is used when the primary objective is keeping one's self-respect. It can be used in conjunction with DEAR MAN and GIVE. Ultimately, this skill is intended to enable the individual to walk away from the situation with self-respect and confidence, regardless of the outcome.

Emotion Regulation

Overview. Another module of DBT is emotion regulation (Linehan, 1993b). Emotion regulation helps one manage emotional reactivity effectively by accepting and tolerating emotions in situations that are beyond one's control. Rather than trying to change the emotion, this skill permits one to reduce its intensity to a bearable level.

Describing emotions. To regulate an emotion, one must first be able to identify it. There are six primary emotions: anger, fear, sadness, shame/guilt, love, and happiness

(Linehan, 1993b). Linehan developed a model that assists in identifying and labeling the primary emotions to determine appropriate skills for a situation. First, the client must ascertain the event—identifying thoughts before, during, and after the event. This consideration encompasses body language and verbal expression and typically requires a conscious inquiry into one’s thinking (i. e., asking, “What was the behavior?”) Ultimately, the information derived from this process helps identify and name the emotion. In sum, it is necessary to bring awareness to the emotion and to sit with the feelings associated with it to regulate better the emotion.

Another concept by Linehan (1993b) in emotion regulation is:

Pain + Nonacceptance = Suffering;

Pain + Acceptance = Tolerable Pain

Accepting an emotion simply means acknowledging the feeling without changing it or judging it. One does not have to like or approve of an emotion to accept it. Nonacceptance, on the contrary, perpetuates suffering by keeping an individual from moving past judging the emotions. Here, the emotion is controlling and consuming. Accepting the feeling actually diminishes its power because the individual can step outside of the emotion mind and into a more wise-minded place. In the wise mind, one is able to tolerate painful emotions by using skills and creating distance from the feelings to address the reality of the situation instead of the feelings alone. Emotion regulation emphasizes the notions that a person is not defined by emotions and that feelings are not facts (Linehan, 1993b).

Goals. The goals of emotion regulation are (a) understanding the emotions one experiences (observing and describing the emotion), (b) learning to understand what emotions do, (c) reducing emotional vulnerability, (d) increasing positive emotions in the

moment, (e) being realistic in setting goals for reaching these emotions, (f) decreasing emotional suffering, (g) thinking rationally rather than irrationally, (h) building mastery, and (i) using opposite action (Linehan, 1993b). Emotion regulation involves nonjudgmental mindfulness of one's emotions, accepting the facts as they are, and learning how better to deal with emotions.

DBT Emotion Regulation Skills

Observing and describing. This skill incorporates mindfulness skills to become aware of present emotions and to assist in verbalizing those feelings. Observing includes noticing body changes as emotions change. Observing also includes bringing awareness to urges and triggers, as well as responses to emotions. Being aware of after effects of an emotional situation is another example of observing. Once noticing emotional states, one can then describe by putting words on the experience.

ABC PLEASE MASTER. This skill is an acronym that is intended to help access the wise mind. The ABC stands for accumulating positive, building mastery, and coping ahead. This consists of creating positive experiences and practicing skills even when not in distress (Linehan, 1993b). The PLEASE stands for ways to cope ahead and to build positive experiences rather than setting up for failure. This includes treating physical illness, eating balanced meals, avoiding mood-altering drugs, getting balanced sleep, and getting exercise (Linehan, 1993b). The MASTER suggests that practicing skills and being effective can increase confidence and build a sense of mastery.

Increasing positive emotions. Difficult emotions are inevitable, but they may be less powerful when one has other positive experiences. This skill aims to accumulate pleasant experiences by increasing one's openness and acceptance of the positive. Increasing positive

emotions is not about invalidating negative emotions. Rather, the goal is to expand one's experiences and provide alternatives for difficult times.

Mindfulness of current emotion. This skill complements observing and describing the emotion. This involves being aware of what one is feeling in the moment and being nonjudgmental of that feeling.

Opposite action. Linehan (1993b) stated that emotions can be changed by acting opposite to current emotions. Acting on urges that stem from emotional reactions is ineffective behavior that keeps one in a negative state. Opposite action helps modify ineffective behavior by removing an individual from an emotionally reactive mindset and into a more stable frame of mind. Acting oppositely allows one to move from one emotion to a more tolerable emotion and to stabilize a person in a place where they can implement skills rather than act out of impulse.

Distress Tolerance

Overview. The final component of DBT is distress tolerance (Linehan, 1993b). Distress tolerance helps one cope with crisis situations in an effective way (Dijk, 2012). It allows one to manage emotions before they get out of control or extreme. It also allows for one to accept what is, rather than changing. This concept is radical acceptance (Linehan, 1993b).

Goals. There are three goals for distress tolerance. They are (a) to learn how to bear pain skillfully, (b) to be able to tolerate and accept distress, and (c) to tolerate and survive crises by accepting life in the moment as it is (Linehan, 1993b). Accepting that distress is a natural part of life is one step to prepare one for these situations so one can plan how to cope effectively in that moment.

DBT Distress Tolerance Skills

ACCEPTS. This is an acronym for distraction skills. Distraction can be with activities, contributing, comparisons, opposite emotions, pushing away a distressing situation, other thoughts, and sensations (Linehan, 1993b).

Self-soothing. Linehan (1993b) stated that one can self-soothe by paying attention to the five senses in the moment. This means creating experiences and putting the self in situations that are nurturing and feel good to either vision, hearing, smell, taste, or touch.

Pros and cons. This consists of making a list of the pros and cons for tolerating or not tolerating the distress (Linehan, 1993b). This can allow one to evaluate the effective and ineffective behaviors that can be used, as well as the benefits and consequences. It provides an opportunity to evaluate the situation and consequences rather than immediately engaging in ineffective coping skills.

IMPROVE. These are skills for improving the moment and are (a) imagery, (b) meaning, (c) prayer, (d) relaxation, (e) one thing in the moment, (f) vacation, and (g) encouragement (Linehan, 1993b).

Radical acceptance. Linehan (1993b) stated that freedom from painful experiences requires acceptance from deep within. This means letting go completely of fighting reality. Acceptance can be defined as nonjudgmentally tolerating the moment and acknowledging what is.

Turning the mind. This skill involves reminding the self to practice acceptance and choosing to accept the self in moments that could be seen as self-defeating. This skill can lead to radical acceptance. This is a conscious decision and an inner commitment to accept.

Half-smile. Another skill for increasing distress tolerance is the half-smile (Linehan, 1993b). This skill accepts reality through the body. A half-smile is when the lips are slightly up-turned and the face is relaxed. This can trick the brain into thinking one has positive emotions about something that may actually be negative.

Willingness versus willfulness. Turning the mind is choosing to accept and doing so repeatedly, which eventually leads to belief. It requires willingness, when one consciously chooses the effective choice, even in difficult situations (Linehan, 1993b).

Contrarily, being willful means knowing what is effective, but consciously making an ineffective choice (Linehan, 1993b). This is refusing to tolerate the moment and can lead to using maladaptive behaviors. Being aware of one's level of willingness and willfulness is a part of distress tolerance.

Summary of Modules

DBT is composed of four modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Mindfulness teaches one to be aware of their emotional state in the present moment in a nonjudgmental way. Interpersonal effectiveness helps one maintain and create meaningful relationships by learning to communicate effectively. Emotion regulation helps one manage emotional reactivity effectively by accepting and tolerating emotions in situations that are beyond control. Distress tolerance helps one manage emotions before they get out of control. In combination, these modules are taught to increase awareness of emotional states and how to cope in distressing situations. The skills taught in the modules provide an opportunity to learn coping skills that can be applied in daily situations, and ultimately create a more effective life—a life worth living.

Chapter 2

Literature Review

To gain a better understanding of how DBT is being used in music therapy, a review of literature on this topic will be presented. This chapter will first provide examples of how standard DBT is being used, as well as adaptations with different populations and settings. The standard use of music therapy with those populations also will be presented. The chapter will then present the way in which DBT is being used in music therapy and will provide examples of music therapy experiences and how they can be used to address DBT skills. The chapter will conclude with the purpose of this study and the hypothesis.

Overview

A search of Behavioral Tech, LLC revealed the research that exists on DBT. There are a total of 18 published randomized controlled trials (RCTs), three published quasi-experimental studies, and one unpublished quasi-experimental study evaluating dialectical behavior therapy (Behavioral Tech, 2013b). There are also 23 studies that are either RCTs, quasi-experimental, or uncontrolled studies that incorporated elements of DBT, skills only, or quasi-DBT. In addition, there are 15 uncontrolled studies evaluating DBT with various populations. A search of PsychInfo indicated there are a total of 266 peer-reviewed articles that address DBT. Reviewing the methodology of the existing research on DBT, there are a total of 124 empirical studies, 111 quantitative studies, 34 interviews, 28 treatment outcome/clinical trials, 20 follow-up studies, 18 literature reviews, 17 clinical case studies, ten longitudinal studies, four prospective studies, three meta-analyses, three

systematic reviews, two qualitative studies, and one retrospective study. PsychInfo revealed two articles specifically on the use of DBT in music therapy, one published in English and one published in German.

These studies evaluated the use of DBT with BPD, substance use disorders, eating disorders, individuals who have attempted suicide, and dual diagnoses. This chapter will review several of the RCTs in the literature that describe the use of DBT with various populations.

DBT to Treat Individuals with BPD and Self-Harming Behaviors

There are many studies that support the use of DBT with BPD. BPD is a mental illness and personality disorder marked by unstable moods, behaviors, and relationships (American Psychiatric Association, 2000). Individuals with BPD often have co-occurring disorders such as depression, anxiety, substance use disorders, eating disorders, self-harm, and suicidal behaviors. Most people with BPD have difficulty regulating emotions and thoughts, impulsive or reckless behavior, and unstable interpersonal relationships. DBT specifically addresses the difficulties present in individuals with BPD, as DBT was initially intended to target issues of self-harm and suicidal behaviors (Choate, 2012). DBT can be effective with the BPD population because of its focus on increasing awareness and identification of emotions using emotion regulation, bringing one's distress down to a tolerable level with distress tolerance, and learning how to appropriate and effectively communicate with others through interpersonal effectiveness module. The four modules of DBT address the areas of need in this population and teach skills to replace maladaptive coping skills (Linehan, 1993b).

Seven well-controlled RCTs across four independent research teams have shown DBT skills training to be effective in treating BPD (Lynch, 2006). Since people with BPD often have emotion dysregulation, these skills can help this population become more aware of their emotions and deal with their emotions in a healthier way. This summary of literature will address DBT and its use with BPD only and not BPD with a comorbid diagnosis.

In a review of studies that examined self-harming behavior and how DBT influences the treatment of women with BDP, Feigenbaum (2010) found that DBT was effective in reducing self-harming behaviors. These results also indicate that self-harm is a result of the inability effectively to cope in a state of emotion dysregulation. Furthermore, she suggested that the emotion regulation and distress tolerance skills taught in DBT are also likely to be effective in reducing self-harm behaviors.

In a meta-analysis to determine the efficacy and the long-term effectiveness of DBT with this population, Kliem, Kröger, and Kosfelder (2010) analyzed 16 studies, eight of which were RCTs and eight of which were neither randomized nor controlled. Using a mixed-effect hierarchical modeling approach, the researchers calculated global effect sizes and effect sizes for suicidal and self-injurious behaviors (Kliem et al., 2010). Findings showed a moderate global effect and a moderate effect size for suicidal and self-injurious behaviors (Kliem et al., 2010). Although DBT is the most frequently used intervention to treat BPD, this study suggests that future research can compare DBT with other active BPD specific treatments that have also demonstrated their efficacy using several long-term follow-up assessment points (Kliem et al., 2010). Such research would help identify DBT's effectiveness in comparison to other interventions.

Van Goethem, Mulders, Muris, Arntz, and Egger (2012) examined DBT and how it affects self-injury and coping behaviors in 19 individuals with BPD. The researchers assessed coping strategies and self-injury behaviors at pretreatment, after 6 months of treatment, and posttreatment. Reliable Changes Indices were used to ensure that changes were solely attributable to the DBT treatment as opposed to other factors. At baseline, participants used passive coping more frequently than active coping, and the researchers found little support for a relation between self-injury and coping (Van Goethem et al., 2012). Van Goethem et al. (2012) also found that posttreatment, fewer participants resorted to self-injury and passive coping and more employed active coping. These results suggest that DBT training led to more active coping skills, but one factor to consider is that no control group was involved in the study.

Linehan, Armstrong, Suarez, Allmon, and Heard (1991) conducted a study that compared a group of women ($n = 22$) aged 18–45 years with parasuicidal BPD who underwent DBT for one year to a similarly matched group of women ($n = 22$) who underwent treatment as usual in the community for one year. This study examined the long-term results of DBT as assessed at pretreatment and at 4-, 8-, and 12-months posttreatment. Results indicated a significant reduction in the frequency and medical risk of parasuicidal behavior among the participants who received DBT in comparison to the treatment as usual participants (Linehan et al., 1991). In addition, the participants who received DBT were more committed to therapy and stayed in treatment more effectively. Furthermore, Linehan (1991) reported that the number of days of inpatient psychiatric hospitalization was fewer for the DBT group than for the control group. Unfortunately, little difference in levels of depression, hopelessness, suicidal ideation, or reasons for living between the groups was reported.

Linehan, Heard, and Armstrong (1994) conducted a study to examine the effectiveness of DBT for BPD at one year posttreatment. This was a follow-up study from a previous study. Women with BPD and a history of parasuicidal behavior were eligible to participate. The 39 women were placed into either DBT treatment or treatment as usual. Linehan et al. (1994) measured efficacy by changes in parasuicidal behavior, psychiatric inpatient days, anger, global functioning, and social adjustment. Results indicated a significantly higher global functioning level for the DBT group (Linehan et al., 1994). Results at posttreatment also indicated that the DBT group had fewer parasuicidal behaviors, less anger, and better self-rated social adjustment at the first 6-month follow-up (Linehan et al., 1994). Furthermore, Linehan et al. (1994) reported during the last 6-month follow-up that the DBT group had fewer inpatient days and had observable increases in social adjustment. One limitation of this study is that the treatment as usual group did not receive identical treatment. For example, the treatment as usual may or may not have included individual psychotherapy (Linehan et al., 1994).

Koons et al., (2001) assigned women veterans ($N = 20$) aged 21–46 years into a DBT or treatment as usual group for 6 months. Similar qualities were used to define efficacy of treatment. Qualities examined were suicidal ideation, hopelessness, depression, and anger expression. The DBT group reported significant decreased levels of all of these symptoms (Koons et al., 2001). Other improvements for the DBT group were decreases in number of parasuicidal acts, anger experienced but not expressed, dissociation, and number of hospitalizations (Koons et al., 2001). Both treatments were effective in reducing depressive symptoms and number of BPD behavior patterns; however, results may not be generalized to

all individuals with BPD, as those with parasuicidal behaviors were excluded (Koons et al., 2001).

Linehan et al., (2006) studied 101 women with recent suicidal and self-injurious behaviors who also met criteria for BPD. The women were divided into two groups, a DBT group and a treatment as usual group with a non-DBT therapist, and received treatment for one year with one year of follow-up. Similar measures were used in this study as in previous studies by Linehan. Results indicated that DBT was associated with better outcomes than the treatment as usual group (Linehan et al., 2006). The individuals receiving DBT were half as likely to make a suicide attempt, required fewer hospitalizations for suicide ideation, and had lower medical risk across suicide attempts and self-injurious behaviors (Linehan et al., 2006). Furthermore, Linehan et al. reported that the DBT group was less likely to drop out of treatment. The study concluded that the results were similar to previous DBT studies, and replicated the effectiveness of DBT. The results also show that DBT is uniquely effective in reducing suicide attempts, and it is more than just the therapeutic relationship or receiving expert psychotherapy that leads to that change (Linehan et al., 2006).

Williams (2010) looked at a combination of Gestalt Therapy and DBT for adolescents with BPD. Specifically, awareness, mindfulness, sensory body experience, emotion regulation, acceptance, and the client/therapist relationship as agents of change were overlapped to create a holistic approach for this population. The DBT concept of mindfulness and the Gestalt Therapy concept of contact both provide increased awareness, which ultimately impacts one's therapeutic process. DBT was combined with different theoretical models and appeared to have positive implications. One limitation is that this study was only conducted with adolescents, and the findings may not be generalized to adults.

In addition to being adapted with adolescents, DBT has also been adapted for children who use nonsuicidal self-injury (NSSI) as a means of coping (Perepletchikova, Axelrod, Kaufman, Rounsaville, Douglas-Palumberi, & Miller, 2011). Perepletchikova et al. studied 11 children (six girls and five boys), ranging from 8–11.5 years from regular education classes who participated in a 6-week pilot study of a DBT skills group. The children completed the Mood and Feeling Questionnaire, Self-Report for Childhood Anxiety Related Disorders, Children’s Coping Strategies Checklist, and Child Self-Control Rating Scale pre and posttreatment. In addition, their parents completed the Emotion Regulation Checklist and the Parent Version of the Social Skills Rating Scale.

Perepletchikova et al. (2011) found that the children had moderate symptoms of anxiety and depression at baseline. Following the treatment, the children reported significant decreases in depressive symptoms, suicidal ideation, and problematic internalizing behavior as well as an increase in adaptive coping skills (Perepletchikova et al., 2011). The participants in the study also reported that the DBT skills were useful and important. This study calls for further research on adapting DBT for adolescents and children, as the duration of treatment was short, the sample was small, and there was no control group. Additional considerations are that DBT with this population required parental reinforcement and involvement in teaching the DBT skills (Perepletchikova et al., 2011). Not all families may be willing to provide the additional assistance necessary for this treatment to work with this population.

DBT was originally designed for BPD and has been effective with adults as well as adolescents and children. Salsman, Harned, Secrist, Comtois, and Linehan (cited in Burckell & McMains, 2011) reported that approximately 36% of individuals diagnosed with BPD fail

to respond to DBT. This statistic provides evidence that additional research is necessary to enhance treatment for individuals with BPD.

DBT to Treat Individuals with Substance Use Disorders

The current research on DBT to treat substance use disorders has been with dually diagnosed individuals with BPD and substance use disorders. Linehan, Schmidt, Dimeff, Craft, Kanter, and Comtois (1999) studied 28 women (aged 18–45 years) with BPD and drug dependency. There was a DBT group ($n = 12$) and a treatment as usual group ($n = 16$). The study obtained results at a 4-, 8-, 12-, and 16-month follow-up. The DBT group implemented DBT protocol (individual psychotherapy, group skills training, and as-needed phone consultation) minus team consultation meetings. The treatment as usual group received alternative substance use and mental health counseling, either in a community program or with their own psychotherapists. Results indicated that the DBT group had a lower drop-out rate (36%) compared to the treatment as usual group (73%). Efficacy of the program was measured by urinalysis and structured clinical interviews. These measures indicated a reduction in substance use among the DBT group, as well as improvement in social and global functioning, particularly at 16-month follow-up (Linehan et al., 1999). This study indicated the efficacy of DBT with individuals with BPD and substance use issues. Results also indicated that within the DBT condition, participants who worked with therapists that consistently adhered to the DBT treatment manual had better outcomes than those who did not follow the complete protocol (Linehan et al., 1999). This suggests that complete protocol was one factor that made DBT effective. This could also be a limitation, as not all therapists may be familiar or trained in implementing the protocol. The clients' success is partly related to the therapist's competence in DBT.

Linehan, Dimeff, Reynolds, Comtois, Welch, Heagerty, and Kivlahan (2002) studied 23 women with BPD who were also heroin-dependent over a 12-month period (average of 36.1 years of age). Linehan et al. (2002) compared the effects of DBT ($n = 11$) versus a comprehensive validation therapy in conjunction with a 12-step program and its effect on substance use ($n = 12$). The women either received DBT treatment or the comprehensive validation therapy and 12-step program. In addition, participants received concurrent opiate agonist therapy and were provided with levomethadyl acetate hydrochloride oral solution (Linehan et al., 2002). The assessment methods were urinalysis, interviews, and self-reports. Results indicated that both treatments were effective in reducing opiate use. Although both were effective, the DBT group maintained the decrease in opiate use through 12 months of active treatment, whereas the other group had an increase in opiate use in the last 4 months of treatment (Linehan et al., 2002). One significant difference amongst the groups was that only 64% of the individuals in DBT completed the treatment, whereas the other group had 100% completion rate. The results indicate that DBT did not have as high of treatment retention as it had in the past when compared to treatment as usual. This may be due to the validating, accepting, and nurturing aspect of comprehensive validation therapy, whereas DBT is intense and structured.

Van den Bosch, Verheul, Schippers, and Van Den Brink (2002) conducted a qualitative study examining whether DBT can be successfully implemented in women with and without comorbid substance use disorders. The hypothesis was that DBT was effective in reducing BPD symptoms among those with substance use disorder, as well as for those with BPD without substance use disorder. This study involved a larger sample ($N = 58$) of women ages 18–70 years with BPD with substance use disorder ($n = 31$) and women with BPD

without substance use disorder ($n = 27$). The study compared DBT with treatment as usual. Results indicated that DBT applies to both individuals with BPD with and without substance use disorders. Further findings were that DBT resulted in greater reductions of BPD symptoms than treatment as usual (Van den Bosch et al., 2002). Therefore, it was found that DBT was effective in reducing BPD symptoms but not more effective than treatment as usual in reducing substance use issues.

Axelrod, Perepletchikova, Holtzman, and Sinha (2011) evaluated improvement in emotion regulation as well as the relationship between improvement in emotion regulation and substance use. Emotion regulation was assessed by the Difficulties in Emotion Regulation Scale, depressed mood was assessed by the Beck Depression Inventory, and the associations with substance use frequency were also addressed at the beginning, middle, and end of treatment (Axelrod et al., 2011). This study involved 27 women with substance dependence and BPD that received 20 weeks of DBT offered in an academic community outpatient substance use disorder treatment program (Axelrod et al., 2011). Results indicated an improved emotion regulation, improved mood, and decreased substance use frequency.

Although other studies have been done on the use of DBT in the treatment of individuals with BPD and substance use disorders, this is the first study that evaluated specifically emotion regulation. Although the results of this study show DBT to be effective in individuals who have substance use disorders, all participants in the study also had BPD, which DBT was created to treat. Although DBT is found to be effective in treatment and enhancing emotion regulation with this population (Axelrod et al., 2011), the database research revealed no outcome studies of the use of DBT with individuals with substance use disorders without accompanying BPD.

DBT to Treat Individuals with Eating Disorders

In addition to substance use disorders, DBT has been shown to be effective for individuals who have eating disorders. Hill, Craighead, and Safer (2011) studied the efficacy of DBT, specifically an appetite-focused DBT treatment program, to treat bulimia nervosa. Women ($N = 32$) with binge-purge episodes at least one time per week were studied over the course of 12 weekly sessions. The appetite-focused DBT group ($n = 18$) met for 12 weekly sessions. The control group received a six-week delayed treatment ($n = 14$). The assessment used was the Eating Disorder Examination interview and self-report. Assessments were conducted at baseline, 6 weeks and posttreatment. At 6 weeks, participants receiving 12-weeks of appetite-focused DBT reported significantly fewer binge-purge episodes. At posttest, a total of 26 participants ($n = 18$ from 12-weekly appetite-focused DBT group, and $n = 8$ from the delayed treatment control group) were abstinent from binge-purge episodes for the past month. Thus, 61.5% no longer met full criteria for bulimia nervosa. This study shows promising results for appetite-focused DBT for individuals with bulimia nervosa; although, appetite-focused DBT needs more research before it can claim it is more effective than traditional DBT or cognitive behavioral therapy for the treatment of individuals with bulimia nervosa (Hill et al., 2011). This study supports the use of DBT treatment for women with bulimia nervosa. The fact that it excluded individuals who also have coexisting BPD can be seen as both a limitation and a benefit of DBT. The benefit is that it shows that DBT may be effective as a primary treatment for eating disorders and not just BPD; The limitation is that results cannot be generalized to the BPD population.

Safer, Telch, and Agras (2001b) studied adaptations of DBT and its effect on 31 women ages 18–54 with binge-purge episodes occurring at least once a week for the previous

3 months. The women were randomly assigned in blocks of eight to a 20-week treatment of DBT, or 20 weeks in a control group that was on a waiting list. Out of the blocks of eight, four women were assigned to the DBT group, and four women were assigned to the control group. Treatment consisted of weekly 50-minute individual sessions. Rather than using appetite-focused DBT, the study implemented traditional DBT, focusing on the emotion regulation module. Efficacy of the treatment was measured by the Eating Disorder Examination, the Negative Mood Regulation Scale, the Beck Depression Inventory, the Emotional Eating Scale, the Multidimensional Personality Scale, the Positive and Negative Affect Schedule, and the Rosenberg Self-Esteem Scale (Safer et al., 2001b). The primary measure was the frequency of binge-purge episodes. Results showed that 28.6% of the DBT group were abstinent from binge-purge behaviors at 20 weeks, whereas the control group had no participants who were abstinent from such behaviors (Safer et al., 2001b). Although only 35.7% of the DBT group met Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for bulimia nervosa at the end of 20 weeks, 80% of the control group continued to meet DSM criteria for bulimia nervosa (Safer et al., 2001b). Results showed no significant differences for mood regulation, emotional eating, affect, and self-esteem between the DBT group and the control group. This study suggests that DBT adapted for bulimia nervosa is effective in decreasing ineffective behaviors (Safer et al., 2001b). Although this study suggests DBT is promising when adapted for this population, Safer et al. (2001b) recommended replicating the study with larger numbers and having more than one control group better to generalize the findings. Safer et al. (2001b) also suggested that future research examine the characteristic traits of the women who were responsive to the DBT treatment.

Telch, Agras, and Linehan (2000) also studied the efficacy of DBT adapted for individuals with eating disorders, particularly focusing on emotion regulation. Their study focused on binge-eating disorder rather than bulimia nervosa and there were few participants in this uncontrolled study. Women ($N = 11$) with binge-eating disorder were given the Eating Disorder Examination. In addition, weight, mood, and affect regulation were measured pre- and posttreatment, as well as at 3- and 6-month follow-ups (Telch et al., 2000). By the end of treatment, 82% of the women were abstinent from binge-eating behaviors and maintained during the 3- and 6-month follow-ups (Telch et al., 2000). This study needs to be replicated with an increased number of participants as well as with a control group before it can be generalized. Moreover, the results may also be more generalizable if the study uses additional measurements for mood, such as the Negative Mood Regulation Scale, the Beck Depression Inventory, the Emotional Eating Scale, and the Positive and Negative Affect Schedule, that Safer et al., (2001a) employed in their study.

Chen, Matthews, Allen, Kuo, and Linehan (2008) looked at DBT with minimal adaptation for women with binge-eating disorder, bulimia nervosa, and BPD ($N = 8$). DBT involved 6 months of weekly skills group, individual DBT, therapist consultation team meeting, and 24-hour telephone coaching. Assessments were done pre- and posttreatment and at 6-month follow-up. Chen et al. (2008) assessed progress with the Eating Disorders Examination, Personality Disorders Exam, and the Structured Clinical Interview for DSM-IV. Although this study suggests that DBT was useful in decreasing binge-eating behaviors and suicidal behaviors, it needs to be replicated with a larger population before generalizing the results.

Glisenti and Strodl (2012) also examined binge-eating behaviors and the use of DBT in its treatment in four case studies of individuals who were obese and also rated high on emotional eating. The studies involved 22 sessions with two participants receiving CBT and two receiving DBT. Assessments studied weight, body mass index, emotional eating, depression, anxiety, and stress measured prior to, during, and after treatment (8-week follow up). The two individuals that received DBT lost 10.1% and 7.6% of their initial body weight (Glisenti & Srtodl, 2012). The individuals who received CBT lost 0.7% and 0.6% of their initial body weight (Glisenti & Strodl, 2012). Emotional eating behaviors decreased, as well as the amount of food eaten in one binge episode. The CBT cases showed no change in those areas. This study suggests that the individuals who received DBT addressed emotion regulation and distress tolerance issues and that DBT was more effective than CBT in decreasing emotional eating behaviors (Glisenti & Strodl, 2012). This article addresses only four cases not randomized and there could be many uncontrolled factors, and more research is needed on the use of DBT with this population. The researchers also stated that in future research it is important that clients have grasped the concept of mindfulness, given these skills were core skills for learning the other DBT modules (Glisenti & Strodl, 2012).

Safer, Telch, and Agras (2001a) reported a 20-session case study using DBT in the treatment of bulimia. The goal of the study was to replace eating disordered behavior with emotion regulation skills. The client, a 36-year-old woman, had a history of bulimia that had not responded to two years of counseling. In the four weeks before treatment began, she reported 13 objective binges and 21 purging episodes (Safer et al., 2001a). Safer et al. (2001a) stated that after engaging in DBT, the binge-purging behaviors rapidly declined, and by the fifth week of treatment, she had maintained abstinence. In the 6 months following

treatment, she reported a total of two objective binge episodes and two purge episodes. While these results must be considered with caution, since they come from a case study, they contribute to the body of evidence that DBT may be effective in treating eating disorders.

Kröger, Schweiger, Sipos, Kliem, Schunert, and Reinecker (2010) looked at DBT as an inpatient treatment for 24 women with co-occurring BPD and anorexia or bulimia who previously did not respond to other treatment modalities for their eating disorders. Of the 24, 9 had anorexia and 15 had bulimia in addition to BPD. The researchers assessed increases in body weight for the participants with anorexia and decreases in binge-eating episodes for those with bulimia at pretreatment, posttreatment, and follow-up. At follow-up, the remission rate was 54% and 34% for bulimia and anorexia, respectively (Kröger et al., 2010).

Fortunately, for the women with bulimia, the frequency of binge-purging episodes was reduced. Unfortunately, for the women with anorexia, the mean weight was not increased posttreatment. For both groups in this sample, global psychosocial functioning was improved posttreatment (Kröger et al., 2010). Although this study suggests that DBT may be effective in the treatment of women with eating disorders, it also shows that this treatment could use improvements as adapted for inpatient use, or an outpatient follow-up component, due to the high remission rates and continued use of eating disorder behaviors after treatment (Kröger et al., 2010).

These studies show how traditional DBT as designed for BPD was adapted to address the needs of individuals with eating disorders. The protocol was adapted in several ways such as using appetite-focused DBT and using DBT as inpatient treatment rather than outpatient. These studies show that DBT adapted for this population can be promising. The studies also indicate what future studies could examine for results to be more generalizable.

DBT to Treat Individuals with Depression

In addition to treating BPD and eating disorders, DBT has also been shown to be effective for individuals with depression. Huss and Baer (2007) looked at DBT and mindfulness-based cognitive therapies in the treatment of depression, specifically acceptance and change. Huss and Baer suggested that the mindfulness component of DBT can be effective for individuals with depression.

Lynch, Morse, Mendelson, and Robins (2003) studied the use of DBT with older adults with depression, comparing antidepressant medication treatment versus DBT (skills training and phone consultations) plus antidepressant medication. They studied 34 individuals 60 years and older over a 28-week period. Results indicated a significant decrease on self-rated depression scores for the individuals in the medication plus DBT group (Lynch et al., 2003). Furthermore, 71% of this group were in remission based on interviewer-rated depression scores versus 47% of the medication alone group. This difference continued at the 6-month followup, when 75% of the medication and DBT group were in remission versus 31% of the medication alone group. The medication and DBT group had significant decreases in dependency and adaptive coping from pre- to posttreatment, whereas the medication only group did not (Lynch et al., 2003). These results indicate that DBT skills training and DBT phone consultations may be more effective when implemented in combination with antidepressants. Note that this study was only implemented with older adults and did not evaluate the use of antidepressants with DBT in other aged individuals with depression. Furthermore, this study had a small number of participants and may not be generalized.

Lynch, Cheavens, Cukrowicz, Thorp, Bronner, and Beyer (2007) reported a study on the use of DBT for older adults with personality disorders and depression. The study examined 34 chronically depressed individuals aged 60 and older who scored at least an 18 on the Hamilton Rating Scale for Depression or at least a 19 on the Beck Depression Inventory. The participants were studied over 28 weeks and were randomly assigned to receive antidepressants only or antidepressants in conjunction with standard DBT group skills training and weekly 30-minute individual telephone consultations. This study did not implement the DBT protocol, as participants did not receive in-person individual therapy (Lynch et al., 2007). The results indicated that 71% of those who received medications plus DBT were in remission at posttreatment versus 47% of those who received medication alone (Lynch et al., 2007). The remission rate continued to increase to 75% at the six-month follow up for those who received DBT plus medication. Although there were not significant differences in depressive symptoms and mood, this study shows that using standard DBT in addition to antidepressants in the treatment of older adults with depression and a comorbid BPD led to remission more quickly than medication alone (Lynch et al., 2007). Moreover, Lynch et al. showed how a new, adapted dialectical model was created for this population and may be created for other populations. It is suggested the study be replicated with larger numbers before using DBT in the treatment of depression.

DBT to Treat Individuals with History of Trauma

Given its development for individuals with BPD, it is not surprising that DBT has been used to treat the effects of trauma, as trauma can cause the onset of BPD. Harned, Jackson, Comtois, and Linehan (2010) studied DBT in the treatment of 51 women with BPD with suicidal ideation and/or engaging in self-injury, 26 whom also met criteria for

posttraumatic stress disorder (PTSD); (Harned et al., 2010). Due to the behaviors associated with BPD, many of these women were excluded from receiving posttraumatic stress disorder treatment. Exclusion criteria for PTSD treatment were imminent threat of suicidal behavior, recent self-injurious behavior (past 4 months), substance dependence, and severe dissociation (Harned et al., 2010). The goal of this study was to reduce those behaviors so the participants could be involved in posttraumatic stress disorder treatment. The participants with and without PTSD were treated with standard DBT for one year and were assessed at pretreatment and at 4-month intervals throughout treatment. Assessments implemented were The Suicidal Behaviors Questionnaire, The Suicide Attempt Self Injury Interview, The Longitudinal Interval Follow-Up Evaluation, and The Dissociative Experiences Scale-Taxon (Harned et al., 2010). Results indicated that by posttreatment, 50–68% of the participants would have met criteria for PTSD treatment, indicating that their exclusion criteria behaviors had decreased (Harned et al., 2010). This study suggests that DBT can be helpful in reducing behaviors associated with BPD. It also indicates that PTSD does not prohibit DBT from being effective in treating BPD. It is suggested that this study be replicated for individuals with PTSD without BPD to assess whether DBT is an appropriate way to treat PTSD (Harned et al., 2010). Furthermore, the participants in this study were women; since the study excluded men, and the findings cannot be generalized to men. On the other hand, given that a large number of individuals with BPD also have PTSD, it is important to further research treatment for these comorbid disorders. DBT can help women with BPD and PTSD to stabilize to a place where they are able to participate in PTSD treatment.

One study that examined the treatment of trauma-related issues with women without BPD was with women who had experienced domestic abuse. A pilot study of 31 women

suggested DBT to be effective for reducing depressive symptoms, hopelessness, and distress with this population (Iverson, Shenk & Fruzzetti, 2009). Iverson et al. implemented a 12-week DBT program modified for female victims of domestic abuse, in which the participants learned different DBT skills from all four modules each week. Each 2-hour group was comprised of 6–8 women and addressed the following: (a) new skills were taught and practiced, (b) the use of previously learned skills was reviewed and encouraged, (c) problems in applying skills to daily life were analyzed and practiced again (targeting, chain analysis, problem solving, commitment), (d) opportunities for engaging in more effective and skillful behaviors in the coming week were planned (generalization such as regular practice focused on treatment targets relevant to daily life), and (e) support, encouragement, and validation were provided both by the therapists and by other group members. Pre- and posttreatment measures were obtained through the Beck Depression Inventory, Beck Hopelessness Scale, Social Adjustment Scale (Self-Report), and the Symptom Checklist. A within-subjects repeated measure of analysis of variance was conducted on all self-report measures to assess treatment effects (Iverson et al., 2009). Results indicated that women who completed the treatment group demonstrated statistically significant improvement on outcomes measures at postintervention compared to their own preintervention scores (Iverson et al., 2009). Findings of this study suggest that DBT can be used to enhance psychological and social well-being in this population; however, this study did not have a control group. In addition, the participants were primarily Caucasian, low-income women and results cannot be generalized to a more diverse population (Iverson et al., 2009).

Steil, Dyer, Priebe, Kleindienst, and Bohus (2011) examined the use of DBT in combination with trauma-focused cognitive behavioral approaches to treat adults with PTSD

from childhood sexual abuse. This study focused primarily on issues of acceptance and safety and was based on three main goals: to reduce fear of trauma-associated primary emotions, question secondary emotions, and radically accept trauma facts (Steil et al., 2011).

Participants ($N = 29$) were women with PTSD arising from chronic childhood sexual abuse plus at least one other comorbid disorder (Steil et al., 2011). Over an average of 82 days, participants received two weekly 35-minute sessions of individual treatment and weekly group treatments: 90 minutes of skills training, 60 minutes of group intervention focusing on self-esteem, three 25-minute mindfulness sessions, and 60 minutes of PTSD-specific psychoeducation. Some participants attended creative arts therapy groups including music therapy. Measurements included the Posttraumatic Diagnostic Scale, Symptom Checklist 90-Revised, Beck Depression Inventory, and State Trait Anxiety Inventory. Participants were assessed pretreatment, posttreatment, and at 6 weeks follow-up, primarily regarding overall PTSD severity, and secondarily depression, anxiety, and symptoms of comorbid disorders. Results indicated a decrease in overall PTSD severity posttreatment and decrease in secondary outcomes (Steil et al., 2011). This study shows the efficacy of using DBT to treat this population in a residential setting, which cannot predict the efficacy of this treatment implemented on an outpatient level. Certain behaviors could have been decreased due to the constant supervision inherently provided in residential treatment. Also, it was not determined which DBT components led to more effective behavior versus the cognitive behavioral components (Steil et al., 2011). Steil et al. (2011) reported that this intervention is more effective than no intervention.

An adapted version of DBT has also been used in the treatment of PTSD for individuals who had been victims of sexual assault or sexual harassment while in the military

(Spoont, Sayer, Thuras, Erbes, & Winston, 2003). This studied both female ($n = 33$) and male ($n = 50$) participants who were studied over about a 4-year time span. Most of the participants (31 women and 42 men) met DSM-IV criteria for PTSD. The participants underwent treatment with adapted DBT. DBT was implemented because the needs of this population have not been effectively addressed through typical treatments for PTSD, such as exposure therapy. Such needs are personality disorders, substance use disorders, and retraumatization. Four major modifications were made to the DBT protocol: limiting the 24/7 therapist coaching calls to normal clinic hours, addition of skills tutors, creation of a DBT step-down group, and decreasing length of session times (Spoont et al., 2003). Efficacy of the program was based on the clients' perceptions and satisfaction. Their input was received via a survey posttreatment. Most (55%) indicated that they were very satisfied with the experience, noting that it increased their quality of life (Spoont et al., 2003). Although this study was not a randomized controlled trial and did not have measurements pre- and posttreatment, this study is significant in that it shows the ways in which DBT has been adapted to meet the needs of different populations that otherwise may not receive the treatment needed. This adapted DBT program provided this population an opportunity to address substance use issues, impulsivity, mood instability, and interpersonal difficulties that they may not have addressed in traditional treatment for PTSD.

Spoont et al. (2003) suggested that traditional treatments for PTSD may not be effectively treating the symptoms and that an adapted DBT program would better meet the needs of this population. Harned and Linehan (2008) suggested that a combination of exposure therapy and DBT can effectively meet the needs of individuals with PTSD and BPD. This study implemented standard DBT with a combination of the PTSD protocol with

two individuals with BPD and PTSD related to an adult sexual assault over a one year time frame. The PTSD protocol uses a 90- to 120-minute weekly exposure session and consisted of three phases: pre-exposure, exposure, and termination/consolidation (Harned & Linehan, 2008). After mastering the DBT skills, exposure therapy was implemented in addition to DBT. The two participants received one individual exposure session and one individual DBT session led by the same therapist once a week. The number of exposure sessions was individualized. Measurements used the PTSD Checklist, Borderline Symptom List, and an Exposure Recording Form (Harned & Linehan, 2008).

The first individual (30-year-old Caucasian female) received 5 months of DBT intervention prior to starting the PTSD treatment. The DBT focused on getting self-injurious behaviors under control. The PTSD protocol was implemented in an 11-week time frame. After treatment, the individual showed an increase in radical acceptance of the trauma, a decrease in the severity of BPD symptoms, and an increase in feeling emotions (Harned & Linehan, 2008). The second individual (48-year-old Caucasian female) received 8 months of DBT intervention prior to starting the PTSD treatment in the eighth month. The DBT also focused on getting self-injurious behaviors under control. The PTSD protocol was implemented in 12 weekly sessions. At the end of treatment, this participant no longer met the criteria for PTSD. Furthermore, the self-injury and suicide urges decreased from moderate to low; the primary emotions associated with the trauma decreased; BPD symptoms decreased; and there was an increase in radical acceptance of the trauma (Harned & Linehan, 2008).

This study shows the effectiveness of integrating DBT with exposure therapy for individuals with BPD and PTSD. Although there are traditional treatments for PTSD, many

of the treatments have exclusion criteria such as individuals who are suicidal, self-injure, or have are multiple diagnoses, which are often traits of individuals with BPD (Harned & Linehan, 2008). Trauma is very common in individuals with BPD, and this is an underserved population. Findings on the efficacy of traditional treatments with PTSD cannot be generalized to the BPD population. This study is significant because it shows how exposure therapy and DBT can be combined to provide treatment for individuals with BPD and PTSD.

Wagner, Rizvi, and Harned (2007) also studied two women in their 30s who had BPD, additional comorbid disorders, and a history of trauma from childhood and adulthood. The treatment of both individuals implemented DBT used in combination with a traditional treatment for trauma. The treatment for the trauma differed, as the first case implemented standard DBT with an exposure-based treatment, and the second case implemented standard DBT with modified prolonged exposure treatment (Wanger et al., 2001a). Although DBT was used as the primary intervention, this study also supports the findings of Harned and Linehan (2008) that DBT can be used in combination with traditional treatment for PTSD for individuals that also have BPD. Although the principles that guide DBT can be effective in treating coexisting problems such as PTSD and BPD, it is suggested that DBT alone has not been shown effective for the treatment of trauma (Wagner et al., 2001a). DBT is more commonly used to stabilize behaviors prior to entering treatment for the trauma, but this study only examined two women with childhood trauma. The results may not be generalizable to individuals who have experienced trauma as adults, men, or individuals with PTSD without BPD.

Summary of DBT

Although DBT was designed for individuals with BPD, it has also been adapted to use with a variety of other populations including individuals with substance use disorders, eating disorders, depression, self-harm, and trauma, and co-occurring disorders. The use of DBT with substance use disorder indicates that it is effective in treatment for this population, specifically in enhancing emotion regulation (Axelrod et al., 2011). DBT in the treatment of eating disorders is effective in decreasing symptom use, specifically binge-purge behaviors (Safer et al., 2001a). In depression, DBT has been effective in leading to remission rates more quickly than medication alone (Lynch et al., 2007). DBT has also been used to treat self-harm behaviors, problematic internalizing behaviors, and suicidal ideation, and to provide adaptive coping skills (Perepletchikova et al., 2011). Furthermore, DBT has been used in the treatment of trauma to reduce depressive symptoms, hopelessness, and distress in women who have experienced domestic abuse (Iverson et al., 2009). Although these studies suggest the effectiveness of DBT in treatment of various populations, each study has limitations, and further research needs to be done in this area.

Music Therapy

Music therapy is the use of music experiences to address individualized nonmusical goals within a therapeutic relationship by a credentialed, board-certified music therapist (American Music Therapy Association, 2013b). It can be used to address physical, emotional, cognitive, and social needs. Music therapists use instrumental and vocal music strategies to facilitate nonmusical changes (American Music Therapy Association, 2013b). The music therapist modifies both the music and music interventions to address

individualized client strength and needs within group and individual settings. Music therapy is based on individual assessment, treatment planning, and ongoing program evaluation.

Music Therapy in the Treatment of Mental Disorders

Music therapy is an efficacious and valid treatment for persons who have psychosocial, affective, cognitive, and communicative needs (American Music Therapy Association, 2013b). Music provides a safe and supportive environment to explore the self. Music therapy with mental health populations can help individuals with self-expression, with communication, with developing relationships, and with addressing issues that may not be able to be addressed using words alone. This can be done through active music making, music listening, and music discussion. One can expect a music therapist to assess emotional well-being, physical health, social functioning, communication abilities, and cognitive skills through music (American Music Therapy Association, 2013b).

There are many goals that music therapists can address through music experiences with the mental health populations. These include exploring personal feelings, increasing self-esteem and personal insight, and making positive changes in mood and emotional states (American Music Therapy Association, 2013b). Music therapy with this population may also address increasing a sense of control over life through successful experiences, enhancing awareness of self and environment, and expressing oneself both verbally and nonverbally. Music therapy can assist in developing coping and relaxation skills, supporting healthy feelings and thoughts, and improving reality testing and problem solving skills (American Music Therapy Association, 2013b). Furthermore, music therapy can provide opportunities to interact socially with others, to develop independence and decision making skills, to improve concentration and attention span, to adopt positive forms of behavior, and to resolve

conflicts leading to stronger family and peer relationships (American Music Therapy Association, 2013b).

Music Therapy to Treat Individuals with BPD

There is limited research on the use of music therapy in the treatment of individuals with BPD. Odell-Miller (2011) found that both theme-based and free improvisation, sometimes involving musical role play, were useful for this population. Music therapy can be used to help this population explore and overcome feelings of shame and to develop self-worth. The sessions began in a structured manner and eventually became less structured for individuals with BPD. Music can provide a link between emotion and thought and can heighten understanding of expression of emotion. Music can also allow for breaking from rigid patterns of thought and lead to lessening destructive behaviors (Odell-Miller, 2011). One limitation is that there is not much research using music therapy with this population, and its efficacy has not been replicated, but there is additional research on the positive effect of creative arts therapies with this population.

Music Therapy to Treat Individuals with Substance Use Disorders

Music therapy has also been used in the treatment of individuals with substance use disorders (Baker, Gleadhill, & Dingle, 2007; Dingle, Gleadhill, & Baker, 2008; Jones 2005). Baker, Gleadhill, and Dingle (2007) studied the use of music therapy in a CBT framework in the treatment with this population. The investigators examined whether music therapy programs within a CBT framework allowed for facilitation of exploring emotions. Over a 7-week trial ($N = 24$, ages 17–52), the impact of a single music therapy session on emotional exploration was assessed using a self-report questionnaire. Baker et al., (2007) implemented CBT techniques such as problem solving, communication styles, and planning one's day.

Emotions explored included depression, anger, and anxiety. Self-esteem and self-identity were also explored. Baker et al. used lyric analysis, song writing/parody, improvisation, and song singing/listening within the CBT framework. Results showed that music therapy did facilitate the experience of mostly positive emotions at a moderate or high degree (Baker et al., 2007). Participants also reported that music therapy was beneficial in exploring emotions, and ultimately allowing them to experience the emotion fully without using symptoms. Baker et al. (2007) suggested that the music and the therapeutic relationship created a safe environment for individuals to explore a range of emotions. One factor to take into consideration is that 87.5% of the participants indicated that they had previously used music to regulate mood.

Dingle, Gleadhill and Baker (2008) conducted a follow-up to evaluate whether CBT in music therapy is an effective treatment for substance use disorders, with a particular focus on client engagement level. Over 7 weeks, 52 individuals with substance use issues participated in a 90-minute music therapy group once a week in addition to the traditional CBT treatment. The music therapy sessions utilized a CBT approach and addressed similar topics as in the 2007 study, including problem solving, communication style, and planning one's day. Emotions were also explored and included depression, anger, anxiety, and issues related to self-esteem and identity. The CBT music therapy sessions differed from the traditional CBT sessions because they provided an alternative way of learning the material. Instead of having predetermined content, the music therapy groups allowed for some flexibility in topics. A self-report questionnaire was used to measure motivation to participate, and 24 individuals completed the questionnaire. Results indicated that 70% of participants were "often" or "almost always" motivated to participate, 83.5% rated their

experience as “enjoyable” or “extremely enjoyable,” and 83% reported they would attend another music therapy group (Dingle et al., 2008). Although this study shows that music therapy was effective, enjoyable, and motivated participation, the study does not indicate how effective the music therapy was in addressing the CBT goals. Limitations are that the study did not have a control group, there were no pre- and postmeasurements to compare results, and there was a low response rate on the self-report questionnaire.

Similar to individuals with BPD using self-harming behaviors to numb emotions, individuals with substance use issues may use substances to numb their emotions; therefore, research with this population focuses on awareness of, identifying, and changing emotions. Jones (2005) supported the use of music therapy with this population and specifically examined which music therapy experiences are more effective in eliciting emotional change with this population in a single session. Participants attended either a songwriting ($n = 13$) or a lyric analysis group ($n = 13$). Measurements were made using a Visual Analog Mood Scale where eleven different emotions were represented. Measurements were completed pre- and postsession.

Results showed no significant difference between the two groups or which approach was more effective in creating emotional change (Jones, 2005); however, it was indicated that music therapy significantly increased positive feelings and reduced negative feelings. On a posttreatment questionnaire, 75% of the participants stated music therapy was a significant tool for their recovery (Jones, 2005). Although it appears that music therapy was effective for this population, there are several limitations to consider. First of all, this study only examined the immediate effects of one session and did not consider the long-term effects or effects of a series of sessions. If this study were to be replicated, it is suggested that there be a control

group that receives treatment as usual with no music therapy experiences used to better compare and contrast findings. Furthermore, this study does not consider that negative emotions are valid and vital in the recovery process. The important goal with this population is to experience emotions, and that does not imply only positive emotions.

Music Therapy to Treat Individuals with Eating Disorders

Music therapy has also been effective in working with people with eating disorders. Music therapy experiences effective with this population are music reinforced relaxation techniques such as stretching, progressive muscle relaxation, breathing, and directed imagery techniques; structured music therapy group techniques such as music and movement, hand bells, choir chimes, group singing, and instrumental improvisation; and insight-oriented music and imagery techniques (Justice, 1994).

McFerran, Baker, Patton, and Sawyer (2006) studied themes in songwriting with this population, specifically with adolescents ($N = 15$, 12–17 years) during a 2-year period. The researchers analyzed 368 lyrical units from 17 songs (McFerran et al., 2006). The units were analyzed using a modified content analysis (McFerran et al., 2006). Each lyrical unit was categorized into one of six themes: identity, relationships, aspirations, reference to disorder and its impact, emotional awareness, and seeking emotional support. The theme of “identity” was most frequently used (28%), with a subtheme of “exploring new behaviors, positive self-talk” being addressed most often (12.5%). This study showed the link between adolescents, their identity formation, and how the eating disorder plays a role in that formation (McFerran et al., 2006). Although this study shows that music therapy effectively invited the participants to share their story in a creative way, McFerran et al. supported member checking in future research, as there may be misinterpretation in the lyric analysis. It may also be useful to study

song writing with adolescents in other treatment settings with different mental health diagnoses (McFerran et al., 2006).

Rather than studying song writing, Trondalen and Skarderud (2007) studied the ways in which improvisation is used and its influence on affect attunement with a man with anorexia nervosa. Affect attunement is the sharing of inner feeling states and is important to address with individuals with eating disorders, which include disorders of affect regulation (Trondalen & Skarderud, 2007). This case study examined the ways in which affect attunement was expressed through musical instruments in music improvisation experiences. Trondalen and Skarderud (2007) asserted that the combination of music improvisation and verbal processing can provide a link between the body and mind, fostering a more coherent sense of self. This study was qualitative in nature and used identification of significant moments as a measurement. All music improvisations were recorded, and one music therapist researcher and the clinical music therapist listened to the recordings and both identified places in which “something was happening.” The places where the two music therapists agreed were identified as significant moments, or moments where the participant was experiencing affect attunement.

This study suggested that music improvisation effectively provided a way for this individual to connect with others and share his process in the disorder through a musical narrative and symbolism (Trondalen & Skarderud, 2007). As this study was a case study, results cannot be generalized. Furthermore, the music therapist implementing this type of work must be aware whether the feelings they are experiencing are their own or the clients (Trondalen & Skarderud, 2007).

Lejonclou and Trondalen (2009) described the use of individual music therapy with two individuals with eating disorders (one with anorexia and one with bulimia). In both cases, creative arts experiences such as creative writing, musical exploration, and movement to music were used to promote health, increase the body-mind connection, and increase self-confidence. This study viewed music as an external way to represent the internal world, and worked towards increasing the connection between the two worlds. These music therapy experiences provided an opportunity for the participants to identify and strengthen their inner resources, identify factors that block them from reaching their full potential, feel empowered, and support internal healing. Lejonclou and Trondalen (2009) suggest using, "... a relating music therapeutic approach to empower the clients, support inner healing, nourish hope of a normal life, and support life itself" (p. 89). The studies were case studies and cannot be generalized.

The use of CBT in music therapy has been effective with individuals with eating disorders. Hilliard (2001) combined CBT and music therapy and examined CBT on three levels: the behavioral issues, the cognitive distortions, and the underlying causes of eating disorders. Music was used to motivate clients as they engaged in the process of recovery. Song writing, singing, drumming, and lyric analysis were used to address CBT techniques. The goals of the music therapy groups, small groups, and individual sessions were (a) to establish a therapeutic relationship, (b) to educate clients about their cognitive view, (c) to address the need for behavioral and cognitive change, (d) to educate the client about body weight and the negative effects of dieting, (e) to reduce the frequency of eating disorder behaviors, (f) to teach problem solving skills, (g) to increase ability to express emotions, (h) to engage in cognitive restructuring, (i) to challenge body distortions, (j) to address relapse

prevention, and (k) to increase effective healthy coping skills (Hilliard, 2001). Music therapy served as a way to address these goals. Large music therapy groups were used to decrease anxiety about treatment, develop a sense of community, and foster healthy peer relationships and small groups were used to increase group cohesion and tension release. Musical games, sing-alongs, song writing, relaxation, music and breathing, music and movement, and music and imagery were also used. Although not music therapy, music was played during meal times to decrease anxiety about eating and increase coping skills.

Groups were often held after meals to discuss cognitive divergences, specifically the guilt and urges to purge after eating while also working towards recovery (Hilliard, 2001). This was addressed through sing-alongs, song writing, and musical games. In addition to teaching distraction techniques, there were also insight-processing groups, where theme-based issues such as self-esteem, embodying a sense of empowerment, and challenging negative body distortions were addressed. Music therapy allowed participants to address behavioral and cognitive issues in a nonthreatening environment in a supportive manner while challenging cognitive distortions and destructive behavioral patterns (Hilliard, 2001). Although the approach was effective for increasing self-awareness, among other positive benefits, the results may be limited to residential settings and may not apply to implementation in other settings.

Music Therapy to Treat Individuals with Depression

Maratos, Gold, Wang, and Crawford (2008) reported a systematic review of music therapy for individuals with depression. The purpose of this study was to identify randomized controlled trials and controlled clinical trials examining the efficacy of music therapy with this population, compare efficacy of music therapy with standard care, and compare the

efficacy of different forms of music therapy (Maratos et al., 2008). Findings suggested that music therapy is accepted by people with depression and is associated with improvements in mood.

Castillo-Pérez, Gomez-Pérez, Calvillo Velasco, Pérez-Campos, and Mayoral (2010) reported the effective use of music therapy in the treatment of individuals with depression ($N = 79$, ages 25–60 years). The participants were randomly assigned to a music therapy group ($n = 41$) or a psychotherapy group ($n = 38$). Exclusion criteria were individuals who take medication for their depression and anyone with a coexisting mental disorder. Prior to the study, participants completed the Zung self-rated depression scale and completed the Beck Depression Inventory each week during the 8-week study. Posttreatment, the participants completed the Hamilton Depression Scale. The music therapy group received one 50-minute session per week at the hospital, which only used Baroque and Classical music. The participants in this group also were encouraged to self-administer a 50-minute session once a day at home. The psychotherapy group was administered cognitive behavioral therapy sessions once a week for 50 minutes. Positive changes were noticeable during the fourth session with the music therapy group, and participants' symptoms had improved (Castillo-Pérez et al., 2010). Positive changes in symptoms continued through the rest of the study into the eighth and final week, with progress being assessed by the Beck Depression Inventory. Those scores for the music therapy participants showed an improvement in 29 participants, lack of improvement in 4 participants, and 8 that discontinued the music therapy group, whereas the psychotherapy group only had 12 participants who showed improvement, 16 without improvement, and 10 that discontinued the study. It was suggested that music can reintroduce pleasure into the lives of individuals with depression (Castillo-Pérez et al., 2010).

The authors recommended that music therapy be used to augment other therapies, rather than be the primary therapy for this population.

One possible limitation is that the study does not state whether the psychotherapy group members were encouraged to do any self-administered therapy work at home for 50 minutes once a day. It is possible that the music therapy group had greater benefits because they were self-administering treatment once a day for 50 minutes in addition to a weekly 50-minute music therapy group, whereas the psychotherapy group only received a weekly 50-minute group and no outside tools. Furthermore, this approach may misrepresent the field of music therapy, as it suggests that the participants were able to provide music therapy to themselves without a music therapist. Although the authors suggested that other studies have supported the use of Baroque and Classical music with this population, only providing this type of music could also be a limitation. If this study were repeated, it could be interesting to compare a music therapy and psychotherapy group versus just a psychotherapy group. This would better answer the question of whether music therapy is effective when used in conjunction with another therapy.

Hendricks (2001) also studied the use of music therapy with individuals with depression in a group setting with adolescents ($N = 63$, ages 13–18 years). The purpose of the study was to determine the effectiveness of adding music therapy techniques to a CBT group treatment for adolescents with depression. Researchers randomly assigned participants to four groups: Group one (junior high) CBT only, Group two (junior high) CBT + music therapy, Group 3 (high school) CBT only, and Group 4 (high school) CBT + music therapy, and conducted the study over a 12-week period. They administered the Beck Depression Inventory and the Piers-Harris Self-Concept Scale both pre- and posttreatment. Significant

differences in depression scores and increased self-concept were found between the groups that used CBT + music therapy versus the CBT groups for both age groups (Hendricks, 2001). The CBT + music therapy groups had improved their depression symptoms and increased their self-concept. Although music therapy appeared to be effective to treat depression when used in conjunction with CBT, this study only examined adolescents and may not generalize to the adult population. In addition, this studied a small number of participants and could be repeated with larger numbers before generalizing.

Chou and Lin (2006) studied the use of guided imagery and music with outpatient individuals with depression. The five participants were individuals with depression who received services from the psychiatric outpatient clinic of a medical center in southern Taiwan. Each individual received eight sessions. A therapist was hired by the researcher to provide the guided imagery and music sessions. Although the therapist providing the sessions held a doctorate in guidance and counseling, had training in psychotherapy and group therapy, worked in clinical psychiatry for ten years, and was a nursing supervisor in a psychiatric ward, the therapist was neither an advanced trainee in this specialty area and nor a fellow of the Association for Music and Imagery. Rather, the therapist's training in guided imagery and music consisted of attending seminars held by music therapy associations in Taiwan (Chou & Lin, 2006). The purpose of this study was to explore the listening experiences of the participants. A semi-structured, in-depth telephone interview was conducted within 24 to 48 hours after each of the 40 therapy sessions to explore the most reflective experience of the sessions (Chou & Lin, 2006). A content analysis method was used to identify 55 important listening episodes, or moments in the music that felt important to the listener, which the researchers categorized into five main themes. The themes that

Chou and Lin, 2006 identified were: (a) leisurely wandering in natural sceneries, (b) creation of surreal virtual surroundings, (c) recollection of past life experiences, (d) submersion in thematic music melodies, and (e) experiencing various physical relaxation events. The interviews helped establish that there were several factors that led to the experience of important listening episodes. Such factors to consider were the music, the individual, the therapist, and the environment (Chou & Lin, 2006). Chou and Lin (2006) also stated that music was seen to have the greatest effect (69.2%) on most memorable and significant imagery of the four factors.

Through this guided imagery and music experience, the participants were able to imagine qualities and situations that were needed to help alleviate symptoms of their depression. For example, Chou and Lin (2006) stated that one participant imagined a natural setting to relax and relieve anxiety. Another participant imagined a death scene and was able to work through feelings of anger and suicidal thoughts. Another participant was able to imagine a positive experience with her husband and realized that she desired intimate interactions. Through guided imagery and music, the participants were able to relax and rest, ultimately leading to improved physiological functions such as mood, blood pressure, heartbeat, and sleep (Chou & Lin, 2006). These examples show that music was an important component to the positive results found in this study. The article also suggests that guided imagery and music was influential in the treatment of individuals with depression; however, this studied only 5 individual case studies and results cannot be generalized.

Music Therapy to Treat Individuals with Self-Harming Behaviors

There is limited research on the use of music therapy to treat self-harm behaviors. The research that does exist supports the use of music therapy to address self-harm primarily

with individuals with developmental disabilities (Ford, 1999). Although using music therapy to address self-harm behaviors with this population has been effective, it has not been generalized to other populations. One music therapy article that addresses self-harm behaviors (Plener, Thorsten, Ludolph, & Stegemann, 2010) is described in section “DBT and Music Therapy.”

Music Therapy to Treat Individuals with History of Trauma

Music therapy has been found to be highly effective in developing coping strategies after a traumatic experience (American Music Therapy Association, 2013c). Music therapy can address increasing understanding and expressing feelings of anxiety and helplessness, supporting feelings of self-confidence and security, and providing a safe or neutral environment for relaxation (American Music Therapy Association, 2013c). Furthermore, music therapy has been shown to have a significant effect on an individual’s relaxation, respiration rate, self-reported pain reduction, and behaviorally observed and self-reported anxiety (American Music Therapy Association, 2013c). Music therapy with this population can address the following goals: (a) provide nonverbal outlets for emotions associated with traumatic experiences, (b) reduce stress and anxiety, (c) create positive changes in mood and emotional states, (d) increase active and positive participant involvement in treatment, (e) enhance feelings of control, confidence, and empowerment, and (f) create positive physiological changes (American Music Therapy Association, 2013c).

Gleadhill (2010) proposed a theoretical music therapy model for working with people with dissociative identity disorder who have experienced trauma, specifically from childhood sexual abuse. The model is based on Lev-Weisel’s (2008) intervention and treatment modalities for this population, which has four therapeutic goals, including (a) symptom

relief, (b) destigmatization, (c) increasing self-esteem, and (d) the prevention of future abuse. Music therapy experiences with a CBT approach were used to address the four therapeutic goals of treatment. The most effective music therapy experience in a single session was a task-oriented intervention, such as song writing and song parody. Other interventions implemented were music-assisted relaxation, instrument play, song listening, and group drumming. Songwriting was found to be most effective in addressing Lev-Weiesel's (2008) four treatment goals, particularly focusing on feelings of shame. The CBT approach, specifically the ABC model (activating event or situation, the beliefs or thoughts, and the consequent feelings and behaviors), was used during the song writing process (Gleadhill, 2010). This was done in a group to decrease feelings of isolation and stigmatization, as well as increase self-awareness which helps in preventing future abuse (Gleadhill, 2010). The CBT approach provided an opportunity for individuals to challenge feelings of shame and negative self-talk. These experiences helped increase self-esteem and provide symptom relief by allowing the individuals to feel like they were a part of a meaningful experience and was able to use the experiences as distraction techniques.

There is limited research on using music therapy with individuals who have experienced trauma. This study outlined a potential model, but it suggested that while implementing this model, it is important to consider the overall framework of the treatment program, session styles, session topics, and group rules and boundaries (Gleadhill, 2010). One possible limitation is that this model was developed for individuals with dissociative identity disorder and may not be applicable to all individuals who have experienced trauma and who do not have dissociative identity disorder.

Strehlow (2009) used improvisation with an analytical music therapy approach to treat children who had experienced sexual abuse. The psychoanalytic framework was based on three aspects of trauma: (a) destroying instances of good relationships, (b) sexualization of relationships, and (c) restriction of the ability to mentalize (Strehlow, 2009). This case study examined the use of analytical music therapy with an 8-year-old girl who had experienced sexual abuse. Through this case study, Strehlow (2009) proposed that music functioned in six stages: (a) music as a way of creating distance (b) music as a space for good and secure experiences, (c) music to make fright audible, (d) music as a way of mirroring emotional experiences, (e) music as a space for experimenting with new experiences of relationships, and (f) music as a space for pleasurable experiences. Additional functions of music with this population are (a) music as a way out of silence; (b) music as a way of mirroring emotional experiences; (c) re-enactment of traumatic relationship patterns through musical interactions; (d) music letting traumatic emotions be perceptible; and (e) music as a way of clarifying, persevering, and modulating unbearable experiences (Strehlow, 2009). This study shows how analytical music therapy was able to provide those functions and work through the trauma.

Although this approach seemed effective for this child, this article was a case study and may not be generalized. As this approach in music therapy uses metaphors, this treatment approach may be limited to individuals with high verbal and intellectual skills and may not be appropriate for all individuals who have experienced trauma.

Amir (2004) also supported the use of analytical music therapy with individuals who have experienced childhood trauma. This study examined a 32-year-old woman who had experienced childhood sexual abuse and was having difficulties forming relationships in her adult life. Amir (2004) described improvisational work in four developmental stages: (a) the

beginning stage: musical façade, (b) diving into the unconscious: exposing the trauma, (c) processing the trauma, and (d) integration/growth and renewal. This helped in exposing, dealing with, and healing the trauma by examining the nature of the trauma, the therapeutic process, the role of the therapist, and the role of the music (Amir, 2004). Techniques used were improvising to a specific title, reading a book while improvising, short projective improvisation, musical life story, improvising dreams, giving improvisations themes, and improvising one's history (Amir, 2004). Although this approach was effective in working with an adult who had experienced childhood sexual abuse, the results cannot be generalized, as this was a case study.

Another approach of improvisation that has been effective with adults who had been traumatized as children is vocal psychotherapy (Austin, 2001). Austin created vocal improvisation techniques such as empathy, mirroring, free associative singing, psychodramatic double, grounding, and holding. One vocal holding technique is the intentional use of two chords in combination with the therapist's and client's voice in order to create a consistent and stable musical environment (Austin, 2001). This approach has been effective with this population because it provides an opportunity to be connected to one's inner self; to explore the unconscious; and to explore memories and associations in a safe, structured environment. Traumatic memories can be stored in the body, and vocal psychotherapy can allow those memories to be accessed and projected through the voice (Austin, 2001). This study reported work with a 28-year-old woman and a 35-year-old woman who had experienced childhood trauma. Through vocal psychotherapy, both women were able to be heard and understood. Through the therapeutic relationship and the music experience, these women were able to further their process of healing the trauma. Although

the results showed that vocal psychotherapy was effective with these individuals, they were case studies and cannot be generalized.

In addition to improvisation, music skills training has also been effective in addressing self-expression and self-esteem, particularly with adolescents who have been through traumatic experiences (Clendenon-Wallen, 1991). Clendenon-Wallen studied 11 adolescents (ages 14–19) over a 12-week period in a verbal support group, examining self-confidence based on the Adjective Checklist. Only 3 of these individuals also received music skills training. Although results indicated that all of the participants had an increase in self-confidence, and there was no significant difference between those who also received music training and those who did not, it also was found that music increased verbalization, socialization, and created a safe space to discuss personal issues (Clendenon-Wallen, 1991). It is suggested that this study be replicated with larger numbers. It could also be beneficial if this were a randomized controlled trial with a music therapy group versus a verbal therapy group, rather than just studying three individuals.

Since this population can have a high level of stress arousal, relaxation and imagery can be used as coping skills. Depending on the client's cognitive and psychological state, the Bonny Method of Guided Imagery and Music can be implemented in treatment (Ventre, 1994). Ventre (1994) studied the use of this approach over a two-year period with a 32-year old woman that had been physically, emotionally, and sexually abused. Through this work, three themes emerged: building strength and trust to restore a sense of power and control over one's life, accessing and experiencing memories and feelings, and healing the wounds of trauma (Ventre, 1994). Ultimately, these sessions allowed this woman to heal the wounds of trauma and look forward to a healthier, more positive future (Ventre, 1994). Although the

Bonny Method of Guided Imagery and Music was effective with this individual, this was a case study and cannot be generalized. In addition, this work took place over a two-year period and may not be as effective in short-term treatment.

DBT Adaptations

Although DBT has a standard protocol specifically for outpatient treatment for adult individuals with BPD, there are several studies that examined the ways in which the DBT protocol was adapted in various ways for working with other populations in other settings (Chen et al., 2008; Glisenti & Strodl, 2012; Hill et al., 2011; Iverson et al., 2009; Lynch et al., 2007; Safer et al., 2001a, 2001b; Steil et al., 2011; Telch et al., 2000). In addition to being adapted for other populations and other settings, it is also suggested that DBT can be effective when combined with other therapy approaches such as Gestalt Therapy and exposure-based therapies (Harned & Linehan, 2008; Spont et al., 2003; Williams, 2010). Furthermore, Lynch et al. validated adapting DBT and creating a new dialectical model for treatment for older adults with depression and personality disorders. This approach combines standard DBT and geropsychology and addresses needs that are unique to older populations. Additions made were a focus on decreasing rigidity and increasing openness to new experiences and teaching skills about creating a life worth living throughout the life course (Lynch et al., 2007). Another addition is a fifth module that is divided into two parts: (a) looking forward and (b) looking back (Lynch et al., 2007). A treatment manual has been developed, and the next step is to conduct a randomized controlled trial based on the treatment manual to examine its effects with this population (Lynch et al., 2007).

Although there are many studies that support the effectiveness of standard DBT without adaptations, the protocol can be limiting for specific populations and treatment

settings. The work of Lynch et al. (2007) supported the use of adapting the standard DBT protocol to be more effective in addressing population-specific needs with other populations and to be more accessible and practical for other treatment settings. Furthermore, the works of Williams (2010), Harned, and Linehan (2008), and Spont et al., (2003) supported the effectiveness of combining DBT with other treatment modalities. Although there are limited studies on the topic of combining DBT with music therapy, further exploration of the topic may benefit a variety of populations.

DBT and Music Therapy

There are many resources that show the effectiveness of using music therapy with mental health populations (American Music Therapy Association, 2013b). Although there are several sources that supported the use of music therapy combined with CBT techniques (Baker et al., 2007; Dingle et al., 2008; Gleadhill, 2010; Hendricks, 2001; Hilliard, 2001), there is a gap in the music therapy literature stating whether and how DBT is being used in music therapy. Two studies describe how music therapy experiences can be used to address the goals of DBT (Kupski, 2007; Plener et al., 2010). Kupski (2007) outlined the use of DBT in combination with music therapy. The work is comprised of several case studies describing the function of music in the treatment of adult clients with BPD in an inpatient psychiatric hospital. He found that DBT in music therapy, specifically improvisation music therapy, helped clients with BPD to connect to, identify, and voice emotions (Kupski, 2007). Furthermore, music improvisation helped the clients make a connection between emotions and actions. This is particularly important with this population as they typically have an “emotion phobia” and avoidance of emotional experiences (Kupski, 2007). Using music

experiences to address DBT skills provided coping skills as replacement behaviors for self-harm.

Plener et al. (2010) also validated the use of DBT with music therapy. Plener et al. led 12 sessions of group music therapy (two hours each) with five female adolescents who had demonstrated self-injurious behavior. One participant had posttraumatic stress disorder and histrionic personality disorder; one participant had adjustment disorder; and the other three participants had depressive disorder, with one having attention deficit hyperactivity disorder as well. Sessions took place in a music therapy facility in the Department of Child and Adolescent Psychiatry and Psychotherapy at the University of Ulm. Within the twelve 2-hour sessions, every participant had a 20-minute individual therapy session with a child and adolescent psychiatrist who had dialectical behavior therapy for adolescents (DBT-A) training. Since the individual sessions happened within the time frame of the group session, the group was fully together only at the very beginning and at the very end of sessions. In addition to group and individual sessions, there were three parent group sessions at the beginning, middle, and end of the program.

The music therapy group sessions started with a short relaxation experience which utilized progressive muscle relaxation, in which participants learned mindfulness and relaxation with recorded music (Plener et al., 2010). In the first two sessions, participants were encouraged to discuss their musical preferences. They did this by bringing in music that was meaningful to them to develop an autobiography or “soundtrack” of their lives. This provided an opportunity for the participants to make connections between the music and their emotional states. After the first two sessions, the music therapy group focused on active music making, specifically recreating precomposed music. The group decided on tracks they

would like to perform as a group and rehearsed them. When performing the chosen songs, participants used electric guitar, keyboards, percussion, bass guitar, and drums and took turns playing each instrument. Flute also was incorporated, as two of the participants had experience in playing. This experience addressed interpersonal effectiveness skills, in that it focused on communication, working together as a group, and identifying one's role within a group (Plener et al., 2010). After a 2-month break, the final session ended with a day in a recording studio to produce a record.

The group band project was based on Keil (2005). Goals for such an experience were (a) interpersonal goals, (b) intrapersonal goals, and (c) general improvement of resources. Objectives were (a) improvement of soft skills; (b) cohesiveness; (c) improvement of therapeutic relationship; (d) activation, expression, and apperception of emotions; (e) improvement of adolescent development; (f) stabilization of self-confidence and self-perception; (g) motivation for therapy; (h) concentration, discipline, and stamina; (i) attainment of structure; (j) improvement of creative urges; (k) improvement of other resources; and (l) improvement of musical skills (Keil, 2005).

The DBT-A individual sessions had an overall theme of emotion regulation and identifying what emotions trigger urges for self-harm behaviors. The first session was primarily psychoeducational and taught about emotions and their relationship to thoughts and behaviors (Plener et al., 2010). Diary cards from the DBT-A manual were introduced at this time. The diary cards were a way to assess nonsuicidal self-injury (NSSI), suicidality, and self-injuring behavior and the way these behaviors are related to emotions (Plener et al., 2010). The diary cards were used as an assessment at the beginning of each session and prompted discussion about emotions and behaviors. The connection between emotions and

behaviors were further explored in the second and third sessions. The fourth and fifth sessions taught emotion regulation skills, which focus on how to increase identification and awareness of emotions. The sixth session introduced interpersonal skills by focusing on communication with family members. The seventh to eleventh sessions were used to identify triggers or difficult situations that create urges to use ineffective behaviors. The last session was a time for the participants to go back and acknowledge the difficult situations from the past 12 weeks that they handled successfully (Plener et al., 2010).

The parent sessions introduced a variety of didactic material as well as experientials. These experiences provided were psychoeducation about NSSI, music therapy, and DBT-A treatment; a mindfulness with music experience; a rhythm activity; a group discussion on their children's NSSI behaviors; how NSSI affects the family members; stress management skill training; and improvements they had noticed in their children throughout the treatment program (Plener et al., 2010).

Measurements for this study were chosen based on their ability to assess NSSI and were the Functional Assessment of Self-Mutilation, Self-Harm Behavior Questionnaire, and Beck Depression Inventory second edition (Plener et al., 2010). Other data for the study came from the weekly diary cards. Effectiveness of the program was also evaluated by a self-designed feedback form that was composed of 5-point Likert scale questions and open-ended questions. This feedback form inquired which elements and experiences were and were not helpful and what changes the adolescents had noticed in their behaviors (Plener et al., 2010).

The goals of this study were (a) to determine the feasibility of a combination of music therapy groups and individual DBT-A to be implemented in outpatient care, (b) to see if the combination of music therapy and DBT-A was effective in reducing clients' NSSI, and (c) to

see how participating in a group project affected individual behaviors and interpersonal skills (Plener et al., 2010). According to Plener et al., in regards to the first goal, the results indicated that the project worked well in an outpatient setting. Although the attendance was usually 100%, some of the groups were missing individuals at times due to suicidal crises that involved hospitalization. Results for the second goal indicated four out of five clients did not self-injure by the end of the program, which remained consistent at the 2-month follow up, in addition to reporting decreased levels of depression (Plener et al., 2010). As for the third goal, the program was reported as a positive experience for the participants and their parents. The participants responded well to the band work and rated it their favorite part of the program.

Although DBT was originally designed for BPD, one limitation of this study is that the researcher felt they were not able to help the one individual in the group with that diagnosis. Plener et al. (2010) suggested that the program would be a better fit for individuals with mild to moderate depression without NSSI. The participants in this study had comorbid disorders, and future studies would need to identify for which population this intervention is best suited. Another limitation is that the sample size was small ($N = 5$), and the results may not generalize, especially to men and adult populations. At the same time, the sample was also extremely heterogeneous (Plener et al., 2010). The participants were very different in their psychiatric histories, diagnoses, and levels of NSSI. Another limitation is that the study took place in an outpatient hospital setting rather than a school setting (Plener et al., 2010). This is a limitation because some of the participants in the group may have had former relationships with the leaders of the group from being hospitalized in the past. It is suggested

that schools rather than external agencies could be more helpful in decreasing NSSI (Fortune, Sinclair, & Hawton, 2008).

Another possible limitation could be that DBT-A sessions were done separately from the music therapy group, rather than teaching and reinforcing DBT skills through music therapy experiences. The music therapy inherently implemented DBT skills, but it is unclear if it was the focus. The active music making can also be viewed as a form of distraction and distress tolerance skill training. Another limitation of the study is that since the group blended theoretical approaches and the participants often left the group for individual DBT-A sessions, not all individuals were always present for the music therapy group. Furthermore, from this study, it is not clear if the benefits of the program were from DBT-A sessions, music therapy, or a combination of the two treatments.

Future studies on this topic could include an RCT comparing the effectiveness of addressing DBT skills through DBT-A versus music therapy, rather than providing the treatments in combination yet separately. The study also needs to be replicated with a larger number of participants. It would also be interesting to see what type of music therapy experiences would be more age appropriate for adults, rather than using the group band approach.

Active and Receptive Music Therapy Experiences

There are many different types of music therapy experiences used with mental health populations, including active and receptive methods (Bruscia, 1998). Active methods are experiences in which the client is actively making music either individually or with the music therapist. This can be recreating pre-existing music and improvisation. Recreating pre-existing music is when a client learns or performs vocal or instrumental pieces or reproduces

any kind of musical form (Bruscia, 1998). In improvisation experiences, the client creates music while playing or singing, extemporaneously creating a melody, rhythm, song or instrumental piece (Bruscia, 1998). The goals addressed in active music therapy can be but are not limited to (a) establishing a nonverbal channel of communication and creating a bridge to verbal communication; (b) exploring different aspects of the self; (c) exploring self in relation to others; and (d) developing creativity, expressive freedom, spontaneity, and playfulness (Bruscia, 1998).

Receptive methods are experiences where the client is listening to music. This can be a variety of experiences such as music for relaxation, guided imagery and music, drawing to music, movement to music, and lyric discussion. The goals addressed in receptive music therapy experiences are, but are not limited to (a) promoting receptivity, (b) evoking specific body responses, (c) stimulating or relaxing the client, (d) developing auditory/motor skills, (e) evoking affective states and experiences, (f) exploring ideas and thoughts of others and self, (g) evoking imagery, (h) stimulating peak and spiritual experiences (Bruscia, 1998). Active and receptive music therapy experiences can be used to address DBT skills (Spiegel, 2010).

Active Music Experiences to Address DBT Skills

Spiegel (2010) stated that active music making addresses several goals including increasing self-esteem, self-awareness, and self-expression. Active music making can also be used to address and reinforce DBT skills.

Recreating pre-existing music. Through playing precomposed music, individuals can address a variety of DBT skills. Being in the moment while making music can allow for an opportunity to practice mindfulness skills and allow the self to engage in the experience

nonjudgmentally. This type of experience also addresses emotion regulation skills by building mastery by learning the musical part. Distress tolerance skills such as distraction can also be addressed with this type of experience. Furthermore, when recreating music with a group of people, this experience can also address interpersonal skills.

Improvisation. Improvisation with a variety of melodic and nonpitched instruments can address mindfulness skills. The music that is created is original and cannot be recreated. There is no wrong way to play the music, and that allows one to be in the moment nonjudgmentally. This type of experience addresses emotion regulation skills by exploring and expressing one's emotions. Being engaged in music making can also serve as a distraction and address distress tolerance skills.

Song writing. Song writing can focus on affirmations, metaphors, and self-expression (Spiegel, 2010). This experience addresses mindfulness by providing an opportunity to focus on a single activity in the moment in a nonjudgmental way. It also addresses emotion regulation by allowing one to experience and express emotions. It allows one to access emotions in a creative and safe environment. Engaging in this type of experience can also lead to building a sense of mastery through a feeling of accomplishment that comes from finishing the song and knowing one contributed in a positive and healthy way. Clients may increase self-worth and self-awareness through the words they write, make meaning through their writing, and feel encouraged by engaging in this type of activity (Spiegel, 2010). Furthermore, when completed in a group setting, song writing provides an opportunity to address interpersonal effectiveness skills.

Receptive Music Experiences to Address DBT Skills

Spiegel (2010) suggested that receptive music experiences can address several goals including self-expression, self-exploration, and emotional release. Listening to music in a variety of ways can be used to address and reinforce DBT skills.

Music listening. Listening to music can provide opportunities for mindfulness, emotion regulation, and distress tolerance skill application (Spiegel, 2010). For example, listening to music and focusing on a specific instrument or voice can be a mindful experience by listening one-mindfully and being present in the moment. Listening to music can also help one identify, describe, and become more aware of feeling states. Music listening can also serve as a distraction (Spiegel, 2010).

Lyric discussion. There are several ways to implement lyric discussions. One way is for the therapist to suggest a song and use it to prompt discussion with the group. This addresses DBT skills by providing opportunities for mindfulness while listening to the music, allowing awareness of the emotions it inspires, serving as a distraction, and providing an opportunity to express oneself in the group. Another way to use lyric discussion is to have the group members contribute songs that are meaningful to them. This provides an opportunity for the individuals to express themselves, as well as to assess how they are feeling, and to become more aware of their emotional states. This addresses mindfulness by being nonjudgmental of their and others' song choices, interpersonal skills by expressing the self in a group, emotion regulation by being mindful of the current feelings, and distress tolerance by providing a distraction. Since songs can bring emotions to the surface, they can be used to understand one's emotions, to learn to tolerate the difficult feelings, and to implement DBT skills to effectively cope with emotions.

Musical Games. This type of music experience such as “Name That Tune,” “Sing The Next Line,” or “Music BINGO” may be used as distraction while also addressing teamwork, reality orientation, and skill reinforcement (Spiegel, 2010). These experiences address mindfulness by focusing on the lyrics and being present in the moment. It can address emotion regulation by increasing positive emotions by doing something that is fun. Furthermore, this type of activity can serve as a distraction and address distress tolerance skills such as self-soothing, willingness, and focusing on one thing in the moment. Since these activities are often done in a group setting, interpersonal effectiveness skills can also be reinforced through participating in these experiences.

Imagery. Guided imagery with music can be used to focus on relaxation and stress reduction (Spiegel, 2010). This could be used to address distress tolerance skills of increasing awareness of breathing and creating a relaxing space in the mind through imagery. Another goal is to connect with the wise mind by taking a “wise mind journey,” which addresses a central mindfulness skill (Spiegel, 2010). A script can be used to give prompts about finding the wise mind and spending time there. Guided imagery can also be used to focus on emotion regulation skills such as building mastery and positive experiences. This can allow one to become aware of the successes experienced in life and create a positive experience. This type of experience can engage all of the senses and can address the distress tolerance skills of self-soothing with the five senses and improving the moment (Spiegel, 2010).

Movement to music. One example of movement that can be used in music therapy to address DBT skills is passing one movement around the circle and taking turns with each group member being the leader (Spiegel, 2010). This allows one to address mindfulness by being focused on one person and movement at a time. This experience can be used to address

emotion regulation by building mastery and building positive experiences. Movement to music may provide an opportunity for one to engage in an activity even if they do not want to, or practicing opposite action (Spiegel, 2010). In addition, it can also address distress tolerance through distraction by engaging in activities.

Summary of DBT and Music Therapy

DBT has been shown to be effective with not only BPD, but also with a variety of psychiatric diagnoses. Although DBT has been an effective way to treat individuals with these diagnoses, there is little research on the use of music therapy to address DBT skills. There are many ways that DBT skills can be addressed through music therapy experiences. Music therapists may already be addressing the four components of DBT (mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation) through music therapy but do not know the DBT language; on the other hand, music therapists who are working with the DBT theoretical frame may not yet have published their work. A survey on the use of DBT components in music therapy would help reveal the ways in which music therapists are using DBT in music therapy. Also, the development of music therapy experiences for each of the four components for different populations would be helpful in applying DBT material to music therapy.

Purpose, Hypothesis, and Research Questions

The purpose of the study was to determine whether DBT is being implemented in music therapy, and if so, how. The researcher hypothesizes that music therapists are more likely to adapt the traditional DBT protocol to address the four components of DBT than to follow a strict DBT protocol in music therapy.

The research questions are:

1. Is DBT being incorporated into music therapy?
2. Who is implementing DBT in music therapy? With whom?
3. What DBT-specific training have music therapists who implement DBT in music therapy received?
4. How is DBT or elements of DBT being incorporated in music therapy?
5. What music therapy experiences are used to address mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness?
6. What are the perceived advantages of incorporating DBT into music therapy?
7. What are the perceived disadvantages of incorporating DBT into music therapy?
8. Why should music therapy be added to a therapy that already has empirical evidence for its effectiveness?

Chapter 3

Method

This chapter describes how the study was conducted. This chapter presents a description of the respondents for the study, the development of the survey instruments, the designs, the procedures, and the data analysis.

Respondents

For the survey, the researcher solicited respondents through email messages sent to 260 board-certified music therapists who work with mental health populations and are current members of the American Music Therapy Association (AMTA). Addresses were purchased from the AMTA's email address list.

A total of 48 music therapists, out of 260 identified, responded to the questionnaire, resulting in a response rate of 18.5%. All responses were included in the results. The respondents were 88% female ($n = 42$), while 13% were male ($n = 6$). The average age of the respondents was 39.3 years, ranging from 21 to 64 years, with a standard deviation of 12.0, but only 28 respondents listed their age. The average number of years' experience as a music therapist for the 29 who answered this question was 13.3 years with a range of 0 to 30 years, with a standard deviation of 10.2.

Nearly an equal number of respondents had completed a bachelor's degree in music therapy (41.7%), as had completed a master's degree program in music therapy (39.6%). Two respondents indicated that they were in a Masters of Music Therapy degree program. Table 1 shows results regarding educational background.

Table 1

Highest Educational Level Obtained

Degree Type	Frequency	Percentage
Bachelor's Degree	20	41.7%
Master's in Music Therapy	19	39.6%
Music Therapy Equivalency	3	6.3%
Other	3*	6.3%
Master's in Counseling	2	4.2%
Doctorate	1	2.0%

Note: $n = 48$

*One respondent indicated that the master's degree was in human development with a concentration in counseling and another had a degree in recreation therapy.

In response to an open-ended question about other licensures, certifications, and trainings in addition to being a board certified music therapist, 25 respondents (52%) provided additional information. Respondents were encouraged to indicate all that applied. Table 2 shows results regarding additional licensures, certifications, and trainings. Responses indicated a majority of respondents practiced in the Mid-Atlantic Region (30%) or the Western Region (30%). Regional representation is displayed in Table 3. Survey respondents were solicited based on the type of facility in which they work. The researcher requested contact information for AMTA members who work in mental health settings, specifically in community mental health centers, child/adolescent treatment centers, geriatric psychiatric units, inpatient psychiatric units/hospitals, drug/alcohol programs, forensic facilities, and correctional facilities. The researcher also contacted AMTA members who work in private music therapy agencies and general hospitals. As many music therapists work in more than one facility, this question asked to list all options that applied. The most

Table 2

Type of Additional Licensures, Certifications, and Trainings Obtained

Type	Frequency	Percentage
Neurological Music Therapy (NMT)	6	12.5%
Bonny Method of Guided Imagery and Music*	5	10.4%
Licensed Professional Counselor (LPC)	4	8.3%
Substance Use Disorder Training**	4	8.3%
Licensed Creative Arts Therapist	3	6.3%
Drumming***	3	6.3%
National Certified Counselor (NCC)	1	2.1%
Kindermusic	1	2.1%
Music Education Certificate	1	2.1%
Certified Yoga Instructor	1	2.1%
NICU Music Therapist	1	2.1%
Trauma Focused CBT	1	2.1%
Academy of Vocational and Professional Training	1	2.1%

Note: n = 25

*Out of respondents that indicated training in the Bonny Method of Guided Imagery and Music, 2 reported that they are Fellows of the Association of Music and Imagery (FAMI). One is in advanced training and one completed Level I. One respondent indicated “GIM”, but did not specify where they are at in their training.

**The respondents who indicated they have a background in substance use disorder have a Graduate Certificate in Addictions Counseling, Licensed Alcohol Drug Counselor, or a degree in Human Services/Alcohol and Drug Studies.

*** Drumming training was reported as music therapy drumming training, drumming workshops, and drum circle facilitator training.

common treatment facility was psychiatric hospitals (47.9%). Table 4 displays results for the treatment facilities in which the respondents work.

Table 3

Percent of Respondents per AMTA Region

AMTA Region	Frequency	Percentage
Mid-Atlantic	15	31.3%
Western	15	31.3%
Southeastern	6	12.5%
Great Lakes	5	10.4%
Midwestern	3	6.3%
New England	3	6.3%
Southwestern	1	2.1%

To inquire further about the type of treatment the respondents provide, the type of treatment setting was also presented to the respondents. Similar to the question about treatment facility, this question allowed the respondents to indicate all that apply. There were 63 responses for this question, indicating that several respondents work in multiple settings. It is uncertain how many respondents answered this question. The most common treatment setting was an inpatient setting (72.9%). Table 5 shows the results for the type of treatment setting.

Table 4

Type of Treatment Facility

Facility Type	Frequency	Percentage
Psychiatric Hospital	23	47.9%
Child/Adolescent Treatment Center/Unit	11	22.9%
Other	11	22.9%
Drug/Alcohol Program/Unit	9	18.8%
Forensic Facility	8	16.7%
Private Music Therapy Agency	5	10.4%
General Hospital	4	8.3%
Community Mental Health Center	3	6.3%
General Psychiatric Unit	3	6.3%
Correctional Facility	1	2.1%

Note: The number of responses ($n = 78$) reflects that respondents indicated more than one treatment facility

Table 5

Type of Treatment Setting

Setting Type	Frequency	Percentage
Inpatient	35	72.9%
Outpatient	9	18.8%
Other	8	16.7%
Day Treatment	7	14.6%
Partial Hospitalization	4	8.3%

Note: The number of responses ($n = 63$) reflects that respondents indicated more than one treatment setting

For the interviews, the researcher chose two music therapist interviewees based on their experience in implementing components of DBT in their music therapy practice. The

researcher chose one music therapist from the United States and one music therapist from Germany, where many DBT and music therapy studies originate. The researcher chose two different countries to compare and contrast the use of DBT in music therapy in the United States and abroad.

Instrument

Since there were no pre-existing surveys on the use of DBT in music therapy, the investigator created a survey called DBT and Music Therapy Questionnaire (see Appendix A). This survey gathered information about the demographics of the music therapist, his or her knowledge of and training in DBT, and how he or she uses music therapy experiences to address DBT skills. The survey was constructed using Google Form through Google Docs and consisted of 24 questions, 8 of which were related to demographics. The survey was sent via email.

The survey consisted of five sections. Section 1 consisted of eight demographic questions. Section 2 collected responses related to DBT training and practice through a series of six questions. Section 3 consisted of one question inquiring about how often music therapists adhere to the complete DBT protocol versus using components of DBT in music therapy. Through a series of five questions, Section 4 inquired about DBT specifically in music therapy practice. The last section of the survey inquired about personal opinions and experiences about using DBT in music therapy. Open-ended questions invited respondents to state any other thoughts they had about using DBT in music therapy and to share a personal experience of using DBT in music therapy with clients.

There were also no pre-existing interviews with music therapists on their use of DBT in music therapy; therefore, the researcher developed *The Use of DBT in Music Therapy*

Interview (see Appendix B & C). The interview with the American music therapist consisted of 19 questions, as it was semi-structured (see Appendix B) and administered via web cam. The interview with the German music therapist was structured, consisted of 19 questions (see Appendix C), and was administered in written form. The interviews addressed similar questions to those in the survey, as well as inquired how the music therapists became interested in using music therapy to address DBT skills, what characteristics they look for in clients when deciding to implement DBT, what resources they used to get their training, and why it is important that music therapy be added to a therapy that already has evidence for its effectiveness.

Procedure

For the survey, three emails were sent out with the link to the questionnaire and the consent form: one with the original request with a one-month due date, a second one two weeks prior to the final date for data collection, and the third one week prior to the final date for data collection (see Appendix D). The third email differed from the first two in that it invited all potential participants to respond whether or not they currently utilize DBT in their music therapy practice, and also gave a week extension on the deadline. There was an increase of 13 responses after the third email. The researcher received IRB approval/exemption prior to sending out the survey (see Appendix E).

For the interviews, a consent form was emailed to both music therapists prior to conducting the interview (see Appendix F & G). For the interview with the music therapist in the United States, the researcher conducted a semi-structured web cam interview, which was audio recorded and transcribed. For the interview with the music therapist in Germany, the

researcher sent an email with the structured interview questions and the interviewee provided responses in written English.

Design

The survey used mixed methods to provide a broader picture of how DBT is being used in music therapy. The quantitative data were comprised of training in DBT and DBT in music therapy, implementation of DBT with specific populations, perceived competence and importance of using DBT in music therapy, how often music therapists adhere to standard DBT protocol versus using components of DBT, how often the four modules of DBT are addressed through music therapy, and which music experiences are being used to address the four modules of DBT. The qualitative data consisted of the responses to the open-ended questions.

The interview used a qualitative method to supplement the information gained from the survey. The interview focused on how two music therapists utilize DBT in music therapy in order to provide a more detailed picture of how DBT can manifest in music therapy.

Data Analysis

For the survey, the researcher computed descriptive statistics for the quantitative data using Google Form available via Google Docs. Qualitative data were analyzed by categorizing responses to questions concerning the perceived advantages and disadvantages of incorporating DBT into music therapy, and personal opinions and experiences of using DBT in music therapy. The researcher analyzed the interviews by categorizing the responses into themes determined by the research questions. The interviews were analyzed in comparison to each other as well as in comparison to the survey responses to find commonalities and differences.

Chapter 4

Survey Results

This chapter will report the quantitative and qualitative results from the 24-item *DBT and Music Therapy Questionnaire*. The information will be presented in four sections, consistent with the survey: DBT training and practice, components of the DBT protocol in music therapy, addressing DBT skills in music therapy, and personal opinions and experiences.

Section 1: DBT Training and Practice

This section of the questionnaire inquired about the respondents' background in DBT training, DBT in music therapy training, and familiarity with the DBT Treatment Manual (Linehan, 1993b). This section also inquired about the diagnoses with which the respondents implement DBT in their music therapy work. Moreover, this section surveyed self-reported competence using DBT in music therapy work and respondents' perceived importance of using DBT in music therapy work.

In regards to where music therapists received training specifically in DBT, the most common response was "self-study" (39.6%), followed by "none" (35.4%). Only 6.3% stated they received DBT training in graduate courses, and only one respondent reported receiving online training. Respondents were prompted to indicate all that applied. Table 6 shows results for sources of training respondents received specifically in DBT.

Table 6

Sources of DBT Training

Source	Frequency	Percentage
Self-Study	19	39.6%
None	17	35.4%
Conference Session	13	27.1%
In-Service Training	13	27.1%
Workshop/Seminar	11	22.9%
Continuing Education	9	18.8%
Other	4	8.3%
Graduate Courses	3	6.3%
Online Training	1	2.1%

Note: The number of responses ($n = 90$) reflects that respondents indicated more than one training type

In regards to training specifically on the use of DBT in music therapy, 52.1% of respondents indicated they did not have any training specific to the implementation of DBT in the context of music therapy. Those respondents who had training indicated they received training from conference sessions (25.0%) and self-study (22.9%). The other options were less common. For example, only 10.4% received training from in-services, and only 4.2% received training through Continuing Music Therapy Education. Table 7 displays the results of sources of DBT in music therapy training.

Table 7

Sources of DBT in Music Therapy Training

Source	Frequency	Percentage
None	25	52.1%
Conference Session	12	25.0%
Self-Study	11	22.9%
In-Service Training	5	10.4%
Continuing Music Therapy Education	2	4.2%
Other	1	2.1%

Note: The number of responses ($n = 56$) reflects that respondents chose more than one training type

The survey presented a question about respondents' familiarity with Linehan's (1993b) skills training book, *Skills Training Manual for Treating Borderline Personality Disorder*, to investigate potential sources for self-studying individuals. This question used a Likert scale from 1 (*not at all familiar*) to 5 (*very familiar*). Only 8.3% ($n = 4$) considered themselves "very familiar" with this source, whereas 43.8% ($n = 21$) were "not at all familiar" with this source. This finding shows that although 39.6% of respondents pursued DBT training through self-study, and 22.9% received DBT in music therapy training through self-study, they did not use Linehan's *Training Manual* as a source of information, and it is unclear which sources are being used for self-study. Linehan's *Training Manual* is a primary text in this approach. Figure 1 represents the results for familiarity with Linehan's text.

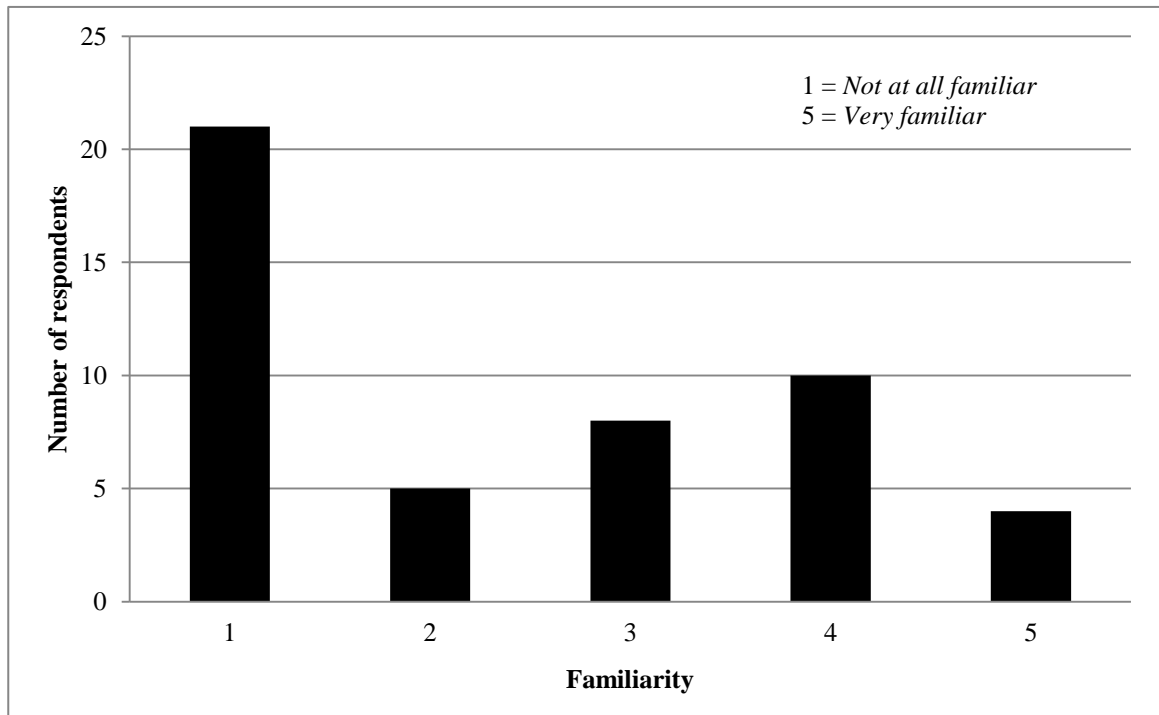


Figure 1. Frequency of Respondents' familiarity with Marsha Linehan's Skills Training Manual for Treating Borderline Personality Disorder ($N = 48$)

The next question asked with which diagnoses/issues the respondents implement DBT and asked respondents to check all that apply to their work. Of 48 responses, the most common diagnosis/issue was reported as borderline personality disorder (50.0%), followed by depression (37.5%). Table 8 displays the results for populations with which the respondents report implementing DBT.

The next question was a self-report of level of competence using DBT in one's work. This question used a Likert scale from 1 (*not at all competent*) to 5 (*highly competent*). The most frequent response (42.2%) indicated the respondents feel "not at all competent." Only 6.7% reported feeling "highly competent." Figure 2 represents the self-reported competency level of using DBT in music therapy work.

Table 8

Populations with which DBT is Implemented

Diagnosis/Issue	Frequency	Percentage
Borderline Personality Disorder	24	50%
Depression	18	37.5%
Substance Use Disorder	15	31.3%
Trauma	15	31.3%
Posttraumatic Stress Disorder	15	31.3%
Suicidal Thoughts/Behaviors	13	27.1%
Nonsuicidal Self-Injury	12	25%
Eating Disorders	9	18.8%
Other	9	18.8%

Note: The number of responses ($N = 130$) reflects that respondents chose more than one diagnosis/issue with which they implement DBT.

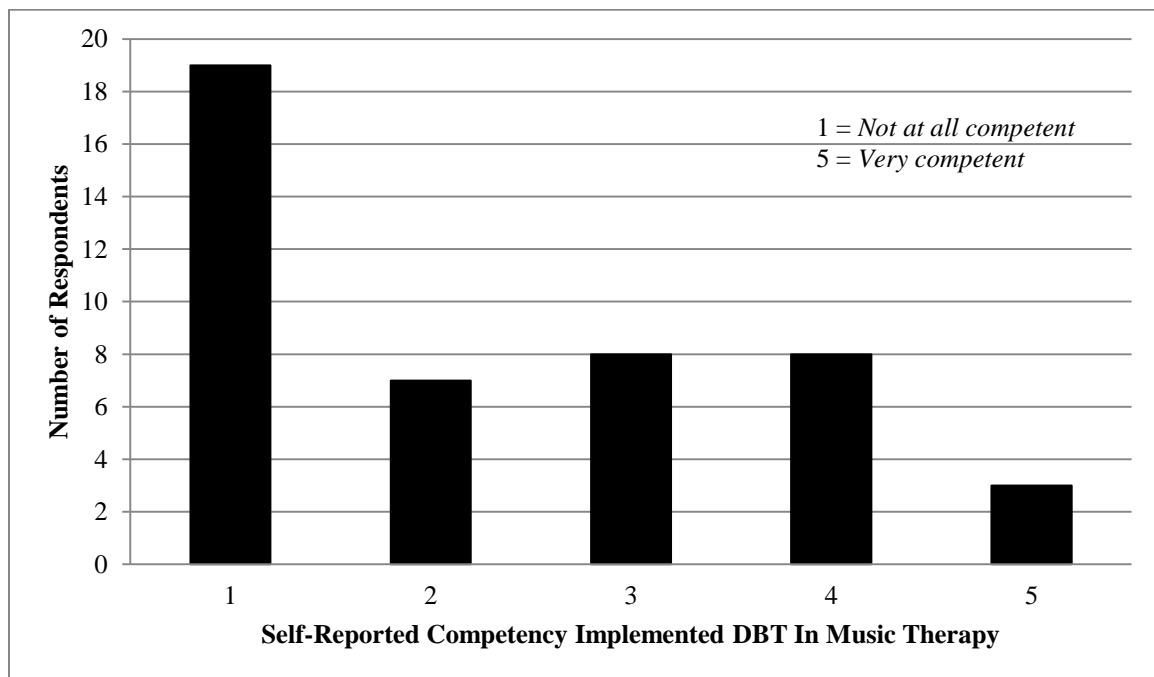


Figure 2. Frequency of respondents' self-reported competency level using DBT in music therapy work ($N = 45$)

In addition to competency in using DBT in music therapy, respondents were also asked to report how important they think it is to use DBT in their work on a Likert scale from 1 (*not at all important*) to 5 (*very important*). Most of the responses were between a 3 and a 5 on the Likert scale (3 = 25.0%, 4 = 23.0%, 5 = 25.0%). Figure 3 displays the results for importance of using DBT in music therapy work.

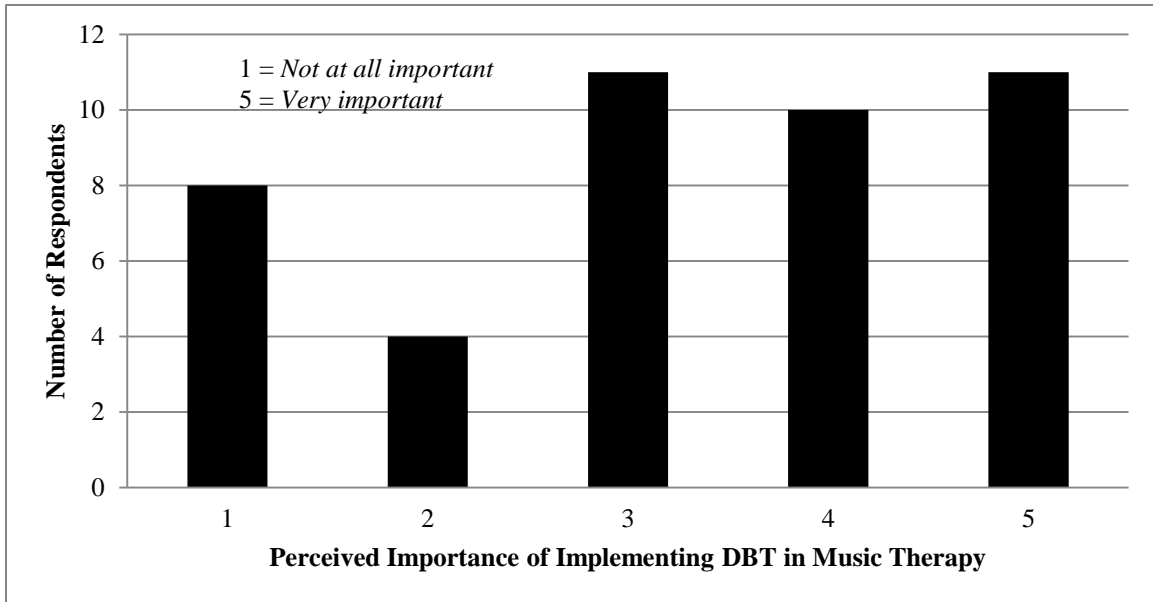


Figure 3. Frequency of perceived importance of using DBT in music therapy (N = 44)

The findings of Figures 2 and 3 suggest that although 73.0% of respondents indicated that they find the importance of DBT in their music therapy work to be a 3 or higher on the Likert scale, 42.2% reported a 1 on the Likert scale in terms of their competency in implementing DBT in their music therapy practice. Only three respondents rated their competency as “very competent.”

This section of the survey reflects that respondents most commonly received training specifically in DBT from self-study (39.6%), whereas they most commonly received training specifically on the implementation of DBT in music therapy was received from conference sessions (25.0%) and self-study (22.9%). Although self-study was the most common DBT in

music therapy, 43.8% of respondents were “not at all familiar” with Marsha Linehan’s *Skills Training Manual*, the main text in the field. It is unclear what were the sources for self-study. The respondents use DBT in their music therapy practice mostly with individuals who have BPD (50.0%) or depression (37.5%). Lastly, this section reflects that 42.2% of respondents feel “not at all competent” in using DBT, while 73.0% indicated that implementing DBT in music therapy work is a 3 or higher on the Likert scale of importance.

Section 2: Components of the DBT Protocol in Music Therapy

This section of the questionnaire inquired about components of the standard DBT protocol, such as individual DBT therapy, DBT group skills training, as-needed phone DBT consultation, and consultative DBT team meetings and how often the respondents use them in their music therapy work. The purpose of this question was to further explore the way in which the DBT protocol has been adapted for use in music therapy. Each component of the standard DBT protocol was evaluated using a Likert scale from 1 (*never*) to 5 (*always*). Table 9 represents how often the respondents utilize the four components of the DBT protocol in music therapy practice.

The results of this section of the survey reflect that music therapists are not implementing the complete DBT protocol in their music therapy work, since only one respondent reported frequently using as-needed phone consultation or consultative DBT team meetings. Rather, music therapists use components of the protocol, with individual DBT therapy and group DBT skills training being most frequently used by music therapists. Since the majority indicated “never” for each component, it is unclear what they are doing that can be considered DBT.

Table 9

Percentage of Respondents Who Use Components of the DBT Protocol in Music Therapy

Protocol Component	Always	Frequently	Sometimes	Rarely	Never
Individual DBT Therapy (n = 41)	0%	7%	12%	20%	61%
Group DBT Skills Training (n = 41)	2%	15%	10%	12%	61%
As-needed phone DBT Consultation (n =39)	0%	3%	0%	10%	87%
Consultative DBT Team Meetings (n = 39)	0%	3%	0%	15%	82%

Section 3: Addressing DBT Skills in Music Therapy

This section of the questionnaire examines how often the four modules of DBT are addressed through music therapy and which music therapy experiences are most commonly used to address the four modules. Nearly half of the respondents (49%) reported that they address mindfulness and half (50%) address emotion regulation frequently. Fewer respondents addressed distress tolerance (40%) and interpersonal effectiveness (32%) frequently. The results indicate that mindfulness and emotion regulation are addressed more often in music therapy practice, followed by distress tolerance and then interpersonal effectiveness. Table 10 shows the frequency with which respondents reported addressing mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness in music therapy.

Respondents provided information about the types of music therapy experiences commonly used to address each module of DBT. The instructions asked them to check all

music therapy experiences that apply to their practice. Results indicated that mindfulness was most commonly addressed through music listening (64.6%). Emotion regulation was reported as most commonly addressed through music improvisation (70.8%), song writing (68.8%), song discussion (68.8%) and music listening (62.5%). Distress tolerance was reported to be most commonly addressed through song discussion (60.4%). Interpersonal effectiveness was reported as most commonly addressed through song discussion (54.2%). Table 11 represents the types of music therapy experiences used to address mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness.

Table 10

Percentage of Respondents Addressing the Four Modules of DBT in Music Therapy Practice

Module	Always	Frequently	Sometimes	Rarely	Never
Mindfulness (<i>n</i> = 45)	9%	49%	22%	0%	20%
Emotion Regulation (<i>n</i> = 45)	7%	50%	23%	0%	20%
Distress Tolerance (<i>n</i> = 45)	7%	40%	22%	7%	24%
Interpersonal Effectiveness (<i>n</i> = 44)	7%	32%	23%	14%	25%

Table 11

Percent of Respondents Who Indicated Using Each Type of Music Experiences to Address Each of the Four Modules of DBT

Type of Music Experience	Mindfulness	Emotion Regulation	Distress Tolerance	Interpersonal Effectiveness
Song Discussion	62.5%	68.8%	60.4%	54.2%
Music Listening	64.6%	62.5%	56.3%	33.3%
Music Improvisation	47.9%	70.8%	39.6%	45.8%
Song Writing	47.9%	68.8%	33.3%	41.7%
Music and Imagery	56.2%	39.6%	31.3%	16.7%
Movement to Music	37.5%	31.3%	16.7%	14.6%
Musical Games	16.7%	18.8%	16.7%	27.1%
Other	12.5%	12.5%	20.8%	16.7%

Note: The number of responses reflects that respondents indicated more than one music experience to address each DBT module.

This section of the survey shows that mindfulness and emotion regulation are addressed most often in music therapy practice, followed by distress tolerance and then interpersonal effectiveness. Music listening is most frequently used to address mindfulness (64.6%). Emotion regulation is most frequently addressed through music improvisation (70.8%), and distress tolerance and interpersonal effectiveness are most frequently addressed through song discussion (60.4% and 54.2%, respectively).

Section 4: Personal Opinions and Experiences

This section of the questionnaire was composed of four open-ended questions that inquired about the advantages and disadvantages of incorporating DBT into music therapy practice. It also provided an opportunity for respondents to share anything else that they

thought was important about incorporating DBT into music therapy. Lastly, it provided an opportunity to share personal stories and experiences of using DBT in music therapy practice.

Advantages of using DBT in Music Therapy. The first question inquired about the advantages of incorporating DBT into music therapy practice. The 28 respondents who answered this question gave a variety of answers that led to several themes. The themes were (a) provides a common language with other treatment team members and clients; (b) allows for teaching skills that can be used posttreatment; and (c) allows the client to learn skills in an integrative, nonthreatening, and motivational way.

The following are several examples of the responses related to providing a common language with other treatment team members and clients:

- “I don’t use it directly, but I can see the advantage of having a shared framework and language for discussing treatment and goals across disciplines.”
- “The only advantage that I can think of is that some of the psychologists at my facility use DBT and it can be helpful in terms of connecting what they are working on with a client with what I am working on with that client so that client can recognize those connections.”
- “For my private clients, it has been something they have been exposed to before in a hospital setting or partial hospitalization program, so I am not starting from scratch. I am simply demonstrating how to use music based interventions in each of the modules. It also makes it much easier to share findings with team members because most are familiar [with] and trained in DBT.”
- “It is an effective method that is recognized and one of the few tools for working with those struggling with BPD.”
- “Aligning the language I use in music therapy with that of DBT provides a common ground with other professionals with whom I work. These concepts are not new to my practice, but the use of the DBT terminology is new. The facility where I work embraced DBT four years ago. We have observed a decrease in repeated hospital admissions, especially in the population of clients with BPD.”

The following are several examples of the responses related to allowing for teaching skills that can be used posttreatment:

- “Incorporating DBT skills into music therapy is essential as it teaches the client skills they can use in the community posttreatment.”
- “DBT modules provide some concrete skills that can help translate learned skills and experiences in music therapy into practical daily use.”
- “A few of the key concepts like mindfulness are foundations upon which DBT can be based and the music makes it easy for clients to remember and implement the strategies.”
- “One advantage is integrating the team treatment plan and helping enforce the benefits of DBT into more aspects of the clients’ day.”
- “One advantage is that the skills in DBT are skills that every person benefits from, and so addressing them in music therapy allows for all clients to develop the skills and benefit from their usage.”
- “I have found it to be very effective for clients, both adolescents and adults. I feel that it hits at the core basics of what the client should learn to be successful upon discharge of the unit.”

The following are several examples of these responses related to learning skills in an integrative, nonthreatening, and motivational way:

- “I believe it helps clients to learn the concept easier by immediately placing them in a safe atmosphere where they can experience the effectiveness of DBT.”
- “From what I have read, music and DBT can be very effective together due to the nonthreatening component of music. Also, music goes to the heart of the matter more quickly than talk therapy and opens the door for insight and growth. In the hands of a skilled therapist, there is the opportunity for tremendous movement when DBT-targeted clients get stuck.”
- “I feel like the use of music as a tool, especially in lyric analysis, gives a clearer picture on the topic we are talking about in the session. I found that lyric analysis is especially helpful when talking about the wise mind, understanding emotions, and discussing pros and cons. I have also found that active music making assists with the core concept of mindfulness.”

- “One advantage is that combining music therapy and DBT allows people with different learning styles to learn the techniques and skills in a different way. That also helps with application and retention. Because music therapy is at its heart, an experiential therapy, it allows for practicing the application component. I think the inherent safety of music and music therapy also creates an environment that has a higher potential for internalizing and accepting the skills.”
- “It provides an integrated experience.”
- “The skills are concrete and useful for many of my clients; music can motivate clients to learn the concepts and help reinforce their implementation.”
- “The skills are useful and relate well in a nonthreatening manner in music. Also, the skills seem to be easier to remember and understand for clients when associated with music.”
- “Music allows clients to express themselves in a different way than just words. Most everyone has music in their lives.”
- “DBT provides a thorough theoretical approach that allows the therapist to provide psychoeducation on self-awareness, the advantages of sitting with discomfort, and attempting to be fully present in the moment. It also is becoming more popular, so clients are interested in understanding how it can benefit them.”

Disadvantages of DBT in Music Therapy. The questionnaire also invited respondents to identify the disadvantages of incorporating DBT into music therapy and 28 respondents replied, including three who wrote, “I do not see any disadvantages.” From the other responses, several themes were noted:

- The DBT concepts may be too abstract for all clients;
- DBT could be limiting and difficult to balance with the music;
- There is a lack of empirical evidence and training on DBT in music therapy;
- Music therapy already inherently addresses DBT skills;

The following are several examples of the responses related to the DBT concepts may be too abstract for all clients:

- “Sometimes our thought disordered clients or low functioning clients struggle with these concepts. Also, younger clients have difficulties with these concepts. Sometimes, it is just not appropriate for everyone I work with.”
- “For some of my clients, some of the DBT concepts are a bit abstract.”
- “At my place of work, DBT groups are generally reserved for clients with a higher level of cognitive functioning. Most of the clients I serve in music therapy (substance disorder treatment groups) would be unable to fully benefit from the use of music therapy interventions enhanced by DBT due to their global assessment of functioning or diagnosis.”
- “I feel that DBT concepts can be complicated for clients with schizophrenia or learning disabilities or neurological disorders (traumatic brain injury, autism, organic brain disorders, etc.) Also, young children may not understand a lot of these concepts.”
- “For some clients, some DBT concepts can seem abstract which can become complicated with nonverbal modalities that may already be abstract.”

The following are several examples of these responses related to the DBT incorporated into music therapy being limiting and difficult to balance:

- “It only minimally addresses goals outside of mental health.”
- “It could disrupt working as a group or disrupt the treatment plan for a separate client in the group setting.”
- “I often have a difficult time with incorporating all concepts of DBT into music therapy, especially if the topic involves more discussion than music.”
- “Due to working with several clients with focus issues, I personally find it difficult to find the balance between the music listening/making and the discussion.”
- “I think that any time we try to combine a particular field of therapy with music therapy, there’s always a risk of pigeonholing our music therapy work; that is, narrowing our interventions down so that they only address DBT needs, skills, and lingo. There is also a risk of your clientele being narrowed.”
- “Reduced flexibility in music therapy interventions.”
- “Music therapy is an action oriented therapy, as music is continually offering a change in the dynamic of the environment just by being present. This can make the initial discussion of DBT harder (for mindfulness) within an ever changing environment where music is incorporated.”

- “Limiting one’s interventions to the protocol.”
- “The full protocol of DBT is too much to manage for an outpatient setting where the therapists work individually and there is not any group work or team approach.”
- “I don’t have a lot of support. I am in a short-term facility where I cannot really map progress. The folks that could benefit do not come to the groups.”

The following are several examples of the responses related to lack of empirical evidence and training on DBT in music therapy:

- “There is not enough literature/research available on DBT in music therapy, so it involves the development of interventions that are not standardized.”
- “Because of the power to move people quickly at an emotional level, it takes a skilled therapist to understand how to contain the emotions that are stirred up. It would seem to me that since music is so fluid, those people who do not contend well with the group shifting would need a very grounded and balanced therapist to provide musical experiences that help people maintain a sense of safety while still making therapeutic strides.”

The following is an example of the response related to music therapy already inherently addressing DBT skills:

- “I personally think DBT is just putting new names on therapy principles that I have used for my entire career and I see no need to rename them, personally. I think it just isn’t necessary to jump on a bandwagon and change the jargon because it is currently the in thing.”

Other thoughts on incorporating DBT into music therapy. This question provided an opportunity for the respondents to indicate anything else they wanted to share and 26 respondents replied. Two themes were identified in response to this question: (a) desiring more training and experience that is accessible and affordable, and (b) the desire for more research supporting the use of DBT in music therapy. Several other respondents indicated an additional limitations, as well as adaptation of the DBT protocol in music therapy in this section.

The following are examples of desiring more training and experience that is accessible and affordable in using DBT in music therapy:

- “At this time, I would not say that I am certified to refer to aspects of my music therapy groups as the use of DBT in music therapy. There is a DBT program at my facility with instructors who have been certified to use DBT skills with clients and therefore, as I am not certified to practice DBT, beyond mindfulness, I could not say that I practice a lot of the other DBT skills mentioned in the survey. I understand how DBT enhances music therapy practice with certain populations, and would be more interested in furthering my studies in this area, but am unable to do so at this time.”
- “I have a goal of providing DBT into my music therapy treatment, but realize that I need the training first. I also am planning to have collaborative supervision of PhD’s and social workers at my hospital who are providing this treatment after receiving the training.”
- “I have not been trained in a way that allows me to feel competent in how to incorporate DBT into my work.”
- “I’m eager to receive more formal training.”
- “I wish I knew more about consciously using this as an intervention.”
- “I would like to learn more about this technique if I plan to continue working in mental health.”
- “It is worth addressing in undergraduate education and included in any future textbooks.”

Some respondents indicated desiring more training and experience that is accessible and affordable in using DBT in music therapy, especially with mental health populations.

- “I feel that if you work in the mental health field, it is essential to know some of the DBT skills to be able to incorporate them into your session somehow. Doing a lot of expressive therapy sessions leads into mindfulness and emotion regulation discussion/skill topics nicely.”
- “DBT and music therapy is effective with clients and helps them to learn and retain the DBT skills.”
- “DBT complements a lot of what music therapy interventions are trying to achieve for goals: self-expression, emotional expression, coping skills, communication skills, boosting self-esteem, and anger management. DBT can be brought into discussion groups quite nicely and when deemed appropriate.

I often have clients make flashcards of crisis survival skills after listening to a song about making choices.”

- “This gives clients an in-vivo experience for practicing skills.”
- “I think that overall, I find it extremely effective to incorporate DBT skills into music therapy. DBT has become a very effective treatment modality for individuals with emotional issues and I believe that music therapists should seriously consider training for it, especially if they are interested in the mental health population.”
- “I want to continue challenging myself to utilize it more and more in my practice.”

Other comments from this section address additional limitations as well as adaptations to the DBT protocol when used in music therapy.

- “I am interested in incorporating components of DBT more in music therapy, but also know that it was developed as a very intensive and comprehensive structured form of therapy, which makes me more hesitant to look into it as becoming a part of my music therapy practice. I plan to learn more about it, though.”
- “In regards to disadvantages, I often won’t label it as DBT if I know that the clients have been resistive to the therapy before. After the relationship is established and they have actively engaged and presented positively to the music-based material, I will tell them how it fits in with what they have already been presented with.”
- “I often incorporate the main concepts from DBT into my music therapy strategies as a basis for counseling concepts, but never use the full protocol.”

Personal experience using DBT. Lastly, respondents were given the opportunity to provide personal experiences of using DBT in music therapy with clients and 14 respondents provided examples. The respondents described what types of music experiences they use to address specific DBT modules. The music therapy experiences indicated were movement to music, improvisation, art to music, song writing, imagery, therapeutic choirs, and lyric discussion. The following responses describe the ways in which music therapy is used to address DBT skills:

- “In movement and improvisation, clients easily observe changes in emotions, and how they can choose music that effects a change for future healthy choosing. In song writing clients can take samples of options for radical acceptance and personalize it. They are often surprised at how simply this can flow and later report its effectiveness.”
- “Every Tuesday, for the practice of coping skills, I use music improvisation and art with my clients. In doing this, I am teaching the clients to take time regularly to relax and disengage from the regular busy aspects of life, in the spirit of mindfulness.”
- “I used a piece of music (Chopin’s *Prelude in d minor [Raindrop]*) that was also used in a fictional movie about Van Gogh’s paintings in a museum. First, I played this piece and the group had been instructed to write. One client with BPD became quite anxious but remained in good control; I discretely checked in with her. Then, I played the scene of the film using the same music, and she was fine, even though they had just heard the same piece twice. This client was quite surprised, and then we discussed how to reframe negative experiences into something more positive, i.e., gaining knowledge, understanding the past is gone and it is possible to move forward, etc.”
- “I use distraction including visualization, art work, and song writing. You can also review pleasurable activities/effective coping skills. For example, implementation of a community music concert can assist with everything from healthy socialization, to containment and expression of emotion, to effectively learning to manage stress/pressure of performance, to teamwork. Relaxation, mindful breathing, and REBT/CBT can be used to reframe negative thoughts and develop affirmations. Other examples are describing an emotion by drawing it or playing it on instruments, journaling of thoughts related to life occurrences/emotions/consequences (similar to emotion regulation worksheets), music and movement, basic yoga, and body awareness.”
- “I direct a therapeutic chorus at my work site, which I feel encompasses a multitude of DBT skills—the clients have to make decisions together and compromise (interpersonal effectiveness). Our warm-ups consist of breathing, stretching, and vocalizing (mindfulness), difficult songs or issues that arise during rehearsals can be frustrating and challenging (distress tolerance and emotion regulation), singing is a great coping skill and has a variety of physiological effects on the mind and body (emotion regulation)...the list goes on...”
- “Out of all the concepts, I have found that the clients seem to fully understand the concept of wise mind in combination with lyric analysis. In these sessions, the clients listen to various songs, and they determine whether or not the lyrics represent a person in emotional mind, rational mind, or wise mind. Several clients seem to understand the concept of wise mind more by the end of the

group, and they are also very likely to talk about ways to get to wise mind when they are in various situations.”

- “When I do an expressive therapy group-like song writing, drawing to music, CD covers, or drum circles, I include in the discussion the importance of emotions and how we can be more aware of our feelings—mindfulness techniques. Also, trying new things—what feelings accompany that and why it is important to be our own cheerleaders and encourage us to try new things, take risks, and do activities because we need to, not because we want to.”
- “Just today, I did a song writing exercise with our adult [partial hospitalization program]. We discussed mindfulness and emotional regulation briefly along with the importance of recognizing what our feelings are and how we know what we’re feeling, etc. They gladly accepted DBT flashcards on these skills which I found on the DBT self-help website and encouraged clients to check out the website. This happened to be a higher functioning group who did well with these concepts and expressed feelings well in their songs.”

Responses to this section of the survey provide examples of advantages and disadvantages of implementing DBT within the context of music therapy. Advantages include providing a common language with other treatment team members, practicing skills that can be used posttreatment, and allowing the client to learn skills in a different way that may be nonthreatening and more motivating. Disadvantages included that DBT is too complex for all clients, the verbal component of DBT may take away from the music, lack of empirical evidence and training, redundancy with skills inherently addressed through music therapy, and the risk of triggering traumatic memories. It was also apparent that respondents desired more experience and training on using DBT in music therapy in order to feel more comfortable implementing it in their practice. Personal examples illustrated the benefits and challenges of using DBT in music therapy.

Chapter 5

Interview Results

This chapter will report the results of the two interviews conducted with music therapists who have experience in implementing DBT in music therapy. One interviewee, Deborah Spiegel, is an American music therapist with 37 years of clinical experience, 11 of which were with adolescents on a DBT milieu at a state psychiatric hospital. The other interviewee is a German woman, Gertraude Scheidt, who has been a music therapist for 19 years working with individuals with various mental health diagnoses, including, but not limited to, substance use disorders, depression, schizophrenia, personality disorders, and eating disorders.

Questions inquired about training in DBT and DBT in music therapy, implementation of the standard DBT protocol versus adaptations, what types of music therapy experiences are used to address the four modules of DBT, and advantages and disadvantages of using DBT in music therapy. In addition, the interviewer inquired about recommendations for training other music therapists who would like to address DBT through music therapy, how they determine when to use DBT with particular clients, how often music therapy inherently addresses DBT skills, and why music therapy should be added to an approach that is already empirically effective.

Research Questions 1 and 2: Is DBT being incorporated into music therapy? Who is using DBT in music therapy? With whom?

The first question inquired whether DBT is being implemented in music therapy. The second question inquired about whom is using DBT in music therapy and with whom. Through the interviews it is evident that music therapy is being used to address components of DBT, specifically teaching and reinforcing the DBT skills from the four modules. This is evident, as Deborah Spiegel has been teaching Continuing Music Therapy Education courses on DBT for the past two years. The demand for these courses shows the desire among music therapists for this type of training. It is also evident that music therapy is being used to address components of DBT in mental health settings both in the United States and in Germany.

The interviewees implement DBT in music therapy with a variety of populations, and not only adults with BPD. For example, Deborah Spiegel noted that Linehan has a new *Training Manual* that does not have “borderline personality disorder” in the title, since research has found DBT can be effective with a variety of populations. Although Deborah Spiegel has implemented DBT with every client in the 11 years she worked on a DBT milieu, she noted that music therapists must use their own judgment on clients’ intellectual and psychological state to decide if it is an appropriate approach to use with a specific person.

Although Gertraude Scheidt has used DBT in music therapy with individuals with BPD, she also has found it also to be effective with individuals with depression and eating disorders. She has found that identification and expression of emotions and mindfulness exercises taught through DBT can be helpful with many different populations.

Research Question 3: What DBT-specific training have music therapists who practice DBT in music therapy received?

This question studied the source of DBT training that music therapists have. It also inquired about specific training on implementing DBT in music therapy. The interviewees had quite different experiences in their sources of DBT-specific training. Deborah Spiegel worked in a facility that provided DBT training through Behavioral Tech (a DBT training organization founded by Linehan for mental health providers and treatment teams), as she worked in a DBT milieu. Deborah Spiegel noticed there was a lack of training sources on the implementation of DBT in music therapy and developed the Continuing Music Therapy Education courses on DBT in music therapy. This also inspired the creation of original songs to address DBT skills. She recommended that music therapists sit in on a DBT skills group at their facility led by other members of the treatment team. Music therapists may start out cofacilitating or facilitating a DBT skills group, and then are able to incorporate their music therapy background to teach the DBT skills.

Not all facilities provide DBT training through Behavioral Tech or other sources. For example, Gertraude Scheidt did not have any formal DBT training. She obtained her DBT-specific training through a doctor at the clinic in which she works rather than through a formal training. She also studied Linehan's *Training Manual* and other research on the topic of DBT. The way in which Gertraude Scheidt obtained DBT in music therapy training was through self-study and combining the exercises in the *Training Manual* with music therapy experiences. A large part of her training also has come from implementing DBT in her personal life, such as through meditation and becoming familiar with Buddhist theories and practice. She stressed the importance of music therapists' becoming familiar with DBT in

their own lives prior to implementing it with clients. Music therapists training in DBT also should include personal mindfulness practice and experimentation with emotion regulation. Furthermore, she suggested that music therapists may not be qualified to implement DBT based solely on their music therapy training, but that further education may be needed to be current in the field through either a training, formal qualification, or self-study. In her case, she received a qualification for Systemic Individual, Couple, and Family Therapy, where she learned about working with clients with BPD and behavior and trauma therapy.

Research Question 4: How is DBT or how are the elements of DBT being used in music therapy?

This question inquired how DBT is being implemented in music therapy, for example, whether components are being addressed, or the entire protocol is implemented. Neither interviewee implements the entire protocol. The components that are implemented differed between the interviewees. For example, Deborah Spiegel primarily used DBT in music therapy through group skills training and individual sessions. Neither music therapist used as-needed phone consultations for current clients, as they are implementing DBT in inpatient settings. One exception was on the DBT milieu where clients who had been discharged were able to call as-needed to speak to staff. For both interviewees, the treatment was adapted from the standard DBT protocol, as it was implemented in an inpatient setting, in one case with adolescents with diagnoses other than BPD and in the other with a variety of mental health populations.

Gertraude Scheidt provides primarily individual and group DBT sessions. She does not necessarily teach the skills in a specific sequence, and rather, chooses skills based on her assessment of what the clients' needs are. There are times when she consults with other team

members, they share ideas on treatment approaches for specific clients, and she stays in contact with the clients' primary therapists.

Gertraude Scheidt has found through her work that it is most effective to first train a client to use DBT skills and introduce DBT concepts in a one-on-one setting, before they are put in a group setting. Learning one-on-one provides an opportunity to learn the skills and practice them before experimenting with them further in a group setting. The music therapist also stressed the importance of implementing this type of work with willing clients who are self-motivated and cooperative. It is important for them to want to gain the experience and be prepared to make effort on their own. It takes self-motivation to initiate implementing the skills in daily life. She also noted the importance of the therapeutic relationship when implementing DBT in music therapy. She believes it is important for the client to be motivated to work with her, as well as have previous experience of being successful through music therapy.

Research Question 5: What music therapy experiences are being used to address the four modules of DBT?

This question inquired what types of music therapy experiences are being used to reinforce skills from the four modules of DBT. There are many different types of music therapy experiences that can be used to address the four modules of DBT, and several ways that music therapy experiences can be developed to focus on DBT skills.

Both interviewees had similar perspectives that music therapy experiences can inherently address DBT skills, while their views on labeling the experiences as DBT differed. For example, Deborah Spiegel believes that most music therapy experiences can serve as a distraction, which is a DBT skill. She also believes that being engaged in a music experience

that involves observing and describing emotions is emotion regulation. She stated that labeling the music therapy experiences as DBT is important and can be powerful. This is because having the DBT language can provide a common language and teach clients how to use the DBT skills in a practical way. This differed from Gertraude Scheidt, as she reported that labeling the skills is not necessarily important for the client, but it is important awareness for therapists, so they know how to recognize symptoms and work effectively with a client.

There are similarities in the ways in which both interviewees develop DBT music therapy experiences. For example, both music therapists expressed the opinion that music therapy experiences they use in non-DBT sessions inherently address DBT skills. Both interviewees use their usual music therapy experiences, but give them a DBT focus by identifying the skills they address. Although the DBT focus of a typical music therapy experience is similar between the interviewees, the way in which they typically implement music therapy experiences differ. For example, Deborah Spiegel stated she used a variety of music therapy experiences such as lyric analysis, imagery, and song writing to address the DBT skills. On the other hand, Gertraude Scheidt described only using improvisation to address the DBT skills, which is consistent with the European practice of music therapy.

Another way that both interviewees develop DBT music therapy experiences is by crafting one based on a specific skill. Although both interviewees reported doing this, their types of music therapy experiences differ. For example, Deborah Spiegel has written several original songs to teach specific DBT skills. Gertraude Scheidt has created prompts for music improvisation based on Linehan's *Training Manual* exercises.

Research Question 6 and 7: What are the perceived advantages and disadvantages of implementing DBT in music therapy?

This question inquired about the perceived advantages of implementing DBT in music therapy. Deborah Spiegel identified that an advantage of implementing DBT in music therapy is being able to provide a common language for the clients, as well as being able to have a common language with other staff members, specifically in mental health settings where DBT is practiced. Furthermore, DBT can provide a structure for therapy that the team all work from. Considering that DBT is implemented as a team approach, a music therapist may be able to reach a client in a way that verbal therapists cannot. Music provides another way to communicate and can add another dimension to the DBT.

Gertraude Scheidt also identified several advantages to implementing DBT in music therapy. One advantage to this type of work is that it gave her confidence, direction, and skills for working with individuals with BPD, an often difficult-to-treat population. In her experience, this population would often be disruptive to the group process, but after implementing DBT in music therapy, she found that the clients with BPD were able to regulate their emotions and be in a more stable place so that they could participate in group therapy more effectively. Both interviewees noted that another advantage is that both DBT and music therapy are evidence-based and experiential. This allows both approaches to be integrated and provide a wide range of interventions.

Although Deborah Spiegel believes that no disadvantages exist, Gertraude Scheidt identified one disadvantage. The disadvantage occurs when therapists apply the *Training Manual* too rigidly and are not flexible in their work. This work must be flexible and adapted to the personal needs of a client.

Deborah Spiegel was asked if one disadvantage could be the challenge of balancing the verbal component of DBT with the music. She stated that the verbal component of DBT does not interfere with the music, as she runs her DBT music therapy groups as she would a typical music therapy group. She feels that many of the same music therapy experiences can be used, just with a DBT focus. In that way, the verbal component of DBT does not take away from the music experience.

Research Question 8: Why should music therapy be added to a therapy that already has empirical evidence for its effectiveness?

Both interviewees asserted that music therapy should be added to DBT, even though DBT already has empirical evidence for its effectiveness. One reason given was that DBT is typically implemented by a team. As a member of the team, music therapists may be able to reach a client in a way that verbal therapists cannot. Both noted that music provides another way to communicate and can add another dimension to the DBT. This is especially true when a client feels stuck expressing verbally.

Both interviewees asserted that music therapy should be added because the two complement each other. Music adds experiential and practical ways to reinforce the DBT skills. The music can be less threatening and provides a safe way to explore ones issues (Kreitler & Kreitler cited in Gfeller, 2005) and identify which skills could be beneficial.

Gertraude Scheidt also believes that individuals with BPD are often creative and open to new experiences, but often are misrepresented. Music can support their creativity and provide a therapy based on their strengths. She stated that music therapy should be added to DBT because “...music has an effect not only on the mind, but also on the body and soul of the client.”

Summary of Interviews

The two interviewees are working in mental health settings and are implementing components of DBT in music therapy with a wide range of populations. They implement components of DBT in music therapy, rather than the standard DBT protocol. Individual and group DBT skills training are the most common ways in which they implement DBT in music therapy. It is less common for music therapists to provide as-needed phone consultations, although they may be part of a consultative DBT meeting, if the facility in which they work provides DBT treatment. This type of work is primarily implemented in an inpatient psychiatric hospital setting, and with adults with an array of mental disorders in addition to BPD.

There is a difference in the way these two interviewees received training in DBT. Deborah Spiegel received formal DBT training from Behavioral Tech through the facility in which she worked. Gertraude Scheidt did not obtain formal DBT training. Rather, she learned about DBT through a coworker and self-study. There are not many sources for DBT in music therapy training, and both interviewees reported self-studying on this topic, particularly with Linehan's *Training Manual*. Continuing Music Therapy Education courses on DBT are offered online and are available to music therapists and other participants from all over the world.

There are many ways in which the two interviewees implement DBT skills through music therapy experiences. Music therapy experiences inherently address many DBT skills and the music therapists may implement the music therapy experiences as usual, but address DBT skills that are reinforced through the experience. They may also take exercises from the *Training Manual* and develop music therapy experiences, such as writing songs specifically

for that exercise or developing prompts for music improvisation. There are many ways that the DBT skills can be addressed through music therapy, and it depends on the music therapists' style.

The interviewees identified many advantages to implementing components of DBT in music therapy both for clients and for therapists. DBT in music therapy can provide a common language for the therapist, client, and treatment team. It can provide an opportunity for clients to practice utilizing the skills in a practical and experiential setting. Music can also provide a nonverbal, creative, and safe way to communicate emotions, and music therapists may be able to reach clients in a different way than other team members are able. Furthermore, music therapists may benefit from this type of work, in that DBT training may provide confidence and structure for working with individuals with BPD who may be difficult to treat through other therapies. Music therapy should be used to address components of DBT because music involves the entire person—body, mind, and soul—not just cognitive capabilities. DBT focuses on perception and expression of emotions and observation and regulation of emotions. Music allows this cognitive therapy to also have a deep emotional emphasis.

Chapter 6

Discussion

This chapter integrates aspects of the survey and the interviews and connects quantitative and qualitative results with current practices in the field of DBT in music therapy. This information is intended to explore the ways that DBT is being used in music therapy and how music therapists are using music therapy to address DBT skills. A discussion of the research questions and a review of the results from the survey and previous studies will be followed by an integration of examples from the interviews that elaborate on several of the survey questions. Implications for practice will follow, and then limitations will be discussed. The chapter will conclude with implications for further study.

Is DBT being incorporated into music therapy? By whom and with whom?

Results of this study indicate that music therapists are using music therapy experiences to teach and reinforce DBT skills. This is being implemented by music therapists who work in mental health settings, primarily inpatient psychiatric hospitals. This is consistent with previous studies that have shown that combining music therapy with cognitive therapies can be effective with a variety of populations such as individuals with substance use disorders, eating disorders, depression, and history of trauma (Baker et al., 2007; Dingle et al., 2008; Gleadhill, 2010; Hendricks, 2001; Hilliard, 2001). In those studies, music therapy was used to address components of CBT. This may suggest that the combination of DBT and music therapy could also be effective.

The field of music therapy is comprised predominantly of women, so it is not surprising that a large majority of the survey respondents and both interviewees were female (American Music Therapy Association, 2013a). Most of the survey respondents were located in the Mid-Atlantic or the Western Region of AMTA. These are two of the four largest regions in AMTA, so the percentages of survey respondents from these regions may be partially a result of demographics of the profession (American Music Therapy Association, 2013a). The AMTA regions also indicate that DBT in music therapy is following a common trend—that it is starting on the coasts of the United States before working its way in. This study also shows that DBT is being implemented in music therapy in Germany (Kupski, 2007; Plener et al., 2010). The respondents most frequently had a Bachelor's or a Master's degree in Music Therapy, which reflects the profession as a whole (American Music Therapy Association, 2013a)

Music therapists who are incorporating DBT into their practice have additional credentials in mental health fields, such as Licensed Professional Counselor and Nationally Certified Counselor. A common additional training was in substance use treatment. Several respondents indicated having advanced training in music therapy such as the Bonny Method of Guided Imagery and Music. Additionally, one of the interviewees has a qualification in Systemic Individual, Couple, and Family Therapy. It can be concluded from these results that music therapists who use DBT in their work have sought out advanced training and continuing education and are likely to be open to incorporating this new treatment approach in music therapy. The respondents may be self-motivated to learn about new techniques. Most of the additional licensures, certifications, and trainings are mental health related. This

may be due to the fact that the criteria for respondents included working in mental health settings.

The most frequent response for treatment setting was psychiatric hospitals, specifically in an inpatient setting. DBT is typically implemented by a team, and multidisciplinary teams are typical in this type of setting. This could also indicate why an advantage of implementing DBT in music therapy was noted as increased communication with other mental health professionals.

These results may indicate that inpatient psychiatric hospitals support implementing DBT in their treatment, which is an adaptation from the original design of DBT. The survey shows that DBT is being incorporated in music therapy primarily with adults with BPD and depression. In addition, it was also noted in the interviews that DBT in music therapy can be effective with a variety of populations and ages.

What DBT-specific training have music therapists who practice DBT in music therapy received?

Of those music therapists who have received training in DBT, most have done so through self-study. Of greater concern is the finding that an almost equal number have received no training at all in DBT or the use of DBT in music therapy. There is a lack of formal training in DBT, whether through facilities, DBT training programs, or graduate education. Even those survey respondents who had completed graduate degrees in music therapy had rarely received DBT training through their graduate courses. Furthermore, even though most music therapists who have had DBT training have obtained the training through self-study, nearly half of the survey respondents were unfamiliar with Linehan's (1993b) *Training Manual*, a main text in DBT training. Linehan even recommends that treatment

providers who are interested in DBT training form a study group and read her *Training Manual* prior to taking an online training or workshop (Behavioral Tech, 2013a). The *Training Manual* provides a basis for the DBT training and is an essential source to be familiar with when implementing DBT (Rizvi et al., 2013). The recommendation to learn the *Training Manual* also was made by both interviewees, and was the main source of training for one of them. Although one interviewee received DBT training through Behavioral Tech at the facility in which she works, not all facilities provide that training and other sources of training are needed.

One noteworthy finding related to training in DBT was the self-reported competence in implementing DBT in music therapy. Almost half of the respondents indicated that they were “not at all competent” while only a few self-reported their competency as “very competent,” despite the fact that most think that DBT is important to their work in music therapy with mental health populations. While music therapists find DBT to be important to implement in music therapy work, they also feel they are not competent enough to utilize it in their practice. Several survey respondents expressed they would like to see more DBT training opportunities. Clearly, there is a need for more training, research, and information on this topic.

Due to this finding from the survey, the interviewees were asked what training they recommend for music therapists who would like to incorporate DBT in their music therapy work. One of the interviewees who teaches a Continuing Music Therapy Education course on DBT in music therapy has received positive feedback from music therapists taking the course and becoming more familiar with the DBT language. Once they are more familiar with the DBT language, they have been able to approach the treatment team at the facility in which

they work and start coleading or leading DBT groups. The other interviewee who did not have formal DBT training suggested first using DBT as a personal practice, such as getting involved with mindfulness and meditation, as well as becoming familiar with Buddhist concepts before implementing it with clients in order to be more authentic in clinical practice. She also recommended having another specialization area or qualification, either through self-study or research to stay updated on current issues in the field of DBT. This would allow for the music therapist to be updated on the most current literature in the field and learn evidence based approaches.

How is DBT or elements of DBT being used in music therapy?

This study revealed that music therapists typically do not implement the full DBT protocol as established by Linehan and that the setting influenced whether or not the full protocol was used. The protocol includes individual DBT sessions, group DBT skills training, as-needed DBT phone consultations, and consultative DBT team meetings. Music therapists adapt the protocol for implementation in music therapy. For example, most respondents reported “never” using as-needed DBT phone consultations. This is likely due to the fact that music therapists implement DBT in inpatient settings, while phone consultations would only be needed with outpatient clients. It is more likely to implement DBT music therapy group skills training and DBT music therapy individual sessions. It is unclear whether the music therapists who implement DBT in music therapy are part of a treatment team, as most indicated they “never” have consultative DBT team meetings. It was noted that familiarity with DBT language facilitates communication with other professionals, but not necessarily in team meetings. It was also pointed out that DBT is typically provided by a

treatment team, and one of them recommended being in contact with a client's primary therapist when a treatment team does not exist.

What music therapy experiences are used to address mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness?

In addition to protocol, the use of the four DBT modules in music therapy was also assessed. Music therapists reported more frequently addressing mindfulness and emotion regulation than distress tolerance or interpersonal effectiveness. In regards to the ways in which music therapy experiences are being used to address each module, music therapists employ different types of music therapy experiences to address the different skills. They reported using music listening most frequently for mindfulness and music improvisation most frequently for emotion regulation. Those who address distress tolerance and interpersonal effectiveness reported more often using song discussion to do so.

Personal examples provided by survey respondents included work with therapeutic choirs and doing art with music, which were not specifically addressed in the survey. The skills taught depend on the setting and facility in which the music therapist is working. For example, some facilities may teach the skills in a specific order versus rather than following an individualized, clinically directed sequence.

The interviews provided more in-depth information and specific examples as to how music therapists are using music therapy experiences to reinforce DBT skills. They also provided an opportunity to explore how music therapists make decisions as to how they develop the music therapy experiences. The interviewees both agreed that music therapy experiences can inherently address DBT skills. Therefore, it is possible to facilitate a music therapy group as usual and give it a DBT focus by identifying which skills are addressed, as

well as using skills in the group as-needed. Another way to develop DBT music therapy experiences is to take a specific DBT skill and create a music therapy experience to address that skill. One of the interviewees created music therapy experiences by writing songs about specific skills. The other developed music therapy experiences by adapting the *Training Manual* exercises so that the exercises were taught through music experiences. The American music therapist uses a variety of music therapy experiences to address the four modules such as imagery and song discussion, whereas the German music therapist addresses the four modules through music improvisation. This differentiation is consistent with the difference in music therapy practice between the United States and Germany.

Since both interviewees stated that music therapy experiences inherently address DBT skills, they were asked their opinion on the importance of labeling the experiences as DBT. One interviewee believes that having the DBT language makes the experience even more powerful and applicable to life outside the therapy sessions. Contrarily, the other interviewee feels it is not important to label the music therapy experiences as DBT; rather she believes it is important for the therapist to be aware of Linehan's theory in order to recognize symptoms and work with clients more effectively. Knowing the DBT language allows for the therapist to apply interventions more precisely and consciously.

Although music therapy experiences can and inherently do address DBT skills, this was not the approach that Plener et al. (2010) used in their study. Plener et al. (2010) implemented DBT and music therapy, but the DBT component was done separately from the music therapy work. Although the music therapy experiences such as practicing and recording songs inherently addressed DBT skills, the focus was not on DBT. The participants left the music therapy group for an individual DBT session, rather than implementing the

DBT into the music therapy session. This is in contrast to the ways in which the respondents described implementing DBT in music therapy.

What are the advantages and disadvantages of incorporating DBT into music therapy?

The survey respondents and interviewees were questioned about the perceived advantages and disadvantages of incorporating DBT into music therapy practice. The advantages were compiled into seven themes: (a) provides a common language with other treatment team members and clients; (b) allows for teaching skills that can be used posttreatment and the opportunity to actively practice the skills; (c) allows the client to learn skills in an integrative, nonthreatening, and motivational way; (d) music can add another dimension to the DBT skills; (e) music therapists may be a member of the treatment team that can reach a client in a way that other team members may not be able; (f) gives the therapist confidence and direction, specifically with working with individuals with BPD; and (g) can provide an opportunity for disruptive clients to participate in the session in a different way.

Although several survey respondents and one interviewee did not identify any disadvantages for incorporating DBT into music therapy, the identified disadvantages were compiled into themes:

- The DBT concepts may be too abstract for all clients;
- DBT could be limiting and difficult to balance with the music;
- There is a lack of empirical evidence and training on DBT in music therapy;
- Music therapy already inherently addresses DBT skills

In addition, one interviewee identified an aspect that was not mentioned by the survey respondents: music therapists may use the manual too rigidly. She asserted that the manual

must be handled flexibly and adapted to personal needs of the client. This may be unlikely, though, since most of the respondents were not familiar with the manual.

The disadvantages bring up several important points. The first point is that the verbal component of DBT may take away from the effects of the music. Those who lean towards music as therapy might be less inclined to incorporate DBT into their work for this reason. This may depend on the way in which the music therapist is implementing DBT in music therapy. For example, using a *Training Manual* exercise/worksheet and addressing the skills through music may require more time spent verbally, rather than implementing music therapy experiences that inherently address DBT skills, such as improvisation. DBT was developed when CBT was ineffective and invalidating in the treatment of individuals with BPD (Linehan, 1993a). Although DBT can be considered a type of cognitive behavioral treatment (Behavioral Tech, 2008), it differs from other cognitive therapies in that its focus is on mindfulness of emotions. DBT is also considered a “new wave” of CBT, which incorporates mindfulness-based approaches that assist in being aware of, accepting of, and provide coping skills for situations rather than focusing on eliminating the situations completely (Hofmann, Sawyer, & Fang, 2010). This suggests that it is possible for the focus to be on the music and emotional aspect rather than the cognitive component. One interviewee noted when there are verbal DBT groups in addition to the DBT music therapy groups, most of the verbal aspects can occur during the verbal therapy group. This may be a disadvantage, as not all facilities may be able to provide that opportunity.

Another point mentioned that can be viewed as a disadvantage is that music therapists already inherently are addressing DBT skills through music therapy experiences, and it may not be necessary to put a DBT label on experiences that music therapists already have been

using before DBT became better known. There are differing opinions on whether it is important for the clients to know the DBT language. Some music therapists believe that knowing the DBT language can make the experience more powerful and help generalize the skills. On the other hand, some music therapists believe that it may only be important for the therapist to be familiar with the language so they can provide effective treatment.

Why should music therapy be added to a therapy that already has empirical evidence for its effectiveness?

The interviewees were asked why music therapy should be added to a therapy that already has empirical evidence for its effectiveness. This question was not addressed through the survey, but it was alluded to in the perceived advantages in the survey that music therapy can provide an integrative, nonthreatening, and motivational way to teach the DBT skills. Both of the interviewees supported the position that music therapy can enrich the process of learning the DBT skills.

One concept of DBT is that it is implemented by a treatment team. All members of the team are valuable and can reach clients in different ways. One interviewee asserted that the music therapist may be able to reach a client through music in a way that other team members cannot through words. The other interviewee believes that individuals with BPD are creative people and are open to new experiences. Music therapy can provide a creative and expressive way to explore the DBT skills. Moreover, she asserted that it is the power of the music that allows clients to be open to learning the DBT skills and assist in becoming mindful of emotions. She stated, “Music is a media that can support creativity, personal expression of emotions, learning to listen and concentrate not only on the music but also on one's feelings, and it has an effect not only on the mind, but also on the body and soul of the

client.” Music can reach all aspects of a person, not just cognition and verbal exploration and expression.

Recommendations for Clinical Practice

A model for dialectical behavior music therapy (DBMT) could be developed similar to cognitive behavior music therapy (CBMT; Hilliard, 2001). This would be a model in which the music therapy experiences implement the DBT skills. DBMT would be an adaptation to the standard DBT protocol. This is because the respondents of this study indicated that they do not implement the full protocol. One major adaptation is that the respondents indicated primarily using DBT in music therapy in inpatient psychiatric settings with a wide range of populations. DBT in music therapy is not restricted to individuals with BPD in an outpatient setting. Previous studies have shown that adaptations to the protocol can still lead to effective DBT treatment, such as implementing DBT with a variety of populations with varying diagnoses and a variety of age groups (Chen et al., 2008; Glisenti & Strodl, 2012; Hill et al., 2011; Iverson et al., 2009; Kröger et al., 2010; Lynch et al., 2007; Perepletchikova et al., 2011; Safer et al., 2001b; Spont et al., 2003; Telch et al., 2000; Wagner et al., 2007)..

Furthermore, a previous report has shown how DBT has been adapted to create a new dialectical model, specifically for older adults with depression and personality disorders (Lynch et al., 2007). This model added modules that focus on looking forward to new experiences as well as looking back on past experiences. This treatment focuses on the unique needs of older adults. Lynch et al. developed a new treatment manual, and its effectiveness is being studied. This may show whether DBT can be effective when implemented in deviation from the standard protocol.

In addition, previous studies have shown that DBT can be implemented and effective in combination with another therapeutic approach. These include the combination of Gestalt therapy and DBT for adolescents with BPD (Williams, 2010), DBT with trauma-focused cognitive behavioral approaches with adults with posttraumatic stress disorder from childhood sexual abuse (Steil et al., 2011), and DBT and exposure therapy for individuals with PTSD and BPD (Harned & Linehan, 2008). These studies show that a combination of DBT with another therapy may be able to reach a more populations than individuals with BPD. These findings also are consistent with the findings of the interviews that music therapy may be able to reach clients in a way that verbal therapy cannot. This could suggest that a new model of DBT could be developed to incorporate music therapy resulting in DBMT.

In DBMT, the DBT protocol would have to be adapted for use in music therapy, as the findings of this study reflect that music therapists are not implementing the complete DBT protocol in their music therapy work. Therefore, it is inaccurate to state that music therapists are doing DBT music therapy. Rather, it is more accurate to say that music therapists are addressing components of DBT through music therapy.

The survey results reflect that respondents desire more training and experience, especially since the majority perceived themselves to be low in DBT competence. The respondents specifically reported wanting training and experience that is accessible and affordable so they can implement components of DBT in their music therapy work. There is an expressed interest in utilizing DBT in music therapy, but a lack of training. Training could increase music therapists' competence level in this type of work. In the meantime, it is

suggested that music therapists become more familiar with Marsha Linehan's texts, specifically the *Training Manual*.

The results of this study are consistent with developments in the field of DBT. For example, it is apparent that music therapists are using components of DBT in music therapy with a variety of populations and not just with individuals with BPD. DBT is not limited to individuals with BPD and has been effective for a wide variety of populations (Glesenti & Strodl, 2012; Huss & Baer, 2007; Iverson et al., 2009; Lynch et al., 2003; Safer et al., 2001a; Safer et al., 2001b; Spont et al., 2003; Steil et al., 2011; Telch et al., 2000). This could make the work valuable and more applicable to more music therapists, and it could benefit a larger population of individuals with whom they work. It is possible that music therapists have not sought out training because it may be rare that music therapists work with individuals with BPD. Increasing awareness that DBT is applicable to various mental health populations may make obtaining training more desirable.

Results indicated that there are perceived advantages to incorporating DBT into music therapy work. Obtaining training in DBT could be helpful in music therapy practice to provide a common language with other treatment team members and clients, as well as teaching practical skills that can be used posttreatment. Knowing that there are possible advantages to addressing DBT in music therapy could provide music therapists with reasons to pursue training.

Along with advantages, there are also perceived disadvantages to implementing DBT in music therapy. Music therapists need to use their clinical judgment in terms of clients' cognitive and psychological functioning level. DBT may not be appropriate to implement with all clients, as several respondents noted that the concepts may be too abstract for some

clients with lower cognitive and psychological functioning. This issue has been addressed and new treatment manuals are being developed that are targeted towards lower functioning clients (Brown, 2011).

Results from one of the interviews suggest that it is important for music therapists who implement DBT in their music therapy practice also to practice it in their personal lives. Similar to other therapeutic approaches, it is important for the therapists to be aware of their own process. It can be helpful for DBT therapists to use DBT in their daily lives before teaching it to clients. This could include practicing meditation and becoming more familiar with Buddhist philosophies.

DBT often is implemented by a treatment team. Music therapists can be and often are an integral part of the treatment team and may be able to present the DBT skills in a unique way. Music therapists who would like to implement DBT in their music therapy work need to be open to collaborating with other members of the treatment team. In addition, this collaboration could be positive for the field of music therapy by having a greater presence with team members.

Furthermore, music therapists who currently implement components of DBT in their practice should consider publishing their work. This study noted the lack of literature on the implementation of DBT in music therapy. For DBT to be viewed as effective when implemented through music therapy, empirical evidence needs to be developed.

Limitations

Several limitations to this study exist. One limitation was the small sample size for the survey, which provided only a glimpse into the current practice of DBT in music therapy. Respondents were solicited since they indicated working in mental health settings. Although

the respondents indicated working in mental health settings, not all respondents implement DBT in their music therapy work. Therefore, it is not known whether the proportions reported are representative of music therapists who practice in mental health. Even though the small sample size may be due to the paucity of music therapists' familiar with and using DBT, the number of respondents is still low. Although the interviews were intended to provide more in-depth information on the use of DBT in music therapy with music therapists who are experts in the field, the interviews included only two individuals and may not generalize to all music therapists experienced in the use of DBT in their music therapy practice. The survey sample was also limited to members of AMTA, excluding all professional music therapists who are not members of AMTA. The survey results may not represent all music therapists who use DBT in their music therapy work. There was also a large number of the solicited population that did not respond to the survey.

Another limitation is in regards to the survey itself. Because the survey did not include the question, "Do you currently implement DBT in your music therapy practice?" it was not possible to sort respondents according to clinical experience with DBT. The respondents who do not implement DBT in their music therapy practice may have influenced the results of the survey questions. For example, although there were 48 survey respondents, it may be that some do not implement DBT in their music therapy practice. On the other hand, respondents who do not use DBT may have been less likely to respond to the survey. The survey may not give an accurate representation of whether and how music therapists are implementing DBT in their practice.

Another limitation of the survey is that there was not an option to further describe the response of "other." This left it unclear what "other" could be for several of the questions

that provided that option. More specific information would have been provided if respondents were able to describe “other” including what sources music therapists are using in their self-study, who is implementing DBT in music therapy practice, their training, and how they are implementing DBT in music therapy.

The research question inquiring about adaptations of the DBT protocol in music therapy was confusing. The results from this question may not provide an accurate or clear description of how music therapists adapt the DBT protocol for their music therapy practice. The question was intended to ask how often the music therapist used each component of the protocol. Rather, the question seemed to be asking how often the music therapist implemented the full DBT protocol in individual DBT session, group DBT skills training, as-needed DBT phone consultations, and consultative DBT team meetings. The results from this section could also suggest that perhaps the respondents are not using any of the protocol because they are not implementing DBT in their music therapy practice. Although it is clear that the DBT protocol is not fully being implemented in music therapy, the results from this question do not provide accurate insight into how the DBT protocol is actually being adapted for music therapy.

Furthermore, there were several questions that encouraged respondents to “indicate all that apply” to their music therapy practice. This type of response gives information on all the possibilities that apply, but this is also a limitation because it makes it unclear which response is utilized most frequently.

Implications for Further Study

While this study provided some insight into the current use of DBT in music therapy practice, the study also brought about new research questions that could be addressed in

research in the future. For example, this study did not ask why music therapists are implementing DBT in their music therapy work and how they first heard about DBT. Future research could help identify if music therapists are incorporating DBT into their work because they want to or because the facilities in which they work are encouraging it.

Future research could replicate the findings of this study and increase generalizability by including a larger sample. It could survey all music therapists working in mental health settings, not just AMTA members. This would provide more insight into how DBT is being implemented in music therapy practice.

This research revealed that music therapists who work in mental health settings are knowledgeable about DBT and value it in music therapy; however, they feel they do not have appropriate training and do not feel competent and comfortable implementing it. There may be ethical concerns with that issue. One ethical concern is that therapists may be encouraged to use DBT although they feel they do not have adequate training and experience, which ultimately impacts the safety of the client. There is also a lack of research to suggest that DBT in music therapy is efficacious. It was revealed that the respondents desired more training in this topic. Future research could survey the type of training music therapists are interested in obtaining on DBT in music therapy. This could provide insight into what types of training programs could be developed to address this topic and would help advance the field of music therapy.

The survey was not able to reflect the decision making process in determining with which clients DBT in music therapy will be implemented. The interviews provided an opportunity to gather more information on how that decision is made. One of the interviewees implemented DBT with all clients, as she worked on a DBT milieu. She stated

that the skills are useful to most clients, but therapists need to use their own judgment about clients' intellectual and psychological functioning and whether it is appropriate to implement DBT. She also stated the importance of the use of DBT being a team decision. The other interviewee works in a psychiatric setting, but not on a DBT milieu; therefore, her decision making process differs from that of the other interviewee. In determining with whom to implement DBT in music therapy practice, she stated it is vital for the client to be cooperative, willing to make changes, and motivated. She also noted the importance of the therapeutic relationship and interest in engaging in music therapy for implementing DBT in music therapy to be successful with a particular client.

Future research could provide insight into how the decision is made to implement DBT in music therapy work. This was briefly addressed through the interviews, but it is still unclear if music therapists are implementing DBT because they find it valuable, or if the facilities in which they work are requiring it. It may be helpful for music therapists and other treatment providers to be aware of the decision making process for implementing DBT. Factors to consider studying are the therapeutic relationship, clients' motivation and readiness for therapy, the treatment team's influence, facility approach, and intellectual and psychological functioning level of the client.

As a result of the study, a new research question evolved. The question is "Why should music therapy be added to a therapy that already has empirical evidence for its effectiveness on its own?" The survey did not explicitly address this question, as the question came about after the survey was sent out to respondents. The question was not asked directly, but several of the survey respondents and both interviewees did answer that question through their perceived advantages of implementing DBT in music therapy. Future research could

address this question with a larger sample. Exploring this question with members of the DBT treatment team other than the music therapist also could provide insight into their perceptions.

It may be of value for future research to further explore the ways in which specific music therapy experiences inherently address DBT skills. Connecting DBT to existing music therapy knowledge may present this topic in a less daunting way and could show that music therapists do not have to completely change their style or session plans to reinforce the DBT skills. It could also motivate music therapists to learn the DBT language. Similar to Spiegel (2010), this information could be compiled to create a source that shows how common music therapy experiences are already addressing the DBT skills. This could help educate music therapists on how to reinforce those skills through an experience they are already using.

Another recommendation for future research is to consider carefully the wording and phrasing of questions. For example, responses to one question indicated how many music therapists implement a specific music therapy experience, rather than how frequently they use it. Also, the question that surveyed the music therapy experiences that are used to address the four DBT modules did not account for if and how the DBT skills are inherently addressed in music therapy experiences. It may have only addressed music therapy experiences designed specifically for addressing the DBT skills. Music therapists may not be aware that they are addressing the skills through music therapy practice, and music therapists who do not consider themselves to be implementing DBT in music therapy may not have answered this question, thus limiting the findings. Furthermore, Plener et al. (2010) used a group rock band approach to address DBT in music therapy, but group rock band was not a choice on the

survey question that inquired about types of music therapy experiences that are used in address DBT skills. This choice should be included in future studies.

It could also be informative to inquire for what symptoms music therapists choose to implement DBT in their music therapy work. This could provide more information regarding the reasons music therapists choose to use DBT. Although the survey results indicate that DBT is being used in music therapy with a variety of populations, an inquiry about how often music therapists use DBT in music therapy with children, adolescents, adults, and older adults could be useful.

Finally, this study revealed that some music therapists who practice in mental health settings are either implementing components of DBT into their music therapy practice, or have an interest in doing so after obtaining more training. Although there are music therapists doing this type of work, there is a lack of research in this area. Future studies could address this sizeable gap in the literature. Eventually, researchers will need to conduct an RCT that evaluates the differences between DBT treatment, music therapy treatment, and DBT and music therapy treatment.

Conclusion

This study has provided an overview of how DBT is currently being implemented in music therapy. This study in comparison with previous studies can offer suggestions for future intervention studies on this topic that could help develop a model or protocol for DBMT.

It was found that music therapists are more likely to adapt the DBT protocol in their music therapy work, and rather than providing DBT music therapy, music therapists address DBT skills through music therapy experiences. Although the standard DBT protocol is not

implemented in music therapy, it was found that addressing elements in DBT through music therapy is effective and beneficial for clients. It was also found that music therapists would like to incorporate elements of DBT into their music therapy practice, but do not feel competent doing so because lack of training. This finding suggests that additional training needs to be developed to encourage options other than self-study. The interviews suggest that facilities that implement DBT are more likely to provide training and have opportunities for music therapists to do this type of work. The interviews also suggest that DBT is an important topic to address in music therapy training, particularly for individuals who plan to work in mental health settings. The study also revealed that there are music therapists doing this type of work, and hopefully will feel encouraged to publish their work to expand the knowledge on this topic.

DBT is a growing field with empirical evidence for its effectiveness with mental health populations. For music therapists to stay updated on the current practices in mental health, it is important to be aware of this theoretical framework. Music therapy can provide a unique way to teach and reinforce the skills. Music therapists may be able to reach clients through music when they cannot be reached through words.

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Appendices

Appendix A

DBT and Music Therapy Questionnaire

The purpose of this survey is to investigate how dialectical behavior therapy (DBT) and its elements are incorporated in music therapy and how music therapy is being used to address DBT skills.

The survey consists of 24 questions, and should not take more than 10-15 minutes to complete.

If you have any questions regarding the survey, please contact:
Carolyn Chwalek, Principal Investigator, cchwalek328@gmail.com, 315-591-5939
Dr. Cathy McKinney, Faculty Advisor, mckinnych@appstate.edu, 828-262-6444
or the Institutional Review Board at Appalachian State University, irb@appstate.edu

Section 1 of 5

Demographic Information

1) Gender:

Choose: Male, Female, Other

2) Age:

3) What is your highest educational level obtained?

Choose: Bachelor's Degree, Music Therapy Equivalency, Master's in Music Therapy, Master's in Social Work, Master's in Counseling, Doctorate, Other

4) Indicate any other licensures, certificates, trainings, etc. you have received:

5) In which AMTA region are you located?

Choose: Great Lakes, Mid-Atlantic, Midwestern, New England, Southeastern, Southwestern, Western

6) How many years have you been professionally practicing music therapy?

7) In what treatment facility do you work?

Check all that apply:

- General Hospital
- Psychiatric Hospital
- Community Mental Health Center
- Child/Adolescent Treatment Center/Unit
- Geriatric Psychiatric Unit
- Forensic Facility
- Correctional Facility
- Drug/Alcohol Program/Unit
- Private MT Agency
- Other:

8) In what type of treatment setting do you work?

Check all that apply:

- Inpatient
- Outpatient
- Partial Hospitalization
- Day Treatment
- Other:

Section 2 of 5

DBT Training and Practice

9) What training have you received specifically in DBT?

Check all that apply:

- Conference Session
- Continuing Education
- Workshop/Seminar
- Graduate Courses
- Self-Study
- Online Training
- In-Service Training

- None
- Other:

10) What training have you received specifically on the use of DBT in music therapy?

Check all that apply:

- Conference Session
- CMTE
- Self-Study
- In-Service Training
- None
- Other:

11) How familiar are you with Marsha Linehan's skills training book, "Skills Training Manual for Treating Borderline Personality Disorder"?

	1	2	3	4	5	
Not at all familiar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Very familiar

12) With which diagnoses/issues do you implement DBT in your work?

- Borderline Personality Disorder
- Posttraumatic Stress Disorder
- Depression
- Eating Disorders
- Substance Use Disorders
- Trauma
- Nonsuicidal Self-Injury
- Suicidal Thoughts/Behaviors
- Other:

13) How competent do you feel using DBT in your work?

Not at all competent	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="padding: 5px 10px;">1</td> <td style="padding: 5px 10px;">2</td> <td style="padding: 5px 10px;">3</td> <td style="padding: 5px 10px;">4</td> <td style="padding: 5px 10px;">5</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	1	2	3	4	5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Highly competent
1	2	3	4	5								
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>								

14) Overall, how important do you think it is to use DBT in your work?

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Section 3 of 5

DBT Protocol

15) When you use DBT with a particular client, how often do you include the complete protocol?

For instance:

	Never	Rarely	Sometimes	Frequently	Always
Individual DBT Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Group DBT Skills Training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As-needed phone DBT consultation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consultative DBT team meetings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Section 4 of 5

DBT Skills and Music Therapy

16) How often do you address the following components of DBT in music therapy?

	Never	Rarely	Sometimes	Frequently	Always
Mindfulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotion Regulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Distress Tolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal Effectiveness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17) What music experiences do you primarily use to address mindfulness?

Check all that apply:

- Song Writing
- Music Listening
- Song Discussion
- Music and Imagery
- Music Improvisation
- Movement to Music
- Musical Games
- Other:

18) What music experiences do you use to address emotion regulation?

Check all that apply:

- Song Writing
- Music Listening
- Song Discussion
- Music and Imagery
- Music Improvisation
- Movement to Music
- Musical Games
- Other:

19) What music experiences do you use to address distress tolerance?

Check all that apply:

- Song Writing

- Music Listening
- Song Discussion
- Music and Imagery
- Music Improvisation
- Movement to Music
- Musical Games
- Other:

20) What music experiences do you use to address interpersonal effectiveness?

Check all that apply:

- Song Writing
- Music Listening
- Song Discussion
- Music and Imagery
- Music Improvisation
- Movement to Music
- Musical Games
- Other:

Section 5 of 5

Personal Opinions and Experiences

21) What are the advantages of incorporating DBT into music therapy?

22) What are the disadvantages of incorporating DBT into music therapy?

23) What other thoughts do you have about incorporating DBT into music therapy?

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24) If you wish, cite an example of personal work with clients using DBT in music therapy.

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Thank you for completing the survey!

If you have questions regarding the survey, please contact:

Carolyn Chwalek, Principal Investigator, cchwalek328@gmail.com, 315-591-5939
Dr. Cathy McKinney, Faculty Advisor, mckinneych@appstate.edu, 828-262-6444
or the Institutional Review Board at Appalachian State University, irb@appstate.edu

Appendix B

Oral Interview Questions

- 1) I am curious in learning more about your demographic background. How long have you been practicing as a music therapist, with what population, and in what setting?
- 2) Did the facility provide training for you?
- 3) Were you able to use your music therapy background to address those skills? Or did you just do the DBT group skills training as it was originated by Linehan?
- 4) Did you use the skills to come up with what music therapy experiences to use or was it the other way around? That the music therapy kind of already addresses those skills and you made them aware of that? Or how did that work?
- 5) It sounds like where you were working in the facility it was all one similar population. Is that right? They all got DBT?
- 6) I guess the question there would be, how do you decide with what clients you are going to use DBT?
- 7) Through the survey it seemed like that was one of the issues that several respondents saw as a disadvantage. Sometimes the DBT skills are too complex for lower functioning clients to grasp and understand. So, it seems like that is something important to consider too?
- 8) DBT was developed for the use with individuals with BPD, but there is a lot of research with other populations. What is your thought on its use with other populations and adapting it for other needs?
- 9) In doing my research, you were one of the very few people that came up in my search that is using DBT in music therapy. I know you got your DBT training from Behavioral Tech, but

what were some of the sources you used to combine music therapy and DBT? Or is that all original work?

10) What training do you recommend for music therapists to have before addressing DBT through music therapy?

11) How is the DBT protocol adapted for music therapy? I think it is hard to say that music therapists are using the full DBT protocol in their work; rather, they are more addressing DBT skills. I am curious about how often would you use individual therapy, group skills training, phone consultation, and team consultations in music therapy?

12) Did you find the program to be helpful for the individuals there?

13) What type of music therapy experiences do you use to address each module? Which ones do you use most often or find most effective?

14) A lot of music therapy experiences inherently address the DBT skills. So, how important do you think it is for music therapists to know the DBT skills and the DBT language if they are doing them already?

15) What are some other advantages that you see for music therapists to be trained in DBT?

16) On the other hand, what are some disadvantages to using DBT in music therapy?

17) One respondent from the survey wrote they find DBT can take away from the music because the discussion can take over. What is your thought on that?

18) Why should music therapy be used with a therapy that already had empirical evidence for its effectiveness?

19) Do you think that the whole team is needed for DBT to be effective? Or what about someone who has a private practice and wants to incorporate DBT by themselves

Appendix C

Written Interview Questions

- 1) How long have you been practicing as a music therapist? With what population do you work? In what setting?
- 2) How long have you used DBT in your music therapy practice? With what diagnosis/diagnoses and treatment settings (individuals, groups) do you primarily implement DBT in music therapy?
- 3) DBT was originally developed for use with individuals with borderline personality disorder. With what populations do you find it can be effective?
- 4) How did you become interested in using DBT in your music therapy practice?
- 5) Did you receive formal training in DBT? If so, where did you obtain your training?
- 6) What resources did you use to get training on the use of DBT in music therapy? Who do you consider to be the founders of DBT in music therapy?
- 7) What training do you recommend for music therapists to have before implementing DBT in their music therapy work?
- 8) How do you determine when or with whom you will use DBT in your music therapy work?
- 9) How often do you use the complete DBT protocol, as Marsha Linehan developed (Individual DBT Therapy, Group DBT Skills Training, as-needed DBT phone consultation, consultative DBT team meetings)? How is the DBT protocol adapted for use in music therapy?

- 10) What are some music therapy experiences you use to address mindfulness?
- 11) What are some music therapy experiences you use to address emotion regulation?
- 12) What are some music therapy experiences you use to address distress tolerance?
- 13) What are some music therapy experiences you use to address interpersonal effectiveness?
- 14) How often do you feel music therapy experiences inherently address DBT skills?
When music therapists address DBT skills without knowing the DBT language, how important is it to label these experiences as DBT?
- 15) In what ways is DBT in music therapy unique and different from other forms of music therapy? How is it similar?
- 16) What are the advantages of incorporating DBT into music therapy?
- 17) What are the disadvantages of incorporating DBT into music therapy?
- 18) Since DBT has research behind its effectiveness, what does music therapy have to add? Why add music therapy?
- 19) What else would you like to share about your thoughts or experiences in integrating DBT and music therapy that was not already mentioned?

Appendix D

Email/Survey Consent Form

Dear Music Therapist,

As a music therapist who provides services in a mental health setting, you are invited to participate in a survey that concerns your implementation of dialectical behavior therapy (DBT) in music therapy, specifically, how its elements are incorporated into music therapy and how music therapy is being used to address DBT skills. This survey is part of my thesis research on the use of DBT in Music Therapy, which I am conducting at Appalachian State University. This was reviewed and declared exempt from further review on June 30, 2013 by the University's IRB.

Your contact information is being used with permission from the American Music Therapy Association, but the information you provide will remain completely anonymous. The website (Google Docs) where the survey is located is a secure site, and it neither stores nor tracks your email address, nor does it attach your email address to your responses. The researcher will have no access to email addresses of those who participate or do not participate in the study, and the researcher will not have the ability to link e-mail addresses to responses. The anonymous data will be included in the researcher's master's thesis, and the study may be submitted for publication and presentation at AMTA conferences.

Your participation in completing this survey is voluntary, and there are no consequences if you decline to participate or decide to discontinue participation at any time. No risks are associated with completing this survey, and you will receive no compensation. You will be asked to complete 24 questions regarding the use of DBT in music therapy; this process should not take more than 10-15 minutes. If you are willing to participate, please continue to access the online survey. By submitting responses to the survey you are consenting to participate. You can choose to respond to all, some, or none of the items.

Please complete the survey by Monday, September 2, 2013.

Questions may be directed to:

Carolyn Chwalek, cchwalek328@gmail.com, 315-591-5939

Dr. Cathy McKinney, Faculty Advisor, mckinneych@appstate.edu, 828-262-6444

Or the Institutional Review Board at Appalachian State University at irb@appstate.edu

By continuing to the survey, I acknowledge that I am at least 18 years old, have read the above information, and provide my consent to participate under the terms above.

Thank you for your participation.

Sincerely,

Carolyn Chwalek, MT-BC

Principal Investigator

Candidate for Master of Music Therapy degree

Appendix E

Email of IRB Approval/Exemption

To: Carolyn Chwalek
CAMPUS MAIL

From: IRB Administration

Date: 6/30/2013

RE: Notice of IRB Exemption

Study #: 13-0305

Study Title: The use of dialectical behavior therapy (DBT) in music therapy: A survey of current practice

Exemption Category: (2) Anonymous Educational Tests; Surveys, Interviews or Observations

This study involves minimal risk and meets the exemption category cited above. In accordance with 45 CFR 46.101(b) and University policy and procedures, the research activities described in the study materials are exempt from further IRB review.

Study Change: Proposed changes to the study require further IRB review when the change involves:

- an external funding source,
- the potential for a conflict of interest,
- a change in location of the research (i.e., country, school system, off site location),
- the contact information for the Principal Investigator,
- the addition of non-Appalachian State University faculty, staff, or students to the research team, or
- the basis for the determination of exemption. Standard Operating Procedure #9 cites examples of changes which affect the basis of the determination of exemption on page 3.

Investigator Responsibilities: All individuals engaged in research with human participants are responsible for compliance with University policies and procedures, and IRB determinations. The Principal Investigator (PI), or Faculty Advisor if the PI is a student, is ultimately responsible for ensuring the protection of research participants; conducting sound ethical research that complies with federal regulations, University policy and procedures; and maintaining study records. The PI should review the IRB's list of PI responsibilities.

To Close the Study: When research procedures with human participants are completed, please send the Request for Closure of IRB Review form to irb@appstate.edu.

If you have any questions, please contact the Research Protections Office at [\(828\) 262-7981](tel:8282627981) (Julie) or [\(828\) 262-2692](tel:8282622692) (Robin).

Best wishes with your research.

Websites for Information Cited Above

Note: If link does not work, please copy and paste into your browser, or visit <https://researchprotections.appstate.edu/human-subjects>.

1. Standard Operating Procedure

#9: <http://researchprotections.appstate.edu/sites/researchprotections.appstate.edu/files/IRB20SOP920Exempt%20Review%20Determination.pdf>

2. PI responsibilities:

<http://researchprotections.appstate.edu/sites/researchprotections.appstate.edu/files/PI20Responsibilities.pdf>

3. IRB forms: <http://researchprotections.appstate.edu/human-subjects/irb-forms>

CC:

Cathy McKinney, School Of Music

Christine Leist, School Of Music

Lisa Grizzard, Psychology

Appendix F

Oral Interview Consent Form

I agree to participate as an interviewee in the research project, "The Use of Dialectical Behavior Therapy (DBT) in Music Therapy: A Survey of Current Practice." The research project is investigating how DBT and its elements are incorporated into music therapy and how music therapy is being used to address DBT skills. The study will be completed by December 15, 2013. I understand that my comments will be audio recorded, transcribed, and used for a Master's thesis and possible publication by Carolyn Chwalek as partial fulfillment for the Master of Music Therapy program at Appalachian State University. The interview will take place one time for approximately 60 minutes. I understand that there are no foreseeable risks associated with my participation. I also know that this study may benefit the field of music therapy and related mental health fields by increasing therapists' understanding of music therapy and DBT.

I give Carolyn Chwalek ownership of the recording and transcript from the interview she conducts with me and understand that the recording and transcript will be kept in the researcher's possession. I understand that information or quotations from the transcript will be published. I understand I will receive no compensation for the interview.

I understand that the interview is voluntary and I can end it at any time without consequence. I also understand that if I have questions about this research project, I can contact Dr. Cathy McKinney, the Committee Chair, at 828-262-6444 or mckinneych@appstate.edu. I can also contact Appalachian State University's Office of Research Protections at 828-262-7981 or irb@appstate.edu.

I request that my name **not** be used in connection with recordings, transcripts or publications resulting from this interview.

I request that my name **be used** in connection with recordings, transcripts or publications resulting from this interview.

Name of Interviewer _____
Signature of Interviewer _____

Name of Interviewee _____
Signature of Interviewee _____

Date of Interview

Appendix G

Written Interview Consent Form

I agree to participate as an interviewee in the research project, "The Use of Dialectical Behavior Therapy (DBT) in Music Therapy: A Survey of Current Practice." The research project is investigating how DBT and its elements are incorporated into music therapy and how music therapy is being used to address DBT skills. The study will be completed by December 15, 2013. I understand that my comments will be audio recorded, transcribed, and used for a Master's thesis and possible publication by Carolyn Chwalek as partial fulfillment for the Master of Music Therapy program at Appalachian State University. The interview questions will be emailed once and if I choose to participate, will send my written responses back. I understand that there are no foreseeable risks associated with my participation. I also know that this study may benefit the field of music therapy and related mental health fields by increasing therapists' understanding of music therapy and DBT.

I give Carolyn Chwalek ownership of the transcript from the interview she conducts with me and understand that the transcript will be kept in the researcher's possession. I understand that information or quotations from the transcript will be published. I understand I will receive no compensation for the interview.

I understand that the interview is voluntary and I can end it at any time without consequence. I also understand that if I have questions about this research project, I can contact Dr. Cathy McKinney, the Committee Chair, at 828-262-6444 or mckinneych@appstate.edu. I can also contact Appalachian State University's Office of Research Protections at 828-262-7981 or irb@appstate.edu.

I request that my name **not** be used in connection with transcripts or publications resulting from this interview.

I request that my name **be used** in connection with transcripts or publications resulting from this interview.

Name of Interviewer _____ Name of Interviewee _____
Signature of Interviewer _____ Signature of Interviewee _____

Date of Interview

Appendix H

Oral Interview Transcript

Interview #1: Deborah Spiegel

Note: C. C. = Interviewer, D. S. = Interviewee

C. C.: I am curious in learning more about your demographic background. How long have you been practicing as a music therapist, with what population, and in what setting?

D. S.: I have been a music therapist for years. I graduated in 1976 and I have worked with a lot of different populations in a variety of settings over those years. For the past two years I have been doing the training [continuing music therapy education], but before that, I worked for 11 years at a state hospital on a locked adolescent unit in a DBT milieu. I started there and I was all happy with the therapeutic effects of what I was doing and how it was working, and then they started DBT.

C. C.: Did the facility provide training for you?

D. S.: Yeah, Behavioral Tech came and trained the team. Then, I was asked to colead with the psychologist for a while. They asked me to then become one of the skills group leaders, so if there were only a few kids, I would be the coleader with the psychologist, and if there were enough kids, then we would split into two groups. They also had smaller skills groups twice a day. They had homework group at night and the recreational therapist and I alternated

on those at night. So, through teaching the skills group, I found myself drawn to wanting to use music to make my point.

C. C.: Were you able to use your music therapy background to address those skills? Or did you just do the DBT group skills training as it was originated by Linehan?

D. S.: Well, I did both. I would be sitting in a group talking about the three states of mind and trying to talk about mindfulness and the kids were all over the place, and they were not focusing on anything, so I would pick up my guitar and strum, and they were like “whoa!” and it really got their attention. So that is where I started to make up a lot of songs and used the pros and cons and different things to reinforce whatever skill it was we were on that day. In my music therapy groups we would do whatever we would do in music therapy, but I would always tie it back to what the skills are.

C. C.: Did you use the skills to come up with what music therapy experiences to use or was it the other way around? That the music therapy kind of already addresses those skills and you made them aware of that? Or how did that work?

D. S.: It kind of works both ways. In the CMTE training, one of the things we did was bring in your favorite [music therapy] activity. We then would look at it and see how it could be used to reinforce any skill. So, I think it is a matter of once you know the skills, you can kind of tailor it and focus it. It could be the same intervention, but reinforcing the [DBT] skills. Then, the other way around is like writing a song or something around a particular skill to reinforce that specifically.

C. C.: It sounds like where you were working in the facility it was all one similar population. Is that right? They all got DBT?

D. S.: For the most part, I worked on the locked adolescent unit and it was a DBT milieu. They were all in groups all day with DBT and it was a completely immersed DBT environment. I also went once a week to the adult unit and had a DBT based music group, but it was different. I didn't know the clients. They were adults that had a lot of psychotic issues, and it was really different focus.

C. C.: I guess the question there would be, how do you decide with what clients are you going to use DBT?

D. S.: I think that would be a team decision. But, in that case with those adults, I would pick one skill and use a music therapy experience and then talk about the skill and tie it into their life. Just one little brief skill and experience.

C. C.: Through the survey it seemed like that was one of the issues that several respondents saw as a disadvantage. Sometimes the DBT skills are too complex for lower functioning clients to grasp and understand. So, it seems like that is something important to consider too?

D. S.: Yeah, exactly. There's a book out by Julie Brown, *The Skills System Instructor's Guide: An Emotion Regulation Skills Curriculum for All Learning Abilities*. She took DBT and modified it and she says, "Do not call it DBT." She addresses emotion regulation skills and simplifies everything. So, mindfulness is getting a clear picture of the self. She splits it up into what is going on inside and what is going on outside. She also describes different thoughts. For example, if we are having a "thumbs up" thought or a "thumbs down" thought.

C. C.: DBT was developed for the use with individuals with BPD, but there is a lot of research with other populations. What is your thought on its use with other populations and adapting it for other needs?

D. S.: I took a workshop with Marsha Linehan, and it was on mindfulness. She had this whole new manual that does not even have BPD in the title anymore, because they have done so much research on it being used with other populations. For example, it is effective with women who are overweight, in prisons, with kids in schools, and different areas. I think they are finding that the skills are useful to pretty much anybody, and I think we have to use our own judgment on their intellectual and psychological state [to decide] if they can use it or not.

C. C.: In doing my research, you were one of the very few people that came up in my search that is using DBT in music therapy. I know you got your DBT training from Behavioral Tech, but what were some of the sources you used to combine music therapy and DBT? Or is that all original work?

D. S.: It is all original.

C.C.: What training do you recommend for music therapists to have before addressing DBT through music therapy?

D. S.: Especially read the skills training manual by Linehan. If you are part of a team, it is really good to attend the skills groups. People have told me that once they have attended the CMTE workshop, they felt like they had the language to speak to the social worker and the psychologist in their treatment team and have found themselves becoming coleaders or skills group leaders and then being able to integrate music in themselves. I am glad to know that it is being useful.

C. C.: How is the DBT protocol adapted for music therapy? I think it is hard to say that music therapists are using the full DBT protocol in their work; rather, they are more

addressing DBT skills. I am curious about how often would you use individual therapy, group skills training, phone consultation, and team consultations in music therapy?

D. S.: We had team meetings every morning because it was an inpatient psych unit. We had consultation team once a week. Then, each client was assigned to one staff member to do 1:1, so they had one or preferably two individual sessions a week, and groups three times a day. Group skills training was twice a day and then homework group at night. Everyone was trained so even when they were in school, the teachers would be reinforcing skills, the nurses, everybody. Sometimes when clients would get discharged they would call in and talk to the nursing staff for phone consultations.

C. C.: Did you find the program to be helpful for the individuals there?

D. S.: Yeah. It amazes me how even in a short amount of time, because it was so intense, how they really got the skills. Someone would come in highly easily triggered or highly aggressive or something, but would then get the mindfulness and awareness to be able to recognize when they were agitated and needed a time out.

C. C.: What type of music therapy experiences do you use to address each module? Which ones do you use most often or find most effective?

D. S.: For mindfulness, my roller coaster song (see Appendix J). I like that a lot for teaching awareness to step back when you are in the point of no return you are about to go off on emotion mind. It teaches [one] to observe and describe and step back from that, and it helps to have the awareness and to look at the pros and cons. It helps to decide, “Should I do this or should I not?” I also use guided imagery a lot for mindfulness. It gives them the sense of, “What is mindfulness? What is wise mind anyway? What is that?” For distress tolerance, I use my pros and cons song (see Appendix K). I really like using that. I told you that story

about the girl that climbed up on the barn and was going to kill herself, but the song came through her head? Pretty much all of the music therapy interventions that I could think of could fit under distraction through contributing or teaching emotions, like the ACCEPT skill. Radical acceptance is also in music therapy all the time. So, understanding emotions for emotion regulation is observing and describing emotions. That is one that we already do a lot with music. The Rational Versus Irrational skill, I like to do that with lyric analysis.

C. C.: A lot of music therapy experiences inherently address the DBT skills. So, how important do you think it is for music therapists to know the DBT skills and the DBT language if they are doing them already?

D. S.: To me, having that language makes it even more powerful because I might know that this is good for “x-y-z”, but to have the language and everyone else in the whole milieu to have that language and the client to recognize that doing this fun activity is actually a way to distract myself from my problems or whatever the skill is. It adds a new dimension.

C. C.: What are some other advantages that you see for music therapists to be trained in DBT?

D. S.: Well, in mental health, I just love DBT. I think the skills are useful for almost everyone. I think it adds a whole dimension to what we are doing.

C. C.: On the otherhand, what are some disadvantages to using DBT in music therapy?

D. S.: I don't know. I do not really see any.

C. C.: One respondent from the survey wrote they find DBT can take away from the music because the discussion can take over. What is your thought on that?

D. S.: In the DBT skills group, that was where the talking happened. In the music therapy group, I would just do my regular music therapy and then wind up by reinforcing the skill. If

anything came up during the group where we needed to use a skill, we would address that in the moment. Otherwise, we just reinforced, “What skill did we just practice?” So, it didn’t take away. For example, if we did lyric analysis, we would bring in a song that describes the self, and they would be talking about the self, and then I would ask, “What skills would you recommend for the singer of the song?” It is still the same activity, just focused on DBT skills.

C. C.: Why should music therapy be used with a therapy that already had empirical evidence for its effectiveness?

D. S.: Because it is being delivered by a treatment team. A team is made up of all of its members and the psychologist isn’t the only one that can reach the clients. A lot of people could be reached through music in a way that the social worker or psychologist could not. That is the value of a team. We are all doing what we do and contributing towards the goals of that one group of clients. DBT is empirical, and so is music therapy.

C. C.: Do you think that the whole team is needed for DBT to be effective? Or what about someone who has a private practice and wants to incorporate DBT by themselves?

D. S.: I think that both can be effective.

Appendix I

Written Interview Transcript

Interview #2: Gertraude Scheidt

Note: C. C. = Interviewer, G. S. = Interviewee.

C. C.: How long have you been practicing as a music therapist? With what population do you work? In what setting?

G. S.: I have practiced as a music therapist since 1994. For two years I was working in a psychosomatic clinic with male clients who have problems with alcohol. Since 1996 I have worked in the Clinic for Psychiatry, Psychotherapy, and Psychosomatics in Heidenheim. The clients have all kinds of psychiatric diagnoses, mostly depression, schizophrenia, personal disorders, neurotic problems, eating disorders and various others. There are two acute wards, one day clinic, and one ward with psychotherapy conception.

C. C.: How long have you used DBT in your music therapy practice? With what diagnosis/diagnoses and treatment settings (individuals, groups) do you primarily implement DBT in music therapy?

G. S.: I have worked with DBT since about 1999. A doctor at the clinic showed me Marsha Linehan's concept, and I adapted it to music therapy. I already had experience with borderline clients, both in groups and in single therapy settings. I found it more effective to first train the client to use the DBT concept in a one-on-one setting before introducing the

client back into a group, where they could experiment with the new skills. In the [1:1] setting the client learns to exercise special behaviour and themes with DBT elements (for example; skills training, mindfulness exercises, regulation and identification of emotions etc.)

C. C.: DBT was originally developed for use with individuals with borderline personality disorder. With what populations do you find it can be effective?

G. S.: It can be effective with clients who have borderline disorders but some elements of DBT can also be used with depressive clients (for example, exercises with mindfulness, identification and expression of emotions, and learning to take a metaperspective of themselves ...). It can also be beneficial with clients who have eating disorders (DBT-E).

C. C.: How did you become interested in using DBT in your music therapy practice?

G. S.: I became interested in DBT when I read the manual and theory of Marsha Linehan. It was a good concept that suited the kind of music therapy that I practice and I had already included some elements of it before I got to know Linehan's texts.

C. C.: Did you receive formal training in DBT? If so, where did you obtain the training?

G. S.: I did not have formal DBT training. I integrated the practice of DBT in music therapy by the help of Linehan's *Training Manual*. I combined the exercises in the *Training Manual* with music.

C. C.: What resources did you use to get training on the use of DBT in music therapy? Who do you consider to be the founders of DBT in music therapy?

G. S.: I don't know who the founders of DBT are, but I refer you to the list of articles with names of music therapists who integrate DBT in their daily work which I sent recently. I also recommend you have a look at the Music Therapy Annual Volume 5, 2009, in which you will find a current article entitled *Emotion Regulation in Music Therapy with Borderline*

Patients in the Context of DBT by Angela Knoche. Apart from the resources I've mentioned, I use as resource my own training, personal meditation and experiencing mindfulness myself.

Note: The list of resources referred to were sent in a separate email:

Linehan, M. M. (1996). *Dialektisch-Behaviorale Therapie der borderline Persönlichkeitsstörung*. München, CIP_Medien.

Linehan, M. M. (1996). *Trainingmanual zur Dialektisch-Behavioralen Therapie der Borderline-Persönlichkeitsstörung*. München CIP-Medien.

Makowitzky, R. (1995). "Über mein Spiel kann ich nichts sagen, denn ich spüre nichts."
Möglichkeiten der Modifikation musiktherapeutischer Standardregeln.
Musiktherapeutische Umschau, 16(2).

Schmidt, H. U. (1999). *Musiktherapie bei stationär behandelnten Borderline-Patienten*.
Musiktherapeutische Umschau, Band 20(1).

C. C.: What training do you recommend for music therapists to have before implementing DBT in their music therapy work?

G. S.: Music therapists who wish to implement DBT would benefit from meditation, mindfulness exercises, experimentation with emotion regulation, and reading Buddhist theories and practice, as it is very difficult to use the techniques with clients without having experienced them personally. I am of the opinion that only having a music therapy qualification, would not prepare a therapist to cope with clients with borderline personality disorder, therefore the music therapist needs an additional specialization, either through an additional formal qualification or through personal study and research whereby he/she becomes familiar with current discoveries in the field. For example, it was very important for me to receive a further qualification. (Systemische Einzel-, Paar- und Familien Therapie. A

three-year qualification that I completed in 2007.) During this training, I learnt a lot about clients with borderline personality disorder, behaviour, and trauma therapy.

C. C.: How do you determine when or with whom you will use DBT in your music therapy work?

G. S.: One criterion I use to determine with whom I use DBT, is that the client should be cooperative and want to gain his/her own experience and be prepared to make efforts of his /her own. There must be a willingness to cooperate with me and to practice the exercises in everyday life. The client should be motivated to work with me and a previous knowledge of and success with music therapy is an advantage.

C. C.: How often do you use the complete DBT protocol, as Marsha Linehan developed (Individual DBT Therapy, Group DBT Skills Training, as-needed DBT phone consultation, consultative DBT team meetings)? How is the DBT protocol adapted for use in music therapy?

G. S.: I don't use the complete DBT protocol, but I adapt some sequences of it during the therapy process. It depends on the themes. We try to adapt Skills training to the client's personal and current needs. I don't offer telephone consultations. In terms of consultative DBT team meetings, I communicate with the doctor of psychiatry and other coworkers who also treat the client, and we share ideas. I ensure that I stay in contact with the main therapist. I adapted the DBT protocol by integrating music therapy exercises into some of the DBT elements.

C. C.: What are some music therapy experiences you use to address mindfulness?

G. S.: When, for example, instruments are played in a group I instruct the participants to observe themselves, to listen to the music, and not to be disturbed or place too much value on

the feelings, thoughts, or associations that come to them while playing.

Another example in a one-on-one consultation would be when I play music for a client having instructed him/her to observe his/her breath, thoughts, imagination, and body without placing a value on it.

C. C.: What are some music therapy experiences you use to address emotion regulation?

G. S.: In order to address emotion regulation, I invite a client who feels anger or impulsiveness to choose an instrument that suits his emotion. When the client begins to play, I could, for example, accompany him with another instrument, and we could try to express the emotion through music. (Through this I express empathy—but I also limit the improvisation). After we finish playing, we reflect verbally what the atmosphere in the music was, how the client felt during and after playing, etc. After that we could continue to express the anger and then to try to develop it in the music, perhaps to start rather playing calmer music or music expressing a more desirable emotion. To be aware of the emotion and then to develop it in a creative playful way is a kind of emotion regulation, and I've found this to be a very effective way for the client to influence what happens with his emotions. Clients are generally far calmer and difficult emotions resolved after this exercise.

C. C.: What are some music therapy experiences you use to address distress tolerance?

G. S.: To address distress tolerance I encourage the client to accept the feeling, to express it through music, and I ask the client what they think would ease the distress, e.g. I could play for them.

C. C.: What are some music therapy experiences you use to address interpersonal effectiveness?

G. S.: Music therapy lends itself very well to interpersonal interaction on the instruments. For example, we only use instruments to play out a musical interpretation of a dispute or we try to discuss without spoken language. One person can try to play the mood of another person with instruments, which encourages empathising. Instruments allow us to experiment with different roles.

C. C.: How often do you feel music therapy experiences inherently address DBT skills? When music therapists address DBT skills without knowing the DBT language, how important is it to label these experiences as DBT?

G. S.: I often feel that music therapy experiences inherently address DBT skills. DBT is an evidence-based concept which helps the therapist to apply interventions more consciously, more precisely. Although I feel labelling techniques using DBT terms is not important, but it is important to know Marsha Linehan's theory, in order to recognise symptoms and handle client more effectively.

C. C.: In what ways is DBT in music therapy unique and different from other forms of music therapy? How is it similar?

G. S.: DBT has many elements from behavioural therapy, something that is not practiced by all music therapists. Perception and expression of emotions, as well as observation and regulation of emotions, are fundamental to both DBT and music therapy. Meditation and the skills suitable for DBT also can be a part of music therapy sessions.

C. C.: What are the advantages of incorporating DBT into music therapy?

G. S.: The advantage is that it is an evidence-based concept with a lot of practical exercises and is very suitable to a wide range of music therapy interventions. I found that it gave me confidence and direction in the treatment of borderline clients. Previously, borderline clients

would often disrupt group therapy, DBT enabled the clients to regulate their emotions to such an extent that they could take part in group sessions.

C. C.: What are the disadvantages of incorporating DBT into music therapy?

G. S.: DBT would only be disadvantageous, [if] a therapist [were] to use the manual too rigidly. It must be handled flexibly and adapted to the personal needs of the client.

Otherwise, in my opinion, it can only enrich music therapy.

C. C.: Since DBT has research behind its effectiveness, what does music therapy have to add? Why add music therapy?

G. S.: Music therapy can complement DBT very effectively. I think music therapy could add exercises to attentiveness, regulation and identification of emotions, body skills, relaxation, and self-awareness, etc. If a client is stuck with verbal communication, and no change is happening, the music may help communicate. If a client does not want to communicate verbally, you can continue the process on a musical and nonverbal level. Then, the problems would become more clear and you can add a verbal reflection about the music, and not directly the person. To speak first about the feelings and atmosphere in the music/improvisation, can make it easier to get to the central themes. The music is less threatening. The process can go on through the music. The therapist and client can improvise about feelings together and the therapist can take part in the process even if it is nonverbal.

C. C.: What else would you like to share about your thoughts or experiences in integrating DBT and music therapy that was not already mentioned?

G. S.: I find it very helpful to include the DBT-concept in my work in the psychiatric clinic. With my personality and my style of music therapy DBT is a very comfortable way to enrich the therapy. I like to work with borderline clients and my experience showed me that they

often benefit a lot from the combination of music therapy and DBT. One reason for this good combination is perhaps that these clients are creative and are open to new experiences.

Music is a media that can support creativity, personal expression of emotions, [and] learning to listen and concentrate not only on the music but also on one's feelings, and it has an effect not only on the mind, but also on the body and soul of the client.

Appendix J

“The Roller Coaster Ride” by Deborah Spiegel

Somebody treated me unfair
I know I really shouldn't care
But I feel like doing something mean
I don't care if it's right or wrong

CHORUS

Oh, here comes the roller coaster ride
I feel the anger swell inside
It's not too late
To be wise

So emotions don't control me
I notice what's happening with me
Hot tears rolling down my face
My heart's beginning to race
My thoughts are those of revenge
Maybe I should relax with my friends instead

CHORUS

Maybe I should go ride my bike
Or I could go for a hike
Walk outside and listen to the brook
I could go read a good book
(add your own lines here)
Run real fast until the anger's gone
Or play guitar and you sing a song

CHORUS

Appendix K

“Pros and Cons” by Deborah Spiegel

Pros and cons
Pros and cons

Think about the consequences when I feel my urges
Think about the consequences when I feel my urges

Stop—and think
Stop—and think

Vita

Carolyn Chwalek was born in Owego, NY. She is the daughter of Tom and Judy Chwalek. Upon graduating high school, Carolyn received her undergraduate education at Baldwin-Wallace College with a Bachelor of Music degree in music therapy in May 2010. In July 2010, Carolyn started her internship at the University of Pittsburgh Medical Center, where she worked 3 months at Western Psychiatric Institute and Clinic and 3 months at the Children's Hospital of Pittsburgh. In January 2010, Carolyn completed her internship and passed her board exam to become a board certified music therapist (MT-BC). She then worked as a music therapist with a variety of populations in the Cleveland area until returning to school for the Master of Music Therapy degree at Appalachian State University in the Fall of 2011. Carolyn's emphasis was in mental health, and she also obtained the Certificate in Expressive Arts Therapy in Spring 2013. While working on her degree, Carolyn worked as a graduate assistant for the Scholars with Diverse Abilities Program at ASU. Carolyn completed the Master of Music Therapy in December 2013.

Following graduation from ASU, Carolyn plans to pursue a career as a music therapist in the NYC area. She is interested in working with individuals in mental health settings, as well as individuals with intellectual disabilities. She also plans to continue her training in Level III in Guided Imagery and Music, under the teaching of Dr. Cathy McKinney.