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Music Therapy, Spiritual Health Needs, and Substance Use Disorders:

A United States Survey Study

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Abstract

Individuals with Substance Use Disorders (SUDs) require multiple levels of care and support for recovery. Moreover, people with SUDs must adopt a new way of living which fosters meaning, personal growth, and connection with others to sustain ongoing sobriety. Research suggests that spirituality can often play an integral role for persons in recovery. There is a paucity of research which examines music therapy's efficacy for addressing the spiritual health needs of individuals with SUDs. A survey was conducted to learn more about how, and if music therapists in the United States are treating the spiritual health needs of people with SUDs. Music therapists reported that "connection with others" and "exploring relationship with self" were the most common spiritual health goals addressed in music therapy. Song discussion and lyric analysis were the most used methods to address spiritual goals. The United States' imperative for the "Gold Standard" of evidence-based practice and its potential influence on music therapy treatment are considered and explored in the context of spiritual health needs. The present study can help to broaden the knowledge base of current trends in music therapy practice in meeting the spiritual health needs for persons with SUDs, as well as provide recommendations for future research, and music therapy educators in the United States.

Keywords: music therapy; substance use disorders; spiritual health; spirituality; addictions

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Introduction

Spirituality as a Pertinent Resource for Individuals in Recovery

Spirituality has been described as what the World Health Organization and United Nations Office on Drugs and Crime [WHO & UNODC, 2020] refer to as "recovery capital, the enhanced ability to sustain recovery from SUDs" (Galanter, 2021, p. 169). In recent years, the role of spiritual health and spirituality in addiction recovery has been the subject of increased research inquiry, further illuminating its importance for individuals with substance use disorders (SUDs) (e.g., Kelly & Eddie, 2020; Galanter et al., 2024).

Defining spirituality presents difficulties due to the broadness of the construct. Whitfield (1984) divides spirituality into "one's relationship in three areas: (1) with the universe, (2) with other people, and (3) with one's self" (p. 14). Spiritual principles can be incorporated in how we relate to and interact with every aspect of our lives, as well as how we derive meaning and cultivate values (Nagai-Jacobson & Burkhardt, 1989; Puchalski, 2003).

Carl Jung considered spiritual experiences as pivotal for the psychic change necessary to arrest the disease process of SUDs (Alcoholics Anonymous World Services, 2001; Jung, 1961). Research supports this notion, in which spirituality has been suggested to play a vital role in the lives of persons in recovery (e.g., Chukwunta, 2018; Dermatis & Galanter, 2016). Furthermore, spiritual change has been associated with various positive health outcomes for people with SUDs, such as increased rates of abstinence (Bluma, 2018; Galanter, 2014a; Tonigan, 2013, 2017), fewer cravings, and decreased depression symptoms (Galanter, 2013, 2014a, 2014b).

Spirituality is also associated with positive outcomes and benefits for several clinical populations. Among individuals with cancer, spiritual well-being has been linked to decreased pain, anxiety, and depression (Yang et al., 2023); improved emotional well-being (Delgado-Guay et al., 2021); and quality of life (Chaar et al., 2018). Spirituality has also been associated with healthy coping mechanisms, and decreased depression for persons with various mental health disorders (Luchetti et al., 2021). However, spiritual health is unique for persons with SUDs, in that growth and transformation in this area is quite often perceived as imperative for sustaining recovery itself (Alcoholics Anonymous World Services, 2001; Galanter et al., 2024; Jung, 1961; Kelly & Eddie, 2020; Narcotics Anonymous World Services, 2008).

Addiction, Connection, and Music

It has been said that "the opposite of addiction is connection" (Hari, 2015). The experience surrounding the vicious cycle of substance addiction can be understood as one of total disconnection and isolation. Detachment not only from the world and others, but also from the self. Crucial to recovery from SUDs is for the individual to somehow cultivate and develop a novel sense of connection in all aspects of their lives.

E. Thayer Gaston eloquently states: "music involves the individual so totally and in such unique fashion that closeness is felt, and painful aloneness may be alleviated" (Gaston, 1968, p. 25). Music's ability to reconnect is just one of its many healing properties that might help to alleviate the "painful aloneness" that is characteristic of SUDs.

Literature Review

Music Therapy for Addressing Spiritual Health Needs in Substance Use Disorders and Other Clinical Populations

Music therapy has gained traction over the past several years as a possible treatment for meeting the clinical, therapeutic needs of individuals in recovery from SUDs. Though music therapy practice in the treatment of SUDs has expanded over recent years, there remains the need for significant research to solidify its stance as an effective form of therapy for this clinical population (Murphy, 2017). Further, there is a paucity of research which examines music therapy's efficacy for meeting the spiritual health needs for people with SUDs.

Borling (2011) organizes the stages of recovery from addiction as bio-physical, psycho-emotional, and psycho-spiritual. The bio-physical deals with the initial physical symptoms of early recovery (i.e., withdrawal and cravings), while the psycho-emotional and psycho-spiritual domains refer to the underpinning emotional and spiritual issues that drive addictive use, as well as overarching spiritual aspects of long-term recovery. Music therapists may be uniquely equipped to address the many needs of clients who are in recovery, specifically in the psycho-spiritual health domain (Borling, 2017).

In a written correspondence with Alcoholics Anonymous co-founder Bill Wilson, Carl Jung (1961) likened alcoholism to a "spiritual thirst of our being for wholeness" (p. 624). This perspective aligns with the idea that recovery from SUDs encompasses spiritual dimensions which transcend mere physical abstinence. Gardstrom et al. (2013) note:

> In comparison to other types of therapy, music is better able to address the deeper work of spiritual recovery—the search for positive identity and longing for wholeness that underpins all other recovery issues. (p. 101)

Music therapists are trained to facilitate specialized therapeutic uses of music, an artistic modality with vast, immemorial spiritual roots and applications. Music has functioned as a vehicle for spiritual healing and connections spanning back to both preliterate and ancient societies (Thaut, 2015). Further, Tsiris (2017) describes a seminal connection between the development of music therapy and spirituality. Specifically, early music therapy models such as Nordoff-Robbins Music Therapy (Nordoff & Robbins, 1965, 1977) and the Bonny Method of Guided Imagery and Music (BMGIM) (Bonny, 1975, 2002) contain spiritual frameworks and philosophies which were fundamental to their development, recognizing the modality's applicability for addressing spiritual health needs.

Bruscia (2014) identifies various facets of music experiences which are foundational to music therapy practice. Spiritual facets of music experiences may afford individuals "deeply felt positive mood," "healing or transformation of suffering," and "experiences of enlightenment and inner wisdom" (p. 154). Thus, when music experiences are facilitated in the context of music therapy, individuals with SUDs may be provided with opportunities to connect with themselves and their inner resources in ways that are integral to spiritual growth. Music therapy provides a safe arena in which people may be in connection with others, strengthen interpersonal bonds, and practice being in the present moment—all processes that are essential to recovery (Borling, 2011; Gardstrom et al., 2013; Miller, 2017).

Music therapy experiences which have been described as helpful in addressing the psycho-spiritual phase of recovery include song discussion, guided imagery and music (GIM), therapeutic singing, songwriting, and music-assisted movement, among other methods (Gardstrom et al., 2013; Murphy, 2015). That said, the abovementioned journal articles and book chapters do not fall under the category of empirical research studies.

Further research is needed to help deepen the understanding of clinical uses of such music therapy methods for addressing spiritual dimensions of recovery.

Over the past several years, researchers have conducted studies spanning a wide variety of clinical populations to examine music therapy's effects on spiritual health needs. Clinical populations that were suggested to have received spiritual health benefits from music therapy include persons with severe mental illnesses (Grocke et al., 2014), receiving cancer care (McClean et al., 2012), who have acquired neurodisabilities (Baker et al., 2017), receiving end-of-life care (Burns et al., 2015; Walden et al., 2021; Warth et al., 2021) and women with addictions in a recovery community (Miller, 2017).

Gaps in the Literature for Music Therapy in Treating Spiritual Health Needs of People with Substance Use Disorders

There is a limited amount of research on music therapy's effects on spiritual health for individuals with SUDs. This area of research needs further inquiry to inform music therapy practice for people with SUDs. Therefore, the purpose of this survey study was to learn more about how, or if, music therapists working with individuals with SUDs are addressing spiritual health needs.

The specific research question is: How do music therapists in the United States meet the spiritual health needs of individuals diagnosed with SUDs? The sub questions are: 1) What spiritual health goals do music therapists identify in their work with individuals who have SUDs? 2)What music therapy methods are commonly used? 3) How do music therapists rate the perceived efficacy of music therapy's ability to address the spiritual needs of individuals who have SUDs? 4) How do music therapists evaluate spiritual growth in their clients who have SUDs?

Method

Materials

A 25-question survey was designed by the researcher and his thesis chair to learn more about how music therapists working in the United States are addressing the spiritual health needs of individuals with substance use disorders. The survey was divided into 5 sections: 1) demographics, 2) work history, 3) music therapy treatment settings and format, 4) music therapy goals related to spiritual health in SUDs, and 5) music therapy methods used to address goals related to spiritual health. Additionally, two experts in music therapy in addictions treatment were consulted with during the survey's construction. Revisions to the survey were made based on feedback received.

The spiritual health goals included in the survey are reflective of principles as reflected in 12-Step recovery literature (e.g., Alcoholics Anonymous World Services, 2001; Narcotics Anonymous World Services, 2008) and existing literature related to music therapy and spiritual needs for those with substance use disorders (e.g., Borling, 2011; Walker, 1995).

Survey Participants

Survey participants were board-certified music therapists in the United States who work or have previous experience working in the field of addictions treatment and could read and write in English. Email addresses of board-certified music therapists who were working in the United States at the time of this survey were provided by the Certification-Board for Music Therapists (CBMT).

Procedure

Email invitations with a link to an anonymized survey hosted by Qualtrics ® was sent to all MT-BCs who consented to allow the CBMT to share their e-mail addresses for research purposes. The first three questions asked participants to confirm eligibility and affirm consent. Participants who responded "yes" to all 3 screening questions were directed to the survey. Those who responded "no" were thanked for their time and directed to the end of the survey. Music therapists who met inclusion criteria were invited to complete the rest of the survey. Five days after the survey was sent, a thank you and reminder email were sent. A final reminder email was sent 10 days after the initial link was emailed. The survey was available for completion for a total of 20 days.

Ethics

This study was determined to be exempt by the Human Research and Ethics Board (HREB) at State University of New York at New Paltz.

Data Analysis

Descriptive statistics were automatically generated by Qualtrics ® in the form of frequency counts, means, and percentages.

Results

In total, 9,758 Board-Certified Music Therapists were invited to complete the survey. One hundred fifty-eight emails bounced; two emails failed to send, reducing the number of potential respondents to 9,598. 218 invitees responded to the survey for a 2% response rate. However, 53 respondents did not complete the survey past the demographic questions. Twenty-one respondents indicated that they did not meet inclusion criteria. The final number of completed surveys was 144.

Music Therapist Demographics

Participants were asked to indicate their gender identity, age range, and race/ethnicity. The majority of respondents identified as white (83%) females (83%) and chose not of Hispanic/Latino or Spanish origin in response to the question about ethnicity (95%). Most respondents were between the ages of 25–30 (25%). Respondents from all geographic regions were represented. Most respondents were from the Mid-Atlantic (23%) and Great Lakes (22%) American Music Therapy Association (AMTA) regions. Most respondents held a master's degree in music therapy as the highest level of education (57%), followed by bachelor's degree (34%). Only 9% of respondents held doctoral degrees.

Respondents were able to select more than one theoretical orientation. The most selected theoretical orientation was Humanistic (n = 101), followed by Cognitive Behavioral (n = 77). The least selected theoretical orientations were Neurologic (n = 18), Transpersonal (n = 19), Jungian (n = 19) and Behavioral (n = 25). See Table 1 for complete demographic information.

Table 1. Music Therapist Demographics.

	# of participants	% of participants
Gender Identity		
Male	17	12
Female	119	83
Transgender	1	0.7

	# of participants	% of participants
Non-binary	3	2
Other	2	1
Prefer not to say	1	0.7
Age		
18-24	6	4
25-30	36	25
31-35	16	11
36-40	17	12
51-55	7	5
56-60	9	6
61-65	9	6
Over 70	4	3
Ethnicity	**(*n* = 143)**	
American Indian or Alaskan Native	2	1
Asian	7	5
Black or African American	4	3
Native Hawaiian or Other Pacific Islander	0	0
White	119	83
Hispanic/Latino/ Spanish Origin		
Yes	7	5
No	137	95
AMTA Region	**(*n* = 141)**	
Great Lakes	31	22
Mid-Atlantic	33	23
Mid-Western	15	11
New England	6	4
Southeastern	28	19
Southwestern	8	6
Western	20	14
Education Level		
Bachelor's degree	49	34
Master's degree	82	57
Doctoral degree	13	9
Theoretical Orientation		
Behavioral	25	
Cognitive-Behavioral	77	
Feminist	28	
Humanistic	101	
Jungian	19	
Music-Centered	54	
Neurologic	18	
Psychodynamic	43	
Resource-Oriented	39	
Transpersonal	19	
Other	36	

	# of participants	% of participants
Credentials, Licensures, Professional Designations	**(*n* = 143)**	
MT-BC	143	100
Fellow of the Association of Music and Imagery	3	2
Analytic Music Therapy	1	0.6
Nordoff Robbins Music Therapy	0	0
Vocal Psychotherapy (Austin Model)	2	1.3
Hospice/Palliative Care Music Therapist	5	3.4
Neurologic Music Therapist	23	16
Other	3	2

Clinical Practice with Individuals with Substance Use Disorders

Most respondents reported practicing music therapy for 6 to 12 years (25%) followed by 1 to 5 years (23%). The majority of respondents reported working with people with SUDs for 1 to 5 years (37%) followed by 6 to 12 years (31%). Respondents were able to select multiple work settings. Most respondents reported working in inpatient facilities (n = 107), followed by intensive outpatient programs (n = 38). Of the respondents who reported working in inpatient facilities, most indicated that the number of music therapy sessions clients received before discharge was greater than 5 (53%).

Respondents were able to select multiple session treatment formats (e.g., group, individual, individual and their family). Group music therapy was the most popular treatment format (n = 131), followed by individual music therapy (n = 79). Most respondents who indicated working in group formats reported the average size of music therapy groups was 8–10 participants (33%), and 5–7 participants (32%). See Table 2 for complete clinical practice information.

Table 2. Clinical Practice.

	# of participants	% of participants
Years Experience as a Music Therapist	**(*n* = 141)**	
1 month to 1 year	11	8
1 to 5 years	33	23
6 to 12 years	36	25
13 to 20 years	27	19
21 to 24 years	10	7
25 years or more	26	18
Years Working with people with SUDs		
1 month to 1 year	21	15
1 to 5 years	53	37
6 to 12 years	44	31
13 to 20 years	16	11
21 to 24 years	4	3

	# of participants	% of participants
Work Setting		
Inpatient facility	107	
Intensive Outpatient Program	38	
Detoxification Unit	28	
Outpatient	36	
Private Practice	36	
Other	22	
Session Format		
Group	131	
Individual	79	
Individual and family	15	
Average Size of Music Therapy Groups	**(*n* = 135)**	
1-3 participants	4	3
3-5 participants	14	10
5-7 participants	44	32
8-10 participants	45	33
More than 10 participants	28	21
# of Sessions Before Discharge (Inpatient Facilities)	**(*n* = 115)**	
1-3 sessions	21	18
3-5 sessions	33	29
More than 5 sessions	61	53

Music Therapy Methods

The second section of the survey asked respondents to identify the music therapy methods used in their work with individuals in the treatment of SUDs. Music therapy methods were largely informed by Bruscia's (2014) four main music therapy methods (improvisational, re-creative, compositional, and receptive). Additional methods were also included, such as lyric analysis, for its presence in the literature for music therapy in addictions treatment (e.g., Silverman, 2015, 2016). All four music therapy methods were reported to be used in music therapy treatment with receptive methods chosen most frequently. Respondents indicated which method variations they used in their work.

Music Therapy and Spiritual Health Goals

The third section of the survey asked respondents to consider which spiritual health goals they address when treating individuals with SUDs, and the music therapy methods used. A total of 136 respondents (94%) answered "yes" when asked if they consider spiritual health goals as a part of their work with persons with substance use disorders. Eight respondents (6%) answered "no."

Respondents were given the option to select which if any of the following spiritual health goals they address during music therapy sessions: *connection with a Higher Power, connection with others, cultivating sense of meaning, achieving catharsis, enhancing sense of wellbeing, exploring spiritual principles as found in the 12 steps* (Alcoholics Anonymous World Services, 2001; Narcotics Anonymous World Services, 2008; see Appendix A for the 12

Steps), *exploring the theme of "letting go" and/or "surrender," exploring meditation, exploring prayer, and exploring relationship with self.* Respondents were also given the option to share other spiritual health goals they addressed if one was not listed.

The most common spiritual health goal for meeting the spiritual needs of individuals with SUDs was "connection with others" ($n = 131$) followed by "exploring relationship with self" ($n = 128$).

Music Therapy Methods Utilized to Meet Spiritual Health Goals

Respondents identified the music therapy methods they utilize to address each listed spiritual health goal. Song discussion was the most utilized method for connection with others ($n = 109$). The second most popular music therapy method for connection with others was lyric analysis ($n = 106$). The two most popular music therapy methods for exploring relationship with self were also song discussion ($n = 81$) and lyric analysis ($n = 74$).

Perceived Efficacy

Respondents were asked to rate the perceived efficacy of music therapy to address spiritual health needs in individuals with substance use disorders on a scale of 1 (not effective) to 5 (very effective). The average perceived efficacy was 4.19 ($SD = 0.81$).

Assessing Spiritual Growth

Respondents were asked to share how they assessed spiritual growth in the people they work with. The most popular way of assessing spiritual growth was novel insight shared by client(s) ($n = 115$). This was followed by self-report of spiritual change from client ($n = 111$).

Discussion

The descriptive data collected in the survey responses illustrate music therapy practices used by music therapists in the United States to meet spiritual health needs of individuals with SUDs. Further, survey responses are suggestive of what music therapists consider relevant to the largely subjective construct of spiritual health needs for individuals in this population.

Music Therapy Clinical Practice

Theoretical orientations

The humanistic approach to music therapy acknowledges each person's unique individuality within the treatment process. Humanistic clinicians work to help individuals harness resources across all aspects of their being, with an emphasis on selfhood, agency, personal strengths, values, and the "here-and-now" (Abrams, 2018). The approach recognizes that while each person contains universal qualities synonymous with humanness and personhood, expressions of humanity are distinctive to the individual.

A humanistic perspective towards SUDs may imply an honoring and acknowledgement of the nuanced individuality in which addiction may vary in its manifestation; thus, the relationship formed between music therapist and client is one that functions as a means for growth beyond the obstacles unique to each person's recovery. Results of this study indicated that humanism was the most popular theoretical orientation selected by music

therapists working in the treatment of SUDs (n = 101). The second most popular orientation was cognitive-behavioral (n = 77).

Silverman (2007) conducted a survey study to evaluate trends of music therapy practices in psychiatric health care, which commonly address needs relating to substance abuse and SUDs. The researcher found that the behavioral approach was the most popular among survey respondents (Silverman, 2007). In the current study's dataset, the behavioral theoretical orientation was the third least popular among survey respondents (n = 25). In a follow-up study of music therapists working in addictions treatment, cognitive-behavioral therapy was the second most popular treatment approach used by their institution, with the 12 Step Model being the most selected (Silverman, 2009).

Behaviorism posits that maladaptive behaviors can be studied and replaced with new, healthier behaviors (Skinner, 1938). Music therapists working from a behavioral orientation utilize music as a stimulus for modifying behaviors based on the ideas of reinforcement principles (Madsen et al., 1968). The behaviorist approach for music therapy to treat SUDs might involve identifying behaviors associated with one's addiction patterns, with music as the impetus to correct maladaptive habits.

Perhaps this potential shift from behaviorism to humanism might be indicative of how music therapists are currently viewing their role as professionals who work with people who have SUDs. The holistic, person-centered approach of humanism realizes that the diagnosis of pathologies such as SUDs do not tell the whole story of the person-in-therapy. Further, to assess music therapy's efficacy solely based on supposed measured behavioral changes does not consider the multitude of other factors which lie beneath the surface of addiction disorders. Rather than targeting specific behaviors related to SUDs, the treatment approach from a humanistic lens places great value on the therapist and client to develop a "helping relationship." Such a relationship may serve as the impetus for the person-in-therapy to mobilize their inner resources as a means for cultivating personal growth (Rogers, 1961).

Foundational principles of humanism, such as the nurturance of agency, resources, and strengths, may help to foster an intrinsically guided growth process in which individuals with SUDs are empowered to search inside themselves for what their recovery means to them, the changes they want to implore, the obstacles to actualizing such changes, and their individual strengths which may serve as resources for a renewed life of sobriety. A perspective and treatment approach which emphasize strengths and relationships situates the client in a role which encourages autonomy. This orientation of the client differs from one in which they are passive recipients of care, where the therapist is positioned as the expert who defines their needs, and determines their success based on a set of target criteria, such as "frequency of inappropriate behavior, as defined by the music therapist" (Rolvsjord, 2010, p. 26) or the identification of outcomes which are observably measurable.

The differences in results between this study and Silverman's (2007), close to twenty years apart, may indicate a paradigm-shift among music therapists who work in mental health populations, including those with SUDs. However, these data and the interpretation of results must be considered with care, as more research is needed to ascertain if the shift is replicable for music therapy in mental health care across its entire spectrum, as this study only sought to understand music therapy trends in the treatment of SUDs. It is important to note that Silverman's (2007, 2009) surveys were conducted almost two decades prior to the current study and may not reflect current demographics and/or practice trends. That said, the lack of research inquiry in the intervening years positions the above studies as the most recent sources of available data to draw comparison from.

Level of education and work experience

Another area worthy of consideration from Silverman's (2007) study is potential shifts in

educational level and work experience of music therapists. Out of 176 survey respondents, most music therapists held a bachelor's degree in music therapy (49.7%). 22.8% of respondents held a master's degree in music therapy, while 29.8% received a master's degree in something other than music therapy. 7.6% earned a music therapy equivalency degree. A small portion of respondents received a PhD in music therapy (1.8%), while others held PhD's in music education (1.2%) or in something else (2.3%).

Most respondents in the current study indicated having a master's degree as their highest level of education (57%). Perhaps in the near two decades since the above study was conducted, music therapists have received higher levels of formal education and specialized training. However, in a different era of music therapy, years of clinical practice may have been a more prominent indicator of training. For instance, Silverman's (2007) study found that on average respondents worked in psychiatric care for 11.3 years. The results of the current study reflect fewer years in practice working with SUDs, in which most respondents reported working in addictions treatment for 1–5 years (37%), with 31% reporting 6–12 years of professional experience with this population.

Taken together, these data might reflect shifts in the music therapy workforce over time. While perhaps graduate opportunities for music therapy may have expanded, years of clinical experience may be lower, with newer professionals with advanced degrees entering the field. However, as noted earlier, these data must be interpreted with caution, as the present study specifically focused on music therapy with SUDs, not psychiatric healthcare as a whole.

Music Therapy Practice and Spiritual Health

Spiritual health goals

The most selected spiritual health goal of "connection with others" ($n = 131$) speaks to what music therapists consider to be of most importance in terms of their work for addressing spiritual health needs for those with SUDs. This seems to relate to group music therapy being the most common session format ($n = 131$), a treatment setting which is conducive to interpersonal relating of clients. The spiritual principle of "connection with others" is often considered pertinent to recovery, which is a central factor of 12 Step meetings, in which individuals with common addiction disorders congregate to share their experience in support of one another.

Helping clients to re-evaluate ways in which they may be in connection with others is clearly indicated when considering the spiritual isolation involved in the disease process of SUDs. The meaningful relationships that are afforded by 12 Step social networks are often indispensable, in which those in recovery are gifted a "protective wall of human community" (Kelly, 2022, p. 557). Community and connection as protective factors might sufficiently alleviate the "painful aloneness" (Gaston, 1968, p. 25) which both parallels and fuels an existence which is largely defined by substance abuse.

Importantly, second to "connection with others" was "exploring relationship with self." This suggests that respondents recognize the clinical indication of addressing both *inter*- and *intra*personal connection for those with SUDs. Low self-esteem has been suggested to be related to individual tendencies towards addiction and substance abuse (Alavi, 2011). Moreover, individuals with SUDs often derive their sense of self and identity through using their substance of choice. There is often a "mourning" stage as the recovering individual grieves their loss of identity as a substance user (Dingle et al., 2015), hence the need for exploring and reconstructing the individual's relationship with themselves.

As the individual detoxes through the bio-physical, entering the psycho-emotional/spiritual stages of recovery (Borling, 2011), the need to examine their relationship with themselves and who they are without the presence of substances is presented as a further

opportunity for growth. Furthermore, novel insight into the self may then lead to a deeper understanding of not only the underpinnings which propelled the addictive cycle of substance abuse, but also a person's sense of identity, values, aspirations, and direction. Music therapy as an experiential treatment modality can afford individuals in recovery not only opportunities to practice being in connection with others, but also to "reconnect with their mind, body, and spirit" (Murphy, 2015, p. 365).

Music therapy methods to meet spiritual health goals

Song discussion and lyric analysis were the most utilized music therapy methods to meet spiritual health goals for individuals with SUDs. This is consistent with Murphy's (2017) systematic review of the literature for music therapy in addictions treatments in which lyric analysis was the most common method across 12 studies.

However, song discussion was more popular for addressing individual spiritual health goals. For the method of lyric analysis, the therapist helps the individual(s) to engage in a structured analysis of a song as the basis for a discussion of relevant therapeutic issues (Dvorak, 2017). Song discussion may offer clients a broader experience, in which various elements of a song including, but not limited to, lyrics and musical qualities (tempi, instrumentation, arrangement, etc.) are utilized as a springboard for a discussion of relevant clinical themes (Bruscia, 2014).

Miller (2017) describes a 12-week music therapy program in a recovery community treatment setting for women. In many of the sessions, the researcher used song discussion to help participants internalize and better understand the spiritual principles of Steps 1 through 3 via traditional AA/NA slogan (see Appendix A for the 12 Steps). Traditional 12 Step slogans frequently contain spiritual themes, functioning as accessible mantras or affirmations which somehow relate to recovery. Examples of slogans explored in music therapy included "one day at a time," "this too shall pass," and "sobriety is a journey… not a destination" (Miller, 2017). Beyond spiritual 12 Step themes, song discussion allowed for other topics germane to spiritual health in recovery to emerge. These included themes of community and support, being in the moment, and feelings of enlightenment (Miller, 2017).

Miller (2017) facilitated song discussions in an integrative manner, as they were combined with other music therapy methods throughout each of the sessions. For instance, the researcher describes a music therapy intervention called "music & mindfulness," in which "guided mindfulness practice focusing on steps 1–3 and the slogans of AA was combined with music as a therapeutic intervention" (Miller, 2017, p. 54). Song discussion was facilitated not solely as a singular experience but was contextualized within the group's exploration of spiritual health themes relating to recovery. Other music therapy experiences (like "music & mindfulness") provided additional pathways to address spiritual health needs as they organically developed throughout the group process.

Group experiences in which song discussions are utilized within a broader music therapy process allow individuals to engage with therapeutic material in ways that connect to both their individual and collective recovery journeys. The therapist can incorporate the insight and contributions presented by participants during their song discussion to shift into other methods to foster further integration of group experiences. Concomitantly, collaborating through such immersive group music therapy processes may help to inspire Yalom and Leszcz's (2005) therapeutic factors, as clients can give and receive support from their peers, contributing to a sense of group cohesion, universality, altruism, and hope throughout different phases and experiences of the session.

The popularity of lyric analysis among respondents may be indicative of the immense pressure the United States places upon therapeutic interventions and modalities to fit within the confines of evidence-based practice, otherwise known as the "Gold Standard"

for healthcare (Tzenios, 2021). Lyric analysis can be understood as an outcome-oriented intervention, in which the effects of therapy are "operationally defined and lend themselves to some form of measurement" (Bruscia, 2014, p. 177). Existing literature for music therapy in addictions treatment examines the efficacy of the intervention for treatment outcomes, such as withdrawal and craving symptoms (e.g., Silverman, 2016).

The broad, expansive nature of spiritual health presents difficulties for quantifiably measuring music therapy's efficacy for treating such needs of persons with SUDs. Critiques of the "Gold Standard" of evidence-based practice suggest that the perspective often results in a "mechanical and linear understanding of the therapeutic process in accordance with the medical model" (Rolvsjord, 2010, p. 26). This conundrum presents challenges for researchers to adequately examine which music therapy methods might provide opportunities for treating spiritual health needs as seen in clients with SUDs, at least in a manner which is objectively quantifiable.

Assessing spiritual growth

The respondents indicated that they mostly assess spiritual growth based on "novel insight shared by the clients" ($n = 115$) as well as "self-report of spiritual growth from the client(s)" themselves ($n = 111$). In other words, the results of this study support the notion that growth in the spiritual domain is assessed mainly by insight shared by the client. Music therapy might be effective to help clients with SUDs access parts of themselves in which they can verbalize some aspect of inner change that is somehow indicative of evidence for spiritual growth.

For this study, the most common instances of assessed spiritual growth are related to what Bruscia (2014) refers to as a "supportive" health change, in which "the changes in therapy give the client the support system and insight needed to fight or live with a health condition" (p. 192). Recovery from addiction differs from many other diseases, in that sustained remission is contingent on daily, lifelong maintenance. Relapse is possible, yet spiritual growth might be a helpful means for arresting the disorder. The results of this study suggest that assessed spiritual growth and/or change that music therapy might be capable of affecting is related to the insight and self-awareness that the modality elicits in the individuals receiving treatment.

Participant comments expand upon self-reports and novel insights shared related to spiritual progress:

> Reported changes in behavior; reports of more empathy/self-empathy and compassion/self-compassion.
>
> Notable change in how they relate with others, how they seem to inhabit their bodies.
>
> Self-report of decrease in urges to use or using.
>
> Maturity embodied through accountability without blaming.

One respondent shared through text responses about whether spiritual health goals were in the scope of music therapy practice, and if it is the music therapist's place to assess spiritual growth. Some respondents noted precautions that they take to mitigate harm when attempting to bring focus to spiritual topics. Certain responses iterated that the proposed addressing of spiritual goals might be contraindicated for individuals with religious trauma and/or people with psychotic disorders. Of note, the results of Grocke et al. (2014) suggest that group music therapy may help to enhance spirituality for individuals with severe mental illnesses (including those with psychotic disorders).

Responses which addressed the former clinical consideration discussed how delineating between spirituality and religion was crucial for clients with religious trauma. One individual explained that they found it necessary to address spiritual topics in a manner that was divorced from the 12 Steps due to the language used in the literature:

> I found it was easier to address spirituality aside from the 12 steps, as the 12 steps do mention "God," which, despite this meaning any Higher Power, can lead to resistance from clients. I focused on various types of spirituality, including finding one's spirituality from nature or from anything greater than them, and combined this with SMART Recovery for clients with religious trauma.

The Religious Trauma Institute (2022) defines the concept as "the physical, emotional, or psychological response to religious beliefs, practices, or structures that is experienced by an individual as overwhelming or disruptive and has lasting adverse effects on a person's physical, mental, social, emotional, or spiritual well-being." It is important to take into the account the sentiment expressed by the above respondent, in that trauma-informed care is needed when addressing spiritual health needs with clients who might have a personal history in which they are unable to move past the spiritual language utilized in 12 Step recovery models due to religious trauma.

Only fifty-four respondents ($n = 54$) reported addressing the spiritual health goal of "exploring spiritual principles as found in the 12 Steps." Silverman's (2009) survey study which examined trends in music therapy practice for individuals receiving care for addiction in rehabilitation settings found that the organizations in which music therapists were working frequently utilized 12 Step facilitation approaches. Perhaps with the increased popularity of behavioral therapy modalities (e.g., CBT and DBT), organizations which treat addictions have shifted away from 12 Step models, which are spiritually oriented.

In contrast, programs like SMART Recovery® (Self-Management and Recovery Training) are secular, and in many ways are informed by the tenets of cognitive behavioral therapy (SMART Recovery, 2025). Worthy of consideration is how this potential shift might result in systemic changes in the perceived role of healthcare professionals in the treatment of SUDs. Such a notion begs the question as to the place of addressing spiritual health needs, which are difficult to quantify, in favor of modalities that are deemed to be of higher efficacy due to their ability to yield "measurable" clinical outcomes, which would then place spiritual health needs in a position of decreased significance and attention.

Perceived efficacy

The majority of respondents found that music therapy was effective in meeting spiritual health goals of individuals with SUDs (94%). Furthermore, these data suggest that music therapy is perceived as most effective for treating the spiritual health goals of improving and exploring connection with others and the self.

Of note, this survey did not provide respondents with a definition of spirituality. Thus, these data are reflective of participants' personal conceptualizations of spirituality and spiritual health needs. However, it is important to recognize that these constructs are often socially and culturally situated. Given the relative homogeneity of the study sample (particularly in regard to race, ethnicity, gender identity, and geographic regions), the respondents' understanding of spiritual health needs may be illustrative of culturally specific perspectives. Such factors should be considered when interpreting the study's findings in relation to music therapy practice and perceived efficacy.

Limitations

The main limitation of this study was its low response rate, with only 144 respondents who met inclusion criteria and completed the full survey after initial and reminder emails were sent. Approximately 9,758 survey invitations were distributed, resulting in an approximate 2% completion rate. However, this percentage likely underestimates the true

response rate, as the total number of music therapists working with individuals SUDs in the United States is unknown. The 2022 AMTA Workforce Analysis identified 90 music therapists reporting work in SUD treatment (American Music Therapy Association [AMTA], 2025). That said, not all United States music therapists are members of the AMTA, eliminating these individuals' participation in these survey-based workforce analyses. A meta-analysis of published survey-based research found that the average survey response rate was 44.1% (Wu et al., 2022). Of importance, while the raw response rate of this study appears low, with over 9,500 survey invitations sent, the number of respondents may represent a reasonable portion of the United States music therapists who work in the treatment of SUDs based on the data reported by the AMTA. However, an accurate number for clinicians working with this population cannot be precisely determined at this time.

The questionnaire being 25 questions might have further contributed to survey fatigue and high number of incomplete responses. Furthermore, the matrix question which prompted respondents to match music therapy methods to spiritual health goals (question 21) had 10 possible spiritual goals, and 25 possible music therapy methods, which might have been difficult to navigate for some, contributing to incomplete responses and/or miss-clicks. These factors could have led to discrepancies in the results.

A further limitation of the present study is related to inconsistencies in question responses. Some respondents did not answer all the questions in the survey. When the total number of responses was less than the total number of survey respondents ($n = 144$), the number of responses was indicated next to the corresponding question item (see Tables 1 and 2). Additionally, several questions were conditional (i.e., follow-up questions specific to treatment formats and work settings). Some respondents either did not complete the follow-up question or responded to it despite not doing so in the corresponding question. These inconsistencies are likely related to unintentional errors and/or omitted questions though may have marginally affected the precision of the dataset.

An important limitation to this study is the lack of questions related to the potential harm addressing spiritual health needs may have. This oversight was highlighted by text responses in which respondents indicated that addressing spiritual health needs in their clients with SUDs is contraindicated due to potential harm, notably for individuals with religious trauma and/or psychosis. This is an area that should be researched further.

In the United States, there is not a unified taxonomy for music therapy methods. Bruscia (2014) provides a comprehensive list of commonly used music therapy methods and their definitions. Though this list is popular among many practicing clinicians, music therapists in different AMTA regions might refer to the methods they use in contrasting ways. Though definitions were provided for most music therapy methods included in the survey, it is possible that a lack of understanding or differences in perspectives on therapeutic music experiences might have led to inadvertent bias or inconsistencies in participant responses.

Lastly, a limitation of this study was that the survey did not provide respondents with a working definition of spirituality. Though providing a definition for such a nuanced construct such as spirituality/spiritual health is a challenge, without a provided definition, respondents were tasked with interpreting the construct of spirituality for themselves when answering survey questions. This could have led to biases and inconsistencies in the results as participants were not supplied with a clear idea of the term as it relates to music therapy practice.

Future Research and Considerations for Music Therapy Educators in the United States of America

The results of this study illustrate the myriad applications of music therapy for meeting the spiritual health needs of individuals with SUDs. The literature for music therapy in the

treatment of SUDs is still scant, with limited inquiry related to the spiritual health domain. Results indicate that "connection with others" and "exploring relationship with self" were the most prominent spiritual health goals addressed by music therapists, with song discussion and lyric analysis as the most popular methods. Future research should examine the application of the above methods to meet such goals for people with SUDs.

Individuals in recovery would benefit from a wider range of experiences to meet spiritual health needs. The potential for innovative uses and therapeutic application of music are boundless. One of music therapy's strengths as an experiential form of treatment is that the clinician can construct meaningful, creative, and remarkably unique experiences to channel the diverse elements of music in such a way that provides their clients with opportunities to meet a multitude of health needs.

Perhaps these data can be perceived as a call for music therapy educators in the United States to consider how it is that current and future music therapists are taught to utilize music as the impetus for effecting change. The lack of overarching variety in selected music therapy methods to meet spiritual health needs for persons with SUDs might be indicative of an inadequate awareness of how musical elements and the full range of music therapy methods might be used in an integral manner to create immersive, enriching therapeutic experiences. These data and the interpretation thereof are suggestive of a need for music therapy educators to help students cultivate a stronger ability to practice in such a way that they are not constricted to rigid uses of music therapy methods.

Rather than viewing music therapy as a practice based on standalone "interventions" which exist solely in the vacuum of techniques which the clinician is comfortable with, what if music therapy education placed a stronger emphasis on the range and possibilities of therapeutic uses of music as a comprehensive set of methods that the clinician can integrate and blend to facilitate rich, colorful, vibrant therapeutic experiences that music therapists are uniquely situated to provide? People seeking treatment for SUDs are especially in need of novel ways of experiencing the world within and outside of themselves to build and sustain the foundations for new, renewed, and meaningful lives in recovery.

Most respondents working with (or who have experience working with) people with SUDs reported a master's degree as their highest level of education (57%). In tandem with advanced graduate education, advocating for increased internship positions in settings where people with SUDs are receiving treatment would help to further support students in their clinical development. The practical experiences of internship under the supervision of experienced music therapists whose clinical practice is guided by clear theoretical treatment approaches are invaluable for students who are interested in working with individuals in this population.

Music Therapy and Potential Shifts Away from 12 Step Models

Silverman (2009) found that the 12 Step Model was the most common treatment approach used by the rehabilitation institutions that employed music therapists. This study found that the spiritual health goal of "exploring the spiritual principles of the 12 Steps" was the second least popular among respondents. Some participants' text responses suggest that the spiritual language used in the 12 Steps could lead to client resistance, which might account for why music therapists would avoid addressing goals related to this recovery model. Furthermore, it might be possible that facilities are presently treating less from a 12 Step Model approach, causing music therapists to address goals related to this recovery model more infrequently. Future research might examine the relationship between music therapists' theoretical orientations, and how the treatment approach of the institutions they work for may influence their clinical practice.

Mitigating and Reducing Harm

Several respondents described the need to mitigate potential harm when attempting to address spiritual health needs of individuals with SUDs and psychosis, as well as for persons with co-occurring religious trauma. Future inquiry is needed to understand how clinicians can address possible harms when addressing spiritual goals for individuals with co-occurring issues that could pose risks for harm. The indications and contraindications of using music therapy methods for individuals with SUDs need more research, particularly when seeking to meet spiritual health needs.

Music Therapy and the Harm Reduction Model

Consistent with the importance of mitigating and reducing harm, the harm reduction model emerged as an alternative approach to substance abuse treatment. Harm reduction contrasts with both the "moral" and "disease" models of addiction; the model focuses on the effects of addictive behavior, rather than moralizing drug use or treating it as a disorder that requires abstinence (Marlatt, 1996). Proponents of harm reduction provide suggestions for policy, procedures, and easy access to low-threshold services "designed to reduce the harmful consequences of addictive behavior" (Marlatt, 1996, p. 785). While the model recognizes abstinence as the ideal outcome, harm reduction acknowledges that addictions are multi-faceted, often connected to social/systemic factors, and appreciates that abstinence within the disease model might not be realistic or appropriate for everyone (MacMaster, 2004). Research suggests positive outcomes from harm reduction programs, such as supervised injection sites and drug-checking services which were shown to reduce overdose and help identify high risk drugs (Levengood et al., 2021; Maghsoudi et al., 2021).

The literature for music therapy and treatment within the harm reduction model is limited. Ghetti (2004) posits that many of the tenets of harm reduction are intrinsic to music therapy processes. Music therapy can help support incremental changes to reduce harm associated with substance use. Furthermore, Ghetti (2004) highlights the malleable nature of music, and how music therapy experiences can be adapted to best meet the varying levels of functioning for clients with SUDs. In addition, music therapy aligns well with harm reduction's "low-threshold" philosophy (Marlatt, 1996), in that rewarding therapeutic music experiences may help to encourage and facilitate further commitment to treatment services (Ghetti, 2004).

Perhaps incorporating treatment theory and methodology from harm reduction may also aid in music therapists' ability to address the spiritual health needs of people with SUDs. The modality's capacity for offering meaningful, autotelic experiences present opportunities for clients to access low-threshold treatment avenues in which they may both connect with themselves and others in profound ways. Further, the person-centered, holistic perspective of the harm reduction model harmonizes well with humanistic music therapy approaches. A non-judgmental, unconditional positive regard for clients with SUDs, irrespective of their present readiness for recovery, may help to create a therapeutic environment in which they are free to express their authentic selves in music therapy. These conditions of de-stigmatization and acceptance may, in turn, foster experiences that engage and support spiritual health dimensions of recovery.

Though music therapists may be working in harm reduction settings (Aldridge & Fachner, 2010; Ghetti, 2004) research is needed to expand upon Ghetti's (2004) work. Moreover, future research could inquire about music therapy for addressing the spiritual health needs of persons with SUDs in harm reduction settings, and/or through a harm reduction treatment lens.

Spirituality, Spiritual Health Needs, and Cultural Considerations

As mentioned previously, the current study reflects a relatively homogenous sample composition regarding participant demographics. It would be beneficial for future research to intentionally center the perspectives of music therapists from more diverse cultural and demographic characteristics. Research inquiry surrounding how clinicians from varied backgrounds conceptualize spirituality, and music therapy's ability to address spiritual health needs in substance use treatment will help to create a more informed, inclusive understanding of the matters discussed in this study. Moreover, future researchers might seek to further understand music therapy practice for addressing the spiritual health needs of individuals with SUDs and how the client's unique cultural beliefs in regard to spirituality may be honored and addressed within the therapeutic process.

Conclusion

Music therapists reported using a variety of music therapy methods to meet relevant spiritual health needs of persons with SUDs. Most respondents reported working from a humanistic theoretical orientation. Song discussion and lyric analysis were reported to be useful in addressing salient spiritual health goals such as "connection with others," and "exploring relationship with self."

Further research is needed to support and demonstrate the efficacy of these popular music therapy methods to meet the spiritual health needs clinicians reported addressing in their practice. The field would benefit from a wider variety of methods to treat spiritual health needs for this population, which might be best addressed by examining and adjusting the role of music therapy education in the United States, in how students are taught to work with the complete range of identified music therapy methods in a more holistic manner.

The prominence of outcome-oriented music therapy methods (i.e., lyric analysis) raises the question of how the United States' imperative for treating within the "Gold Standard" of evidence-based practice might influence the perspectives and subsequent methods music therapists are utilizing to address spiritual health needs of persons with SUDs. To reiterate, the humanistic theoretical orientation was most the selected response for this study. However, is it possible that United States music therapists are perhaps operating more from a practice which emphasizes *outcomes* as the indication for change?

In conclusion, this study provides music therapists and related health professionals with an idea of current trends in music therapy for meeting spiritual needs of individuals with SUDs. These data and suggestions based on the interpretations thereof will hopefully serve to spark further interest in researching the efficacy and practices of music therapy for treating an often overlooked yet, arguably, paramount health domain for persons in recovery.

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Appendix

The 12 Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10.Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.
(Alcoholics Anonymous World Services, 1981, 2001).