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Resource-Oriented Music Therapy for Adults with Autoimmune Disease and Mood Disorders:

Clinical Protocol

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Abstract

Up to 50 million individuals in the United States are currently living with autoimmune diseases (AD). ADs can affect multiple systems in the body and impact the daily life and mental health of those living with ADs. While there are several pharmacological treatments that improve symptoms, many individuals, often women, remain underdiagnosed and have a high occurrence of mood disorders. Since music therapy has been shown to have a positive impact on individuals with mood disorders, it may be effective for adults with AD who have mood disorders, particularly when a resource-oriented approach is utilized. This study will outline the clinical treatment protocol used within the context of a feasibility study. This research will present the overall clinical approach and music therapy interventions. It is our hope that these descriptions and reports may be useful to other clinicians supporting adults with ADs. Limitations and suggestions for future research and clinical practice will also be discussed.

Keywords: music therapy; autoimmune disease; resource-oriented approach; mood disorders

According to the National Health Council (2024), autoimmune diseases (AD) may be becoming more common. AD occurs when the body's immune system attacks healthy tissues and weakens the body's functioning (Cleveland Clinic, 2024). There are more than 80 known ADs, and common diagnoses include type-1 diabetes (T1D), multiple sclerosis, and rheumatoid arthritis. According to the National Stem Cell Foundation (2025), five to eight percent of the population in the United States has one or more ADs, and it is the

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third most common cause of chronic illnesses in the US. Abend et al. (2025) reported that 63% of those with an AD are women. Further, Casella (2025) suggested that ADs may be underdiagnosed and underreported due to difficulties in detecting and receiving a diagnosis. Despite the inconsistencies in reporting, AD is prevalent, though it appears to be understudied which limits diagnostic testing and treatment options (National Institutes of Health, Office of Autoimmune Disease Research, 2025).

Comorbidity with Mood Disorders

Adults living with AD may experience a variety of symptoms, including depression and anxiety, pain and discomfort, stress, and social isolation (Global Autoimmune Institute, 2024). Individuals living with AD may experience prolonged stress due to the chronic nature of AD, and increased stress may worsen symptoms of their AD. For example, stress may cause higher blood sugar levels in individuals with T1D and promote physical pain and sleep disturbance in those with Lupus. Additionally, symptoms of mood disorders such as depression may also be associated with poorer AD management (Berk et al., 2023). Rakshasa-Loots et al. (2025) found that individuals living with AD may be twice as likely to have an affective disorder such as depression, anxiety, and bipolar disorder than the general population. Sloan et al. (2024) noted that 57% of individuals with rheumatic autoimmune diseases experience anxiety, while 55% experience depression. In addition to experiencing depressive symptoms, Pryce and Fontana (2017) found that 50% of individuals with AD experience decreased quality of life.

Despite findings that suggest individuals living with AD may frequently experience mental health challenges, 50% of those with AD appear to underreport these challenges due to rarely being asked about it by a medical provider or fear of being stigmatized (Sloan et al., 2024). Furthermore, symptoms of autoimmune disease and psychiatric illnesses may be similar, thus potentially resulting in individuals being misdiagnosed with a psychiatric illness rather than AD (Trachman, 2025). Because women are more likely to be given a psychiatric diagnosis (Eaton et al., 2012), gender bias in medicine may contribute to difficulty and delay in receiving an accurate AD diagnosis. Additionally, psychiatric misdiagnosis of AD may lead to worsening mental health.

Music Therapy for Treatment of Mood Disorders

The use of music therapy (MT) in conjunction with pharmacological treatment and standard care has shown to decrease anxiety and depression (Aalbers et al., 2017; de Witte et al., 2022; Erkkilä et al., 2011). Positive outcomes of MT include enhanced mood, enhanced sleep quality and quality of life, and decreased disease severity and anxiety for people with depression (Gassner et al., 2022). Additional benefits include improvements in social support, emotional engagement with music, perceived control of health promotion (Pothoulaki et al., 2012), social interaction, interpersonal communication, autonomy, emotional release, healthy sense of self, and self-awareness (Lawendowski & Bieleninik, 2017). MT also assists in decreasing trait anxiety (Archambault et al., 2019), state anxiety (Scheufler et al., 2021), and mood disorders (Hense et al., 2018). MT interventions show promise for improving health outcomes for those with anxiety and depression and other health impairments (March-Luján et al., 2021), however, there are no known studies examining the use of MT with adults with AD and a mood disorder.

ADs are increasingly common and affect many individuals in the U.S. Despite this, ADs remain underdiagnosed, particularly among women, due to inconsistent research, symptom overlap with mental health conditions, and potential gender bias in diagnosis. Many individuals with AD experience co-occurring mood disorders such as anxiety and

depression. Unique treatment options are needed to meet the specific needs of those living with ADs. Due to its effectiveness in treating individuals with mood disorders, MT may be an effective treatment option to assist individuals in improving quality of life and coping strategies.

The purpose of this study was to demonstrate how MT was utilized for adults with AD and a mood disorder. Our primary aims were: 1) To evaluate the feasibility of recruitment and retention for a small cohort of participants. 2) To evaluate the participants' experiences of the study procedures and MT and 3) To assess the suitability of the outcome measures and potential effectiveness of MT.

The findings of this study are reported elsewhere (Schwantes & Smith, 2025). The treatment approach, details of the intervention, the clinical decision making, and the contexts for service are discussed in this report. We aim to share this information with other clinicians to increase the discourse in MT on supporting individuals with ADs and to increase individuals' access to specialized services.

Method

Researchers and Reflexivity

Clinician/Researcher 1

I am a board-certified music therapist with a graduate degree in MT and a graduate certificate in expressive arts therapy. I have been practicing MT for two years since completing my internship at a regional medical and behavioral health hospital. I live with two autoimmune diseases and a diagnosed mood disorder. Additionally, my interest in this research lies at the intersection of my experience working in mental health care and experience of living with AD. My role in this study involved working with the second researcher on developing the research protocol, implementing all MT sessions, and engaging the participants in pre and post treatment period assessment. I engaged in weekly supervision with the second researcher.

Researcher 2

I am a board-certified music therapist and an MT educator. Much of my work has centered on community engaged approaches to clinical care and research to improve access and to create meaningful MT interventions focused on individual and community strengths and resources. I have worked from a culture-centered, community music therapy, and feminist approach in my scholarship, clinical practice, and pedagogy. I created the overall research design of this project in collaboration with the first researcher/clinician and others with ADs. During weekly supervision with the first researcher, I provided support and resources, helped to mitigate countertransference, discussed participant experiences, and helped to maintain research fidelity and adherence to our collaborative resource manual (described below). While I have been diagnosed with a mood disorder, I do not have an autoimmune disease, so I have relied on the first researcher's lived experience to guide how this research protocol unfolded.

Community-Engaged Research

In an attempt to better understand the population before beginning the study (Wallerstein & Duran, 2010), we met with additional adults living with AD to discuss which MT interventions may be most beneficial, considerations for treatment based on what is missing in other treatment contexts, the frequency and duration of sessions, in what

settings sessions should occur to increase accessibility, and other considerations the clinician needed to make when working with adults living with AD and a co-occurring mood disorder. Those who contributed to these discussions provided feedback and ideas that we incorporated into the research design, considerations for measurement tools and assessments, and for the overall treatment period and context. The group also voiced the importance of providing care which focused on participant resilience and not just on the myriad problems individuals with AD face.

Ethical Considerations

Appalachian State University's Institutional Review Board approved this study on February 2, 2025. Prior to participating in the study, we provided participants with an overview of the study in plain language and obtained written consent to participate.

Recruitment

We recruited participants primarily via social media. Our flyers were posted to our personal and professional social media pages, which were then reshared or boosted by friends and colleagues. We also posted flyers in public places, including doctors' offices and health centers. Of the 18 individuals who inquired about the study, six met inclusion criteria and were included in the study. Prospective participants first contacted the second author to express interest in participating in the study, confirmed they met eligibility criteria, and signed consent forms. The second author then gave their information to the clinician, who was responsible for scheduling and facilitating the intake interview and all sessions.

Eligibility

Eligible participants for this study met the following criteria: were at least 18 years old, lived with a self-reported autoimmune disease, lived with a self-reported mood disorder, and had either a) a device that supported telehealth services with audio and video capability or b) had transportation to our local MT clinic. Individuals who were under the age of 18, did not have an autoimmune disease and a mood disorder, or were living with active psychosis, schizophrenia, or an intellectual or developmental disability were excluded from the study. Participants who were not eligible for the study based on missing one of the qualifications were referred to free MT services through our university-affiliated clinic. Two individuals, both of whom had a mood disorder and a health impairment not identified as an autoimmune disease, accessed 8 weeks of individual MT sessions in person or via telehealth.

Participants

The participants who were a part of our study will be described broadly to protect their confidentiality. Most participants were women in their mid-30s, held at least an undergraduate degree, and resided in rural areas. Their primary AD diagnoses included T1D and other endocrine-related ADs. Most had both depression and anxiety, and two individuals were diagnosed with bipolar disorder. Participants reported a broad spectrum of AD-related symptoms such as gastrointestinal issues, social anxiety, persistent worry, poor sleep, joint pain, nausea, general body pain, and heart-related distress. Only one participant had symptoms sufficiently managed with medication to avoid missing work or needing disability-related social security. The other five had to miss work regularly or accessed disability-related financial support. Two participants identified as Black or Latinx. Four noted music as a key coping strategy, and all participants described additional coping

mechanisms along with supportive individuals in their lives. All participants completed the entire research protocol from pretest to posttest. We did not have any dropouts in our study.

Settings

At the onset of the treatment period, participants chose whether they wanted to meet in-person or via telehealth for 8 weeks of individual MT sessions. Five participants chose to meet via telehealth, while one participant received in-person sessions at an MT clinic. Providing the options for telehealth sessions was an ethical consideration to increase access to services, especially for individuals located in rural areas. In addition to increasing access to care, we hoped that two meeting options would provide participants with an opportunity to exercise agency, even before sessions began. Sessions lasted approximately 50 minutes each. Five out of six participants had eight MT sessions, and one had only seven. Participants could reschedule their sessions when necessary, and the clinician made every effort to reschedule missed sessions within the same week. A total of 16 sessions across the six participants had to be rescheduled.

Theoretical Background

Resource-oriented music therapy (ROMT) is an approach grounded in empowerment and views music as a valuable health resource (Rolvsjord, 2006). Music therapists using ROMT tailor interventions to the individual's context, strengths, and life experiences, aiming to improve self-awareness and foster personal growth (Rolvsjord et al., 2005). ROMT is an asset-based approach that allows for the client to continually live in recovery, with the presence of a chronic health condition and mental health diagnosis. ROMT centers salutogenesis, shifting the focus to health promotion and quality of life enhancement. Simultaneously, we recognize that adults with AD can develop skills and strategies through MT to mitigate the effects and symptoms of their disease. Due to its emphasis on client-directed and strengths-based approaches, it is particularly suited for working with adults with AD as this approach offers increased agency and empowerment. Working from an ROMT perspective requires a systemic understanding of mental health care and an awareness of the clients' political and social agency (or lack thereof). ROMT is differentiated from other person-centered approaches due to its reliance on building an individual's resources and skills, beyond offering them unconditional positive regard and empathy.

Music Therapy Interventions

Below, we will describe the MT interventions used throughout this study as well as examples of the therapeutic rationale behind our approach and brief clinical examples taken from the clinician's documentation. Prior to developing these interventions and the resource manual, we immersed ourselves in ROMT theory and research. It is our understanding that the interventions themselves are not enough to impact change. When working with adults with AD, using an ROMT approach is critical to providing the best support to the individuals with AD. Rather than focusing only on the deficits or challenges people with AD face, using an ROMT approach recognizes that individuals with AD and mood disorders actively employ a variety of strengths and resources to manage their daily lives. When provided with opportunities to develop and enhance these new resources, individuals have the potential to increase their own empowerment or self-determination (Rolvsjord, 2004). Further, simply implementing the interventions in a directive way could have been harmful (e.g., *Not acceptable, proscribed therapeutic principles)*.

The participants collaborated with the clinician on interventions used throughout the study to tailor them to their unique preferences and circumstances. During the intake interviews, the clinician described common MT interventions to the participants. Then, at the beginning of each session, the clinician inquired about: how the participant was feeling, any updates they wanted to share, and anything that stood out to them from the last session. Based on this initial discussion, the clinician suggested two or three MT interventions, while also giving therapeutic rationale for them. For example, if a participant expressed that they were feeling stressed, the clinician suggested interventions for stress management such as relaxation, writing or drawing in response to music, or playlist building. Providing fewer choices reduced decision fatigue (Berg, 2025; Chen et al., 2018), and participants could make a more informed choice having the therapeutic rationale. As some participants became more familiar with interventions, they frequently identified which ones they wanted to engage in without direction from the clinician, while other participants continued to ask for options. Due to the variety of interventions that could have been used, understanding the possible benefits and contraindications for each was crucial in providing supportive and ethical care and to follow the guidelines set by the resource manual.

Resource Manual

To ensure validity and replicability of this feasibility study, a resource manual was created to establish guidelines for practice that are true to a resource-oriented approach (Rolvsjord et al., 2005). Please see the manual below. The principles outlined in the manual were general guidelines for practice, rather than techniques that were strictly followed. Principles stated in the resource manual are categorized into four sections: *Unique and essential therapeutic principles*, *Essential but not unique therapeutic principles*, *Acceptable but not necessary therapeutic principles*, and *Not acceptable—proscribed therapeutic principles*. The clinician primarily utilized the original principles developed by Rolvsjord et al., however two of the principles (2.7 and 2.8) were moved from *Acceptable but not necessary therapeutic principles* to *Essential but not unique therapeutic principles*. The clinician added principle 2.9 *Using music as a health resource* to *Essential but not unique therapeutic principles*, and added two additional principles (4.5 and 4.6) associated with living with an AD to *Not acceptable—proscribed therapeutic principles* based on feedback from the community-engaged process. All of the principles were made into a checklist that the clinician reviewed before and after sessions to ensure they were working from a resource-oriented approach. The clinician and researcher 2 reviewed the checklist during supervision.

Figure 1. Resource Manual.

Resource Manual

1. Unique and Essential Therapeutic Principles
1.1 Focusing on the clients' strengths
1.2 Recognizing the client's competence related to their therapeutic process
1.3 Collaborating with the client concerning goals of therapy and methods of working
1.4 Acknowledging the client's musical identity
1.5 Begin emotionally involved in the music
1.6 Fostering positive emotions

2. Essential but not Unique Therapeutic Principles
2.1 Engaging the client in music interplay (such as musical improvisation, creating songs, playing pre-composed music or listening to music)
2.2 Acknowledging and encouraging musical skills and potentials
2.3 Reflecting verbally on music and musical interplay
2.4 Listening and interacting empathetically
2.5 Tuning into the client's music expressions
2.6 Collaborating with the client concerning the length and termination of therapy process
2.7 Providing therapeutic rationale (moved from section #3)
2.8 Sharing one's own experiences (moved from section #3)
2.9 Using music as a health resource (added)

3. Acceptable but not Necessary Therapeutic Principles
3.1 Teaching instruments/music
3.2 Having music as the primary goal of therapy
3.3 Reflecting verbally and musically on problems

4. Not Acceptable- Proscribed Therapeutic Principles
4.1 Neglecting the client's strengths and potentials
4.2 Having a strong focus on pathology
4.3 Avoiding emerging problems and negative emotions
4.4 Directing in a non-collaborative style
4.5 Not respecting clients' identities (added)
4.6 Not Respecting client's expertise in their own experience (added)

Session Structure and Clinical Decision Making

The participants and the clinician met at times that worked for the two of them. Sometimes the participant needed to reschedule due to health or personal reasons. The session structure and format changed each week depending on how the participant felt during the check-in. The clinician then determined which interventions and approaches from the resource manual would best meet the needs of the participant on that particular day. For example, in the first session, one participant shared they were feeling sick and discussed various stressors. Based on this check-in, the clinician provided options for interventions that may be beneficial for stress management and relaxation, and the participant chose to engage in a progressive muscle relaxation. In preparation for the experience, the clinician discussed what the participant might experience and played a brief excerpt from the music chosen based on participant preference determined during the intake at the beginning of the study. After briefly listening to the song selected by the clinician, the participant confirmed that they could hear the music, however, they shared that the piano in the music was promoting anxiety. The clinician then provided different music options, that were appropriate for relaxation, and the participant chose the music they wanted.

Music Therapy Interventions

MT interventions used during the sessions included: creating playlists (Geipel, 2019), creating iso-principle playlists (Heiderscheit & Madson, 2015), song discussion (Dvorak, 2017), music assisted relaxation (Scheufler et al., 2021), progressive muscle relaxation (Robb, 2000), supportive music and imagery (Paik-Maier, 2010), writing/drawing in response to music (Atiwannapat et al., 2016; Chen et al., 2024; Fox, 2019), songwriting (Baker, 2015), improvisation (Wigram, 2004), electronic music creation (Crooke & McFerran, 2019), and learning instruments (Oden, 2014). Of these interventions, receptive MT experiences such as music listening, playlist building, and writing/drawing in response to music were used most frequently.

Table 1. Music Therapy Interventions and Descriptions.

Intervention	Purpose of Intervention	Description	Special Considerations	Example
Creating playlists (Geipel, 2019)	Increase coping; Promote positive feelings such as hope, joy, calm, uplift, and motivation; Support activities of daily living.	Participants and the clinician collaborated on the theme of playlists created and music chosen from them. At times, participants selected the music, while others would ask the clinician to choose songs. For each song shared, participants and clinician discussed the themes of songs, specific lyrics, instrumentation, and associations of the song.	Discussing the songs throughout this intervention is vital to helping participants connect more intentionally and deeply with the music. Helping participants identify what musical characteristics resonate with specific states such motivation and calmness may help them to choose and listen to music more intentionally outside of the therapeutic space.	One participant made three playlists that included songs that promote joy, calmness, and a combination of them over two sessions. After listening, the participant and the clinician made observations about the music, the song themes, associations with the music, important lyrics, and reflections on how the instrumentation of the song did or did not match the songs' messages.
Electronic music creation (Crooke & McFerran, 2019)	Increase expression; increase coping; Promote sense of control; improve self-esteem.	Participants and the clinician collaborated on the methods of working, which included the platform for the creation (either Garageband or Chrome Music Lab). During these interventions, the clinician supported the exploration of these platforms.	Creating electronic music was different for each participant, depending on their previous experience. In some cases, the clinician's role may be more of a teacher at first, while participants may teach the clinician their skills at other times. Therefore, the clinician's flexibility to shift between therapeutic roles is emphasized.	For one session, one participant created electronic music via Garageband and taught the clinician how to use the platform. Before the study, the participant had made music with the platform for years and reported it as a helpful resource for health. In subsequent sessions, the participant shared their previous creations with the clinician.
Improvisation (Wigram, 2004)	Increase expression; increase coping.	The participants and the clinician discussed the methods of working including what instruments to use, choosing musical structure (tempo, key signature, etc.) if needed/wanted, and what might be explored. In some cases, participants chose to improvise by themselves, and other times they wanted to play with the clinician. After each improvisation, the	Improvisation may be structured or unstructured, depending on the participant and situation. The clinician may need to shift between leading, observing, or collaborating.	After the check-in, one participant was not sure what they wanted to explore, but stated they were interested in playing the piano. The participant sat down at the piano and paused before describing they were feeling conflicted due to family stressors, and they discussed their tendency to shy away from feeling and processing these stressors. The

Intervention	Purpose of Intervention	Description	Special Considerations	Example
		clinician and participant processed the experience before either returning to an improvisation or moving on to another intervention. To process, the clinician may ask questions such as: • How was that experience for you? • What did you notice? What stood out? • What emotions did you feel? • If you were to improvise again, what would you explore?		clinician prompted the participant to explore the situation and emotions by improvising on the piano while the clinician observed. While processing the improvisation, the participant shared that it felt good to play and that they almost cried. Improvisation appeared to provide the participant with an opportunity to explore situations and feel unpleasant emotions that they shared they would typically shy away from.
Iso-principle playlists (Heiderscheit & Madson, 2015)	Improve coping; Mood management; Improve mood; Explore emotions such as anxiety, overwhelm, and heaviness, while also promoting feelings such as hopefulness, contentment, and calmness.	The clinician provided a rationale for this intervention and explained what an iso-principle and the process of entrainment were. The clinician then prompted the participant to choose an unpleasant emotion or state they felt often, such as anxiety, depression, etc. and then identify an emotion or state they wish they felt instead. After identifying these emotions/states, the clinician supported the participant to begin selecting music for the playlist. They listened to songs and discussed themes and musical characteristics before placing it on the playlist. This process was completed for each song so the participant could put the songs in an order based on the emotions/states identified at the beginning.	Building iso-principle playlists requires song discussion, whether it is brief or in-depth. The clinician's role is to help the participant engage more deeply with the music. Discussing the juxtaposition or congruence between songs' lyrics and instrumentals (or different instruments) may be useful. Because of varying associations and thoughts, participants may choose a different placement on the playlist than the clinician. Ultimately, the participant should choose the placement of songs for their playlist.	During the check-in, one participant began discussing various stressors, identified they were feeling depressed, and presented with a sad affect. When given options for interventions, they chose to build an iso-principle playlist. They stated they wanted to build a playlist that explored heaviness to hopefulness. The participant began choosing songs and before the clinician could prompt, they began discussing their associations with the song and the songs' lyrics and instrumentals. During this process, the clinician served as a witness, while also providing some feedback on the songs. Throughout the session, the participant's affect began to brighten and at the end of the session, they shared they felt "much better" and uplifted. At the next session, the participant showed the clinician edits they had made to the playlist since the previous session.
Learning instruments (Oden, 2014)	Learn and practice positive outlets, increase expression, improve self-esteem through a sense of mastery	Before diving into the experience, the clinician and participants discussed what the participant felt confident with, needed more help with, and their goal for the session. This conversation helped the participant and clinician structure the session.	Each participant will learn an instrument at a different pace, depending on their previous experience with the instrument. Beginning and ending the experience with a check-in may help tailor the experience to the individual and provide	Throughout the study, one participant learned the guitar for 4 sessions, and 1 session was spent reviewing and exploring the piano. One participant learned basic chords, and practiced with a phone application (Guitar Tuna) outside of the session.

Intervention	Purpose of Intervention	Description	Special Considerations	Example
			them with an opportunity to work towards what they feel is important to them.	
Music Assisted Relaxation (MAR; Scheufler et al., 2021)	Promote relaxation; decrease physical tension or discomfort throughout the body; Promote stress management.	After tailoring the relaxation based on what each participant needed, the clinician played short samples of music, and the participant then chose their preference. Participants then settled into a comfortable position and closed their eyes if they felt comfortable doing so. The clinician then led the relaxation. Some relaxations focused on taking measured breaths, while others included breathing specific colors or qualities or allowing body parts to become heavy and warm.	Providing opportunities for participants to collaboratively tailor experiences may help to promote agency. Providing options for the participant to choose from may also provide the participant with an opportunity to share what relaxation techniques they may not enjoy or find useful.	One participant shared they had a painful migraine and chose to engage in MAR. The participant and the clinician discussed options for the MAR, including focusing on breathing, imagining the breath has specific qualities or colors, etc. The participant verbalized they wanted to focus on imaging the breath had colors and sending it to different body parts. The clinician led the relaxation, prompting the participant to imagine breathing in blue air and breathing out orange. The clinician also prompted the participant to send the breath to the feet, legs, abdomen, back, chest, arms, shoulder, neck, and head. Afterwards, the participant stated they felt a little better.
Progressive muscle relaxation (PMR) (Robb, 2000)	Promote relaxation; decrease physical tension throughout the body; Promote stress management.	Before beginning the experience, the clinician gave an overview of what the participants could expect from the experience and provided short samples of music, to which the participant would then choose which song they preferred. The clinician prompted the participants to settle into a comfortable position and close their eyes if they felt comfortable doing so. The clinician first prompted the participants to notice their breath, and then elongate the breath, before prompting them to tense and release various muscle groups. Most frequently, the clinician started with the feet and worked towards the head.	Because PMR involves tensing muscles, some participants may experience discomfort, especially if they have had pain or discomfort prior to engaging in PMR. Because of this, clinicians are advised to ask the participant if they have been experiencing any pain or discomfort, and if they would like to skip over these body parts during the experience. Clinicians may also preface the experience by encouraging the participant to skip over any part of the body if they notice pain or discomfort during the experience.	One participant shared they were dealing with various stressors and expressed it was “emotionally draining.” They shared they were seeking support and taking care of themselves. The participant mentioned that yoga had been a beneficial activity for them, as it provided an opportunity to “release.” The clinician asked the participant what they felt would be most beneficial to explore, and they expressed interest in a relaxation experience. The clinician gave options for relaxation experiences, and the participant chose PMR. When asked about music, the participant stated they wanted to hear the same music as the previous session (when they did PMR) and did not identify specific areas of the body that needed to be skipped when prompted. Afterwards, the participant shared the experience “felt good” and that they felt “centered.”

Intervention	Purpose of Intervention	Description	Special Considerations	Example
Song discussion (Dvorak, 2017)	Exploration and expression of self and various situations such as stressors, health status, relationships, and social change through music.	Discussions of songs were frequently had, as receptive music was most used throughout the study. After listening to songs, participants and the clinician discussed the song. Prompts frequently given by the clinician included • Why they chose the song • What lyrics or instrumentation stood out to them • Discuss the congruence or juxtaposition between the lyrics and instrumentals • What themes were explored • Any emotions that the song may have prompted	The clinician's role is to collaboratively help the client connect more deeply to the music shared.	One participant frequently engaged in song discussions as this participant's preferred intervention appeared to be music listening. Discussions often included reminiscing on memories associated with the song. The participant shared about loved ones, memories from their childhood, how songs resonated with their political frustrations, and how songs represented their experience living with autoimmune disease.
Songwriting (Baker, 2015)	Increase expression; Improve self-esteem through a sense of mastery.	Participants and the clinician discussed methods of working which included options to rewrite existing songs, using artificial intelligence (AI) programs to create songs and then edit them (if participants felt comfortable), or write songs from scratch. One participant chose to briefly explore editing a song generated by AI, while another chose to write from scratch. In both of these processes, the clinician's role was to help the participant identify themes they wanted to explore, and provide suggestions on formatting for the song.	The clinician's role is to support the songwriting process by making suggestions. Suggestions may include changes in wording, rearranging specific lyrics, and changes in the structure of the song. Furthermore, the clinician's role is to help the participant identify how they want the song to sound, which includes identifying tonality (major/minor), selecting chord structure, creating a melody, and choosing the tempo. Ultimately, the clinician's role is to use their musical knowledge to help the client use all aspects of music to express themselves.	During a check-in, one participant shared about political and social stressors. The clinician noticed that these stressors had been discussed in previous sessions, and the participant and the clinician discussed how songwriting may be an expressive outlet for these stressors. The participant also shared they frequently wrote poetry, so the clinician and the participant discussed how poetry and songs were similar. The participant and the clinician briefly wrote a verse and chorus for a song that included themes of nature and hope. After this session, the participant expressed wanting to shift to writing poetry in response to music.
Supportive music and imagery (SMI) (Paik-Maier, 2010)	Promote relaxation; promote positive emotions; increase stress management.	The clinician provided participants with an overview of the experience so they could know what to expect. Before beginning the experience, participants were prompted to think of and describe a real or hypothetical place that promoted a sense of comfort. Participants were prompted to describe what they saw,	Clinicians may require additional training to ethically implement this experience. Furthermore, SMI is intended to be a highly structured imagery experience. Knowing and understanding the structure and contraindications of this experience are crucial.	The participant joined the session and shared that they were recovering from a migraine. The clinician asked what they felt would be beneficial to explore, and the participant chose SMI as it was an option explained in a previous session. The participant began to describe a scene where they were sitting in

Intervention	Purpose of Intervention	Description	Special Considerations	Example
		heard, smelled, tasted, and felt in detail as the clinician wrote the descriptions down. Then, the clinician read the descriptions back to the participant and asked if they wanted to edit any of the descriptions. The clinician then provided two options for music, and the participants chose their preference. Participants were then prompted to settle into a comfortable position and close their eyes if they felt comfortable doing so. As the music began, the clinician prompted the client to notice and elongate the breath before reading the imagery script. After the music ended, participants were encouraged to begin writing or drawing, or to stretch or move as needed. The participant and clinician then processed the experience. Questions frequently asked were • How was that experience for you? • What did you notice? What stood out? • Is there anything you would like to share about what you wrote or drew? • How do you feel? Is this different or the same as before?		the middle of the woods and they expressed they felt calm and safe. The clinician prompted the participant to elaborate on what they saw, were touching, heard, smelled, tasted, and felt. The clinician read the details the participant provided back to them, and the participant made a few edits and confirmed they were ready for the experience. The clinician and the participant worked together to choose the music, and then engaged in the intervention. Immediately after the imagery experience ended, the participant was invited to draw. Once finished, the participant shared the experience was "really good," "felt like home," and that they got "a little emotional." They continued to share about their creation, sharing they drew the trees as they saw in their imagery. This experience then prompted the participant to begin exploring safety, dedication, and love through drawing/writing in response to music.
Writing and drawing in response to music (Atiwannapat et al., 2016; Chen et al., 2024; Fox, 2019)	Increase self-expression; Increase emotional expression; Increase coping; Promote increased presence and feelings of peace and motivation	After identifying they wanted to draw and/or write to music, participants were prompted to identify what music they wanted to hear, and what themes they may want to explore. Participants had the option to choose the music or ask the clinician to choose the music. Participants chose to explore a variety of themes, and each experience was tailored to each participant's unique preferences and situation. Some participants chose to listen to relaxation music chosen by the clinician, while others chose and played music from their streaming platform. Participants were encouraged to write or draw in response to the music. After writing or drawing,	The clinician's role is to support the participant in exploring whatever is important for them. The clinician may ask questions about the client's writing or drawing. However, the clinician's role is *not* to place value or interpret the participants' experience or product.	Example #1: One participant chose to write while listening to music that had "feminine energy." They identified artists such as Natalie Jane, Lydia The Bard, and Morgan St. Jean, and the clinician played songs. After the experience came to an end, the participant shared how each song had an impact on how they wrote about their identity and sense of self. Example #2: Another participant shared they wanted to draw to music that was uplifting. The participant asked to hear more Khruangbin, and the clinician played it while the participant drew. The

Intervention	Purpose of Intervention	Description	Special Considerations	Example
		participants and the clinician processed the experience. Questions frequently asked were • Is there anything you would like to share about what you wrote or drew? • What did you notice as you engaged in this experience? • What did you notice about the music? How did the music impact your experience? • How are you feeling? Is this similar or different to before?		participant shared they drew different fish on various backgrounds in response to the music. The participant shared this experience was uplifting and motivating for them and requested it for the next session.

While many of the principles of the resource manual are related to how the clinician interacts with the participant, having a framework or connection between the resource manual and the treatment interventions may be useful. For example, receptive MT experiences were tied to developing music as a health resource (Principle 2.9). Participants reported using these between sessions as needed and mentioned that they would utilize these skills after the completion of the study. Electronic music creation and improvisation were tied to Principle 1.4 (*acknowledging the client's musical identity*) as well as 2.2 (*acknowledging the client's musical skills*). Learning instruments was tied to both 1.4 (*acknowledging the client's musical identity*) and 2.2 (*acknowledging and encouraging musical skills and potentials*). Relaxation-based experiences focused primarily on 2.9 (*Using music as a health resource* [*added*]), but also 1.2 (*recognizing the client's competence related to their therapeutic process*) and 1.3 (*collaborating with the client concerning goals of therapy and methods of working*).

Assessment of treatment fidelity

In addition to using the resource manual checklist, the clinician wrote detailed notes following each session and shared these with the second researcher. During the study, the clinician had weekly individual supervision to review session notes and discuss the resource manual, participant experiences in MT and challenges that arose. The clinician also met for group supervision with other graduate students to discuss using digital audio workstations (DAWs) and providing sessions via telehealth. Group supervision did not include any participant information and focused primarily on the mode of delivery. The second author provided supervision to the clinician by using the resource manual and theoretical approach as the primary guidelines for feedback.

Findings and Discussion

The purpose of this report was to outline the treatment approach and MT interventions used with adults with ADs and a mood disorder. Through a community engaged research approach (Wallerstein & Duran, 2010), relying on the lived experiences of adults with AD, we developed an ROMT (Rolvsjord, 2006) treatment approach to support individuals living with AD and a mood disorder. The outcomes of the MT treatment are presented elsewhere (Schwantes & Smith, 2025), however, there are some general observations we

will discuss in this section based on the presentation of the treatment approach, interventions, and brief examples provided.

This paper presents a pragmatic, real-world application of music therapy to an understudied population in our field. While conclusions about treatment effect cannot be drawn from this report, we do believe there are useful findings from the presentation of this treatment protocol. An ROMT approach provided the participants with agency and involvement in their treatment—they had opportunities to give feedback and direction to their care. Rather than remaining passive recipients of care, they edited relaxation scripts, made adjustments to music selections made by the clinician, created their own playlists, and even taught the clinician intricacies of utilizing DAWs. Rather than the clinician being the expert, she was often in the role of witness, supporter, and guide. This collaboration and shifting of roles are a critical aspect of the ROMT approach which was upheld during the treatment condition. Maintaining the ROMT perspective throughout treatment was an inherent part of the study. When working with individuals with AD who have fewer opportunities for agency and self-efficacy, working from the ROMT perspective provided a space in which the participants exercised choice and agency.

The use of the resource manual and accompanying checklist were critical to the adherence of the treatment approach (Rolvsjord et al., 2005). Reviewing the checklist prior to each session provided the clinician with the space to reflect on her role and remember what the *Unique and essential therapeutic principles* of treatment were as well as a reminder of the *Not-acceptable—proscribed therapeutic principles.*

The participants also selected the location for their MT sessions to take place. Providing a virtual and in-person option (for local participants) ensured that the participants were comfortable in their setting and had fewer barriers to accessing the treatment. In addition to this flexibility, the clinician also allowed participants to reschedule to an extent due to health and personal factors. Even with these adjustments, all but one of the participants received the full dose of treatment. We anticipate that the regular participation and involvement during each session and completion of the treatment was due to this flexibility.

Since the clinician personally understood and empathized with individuals who have ADs and mood disorders, supervision was a necessary component to providing ethical care (Severinsson, 2014). Supervision allowed space for the clinician to explore her own personal experiences and how they impacted the treatment as well as understanding when countertransference may be occurring. In addition, the second researcher could check in with the clinician about her own health and wellbeing. While the clinician had developed myriad coping strategies and health resources prior to engaging in this study, having this weekly touchpoint provided the space for that discussion to occur should the burden of conducting research with this vulnerable population become significant.

Broader Context and Stressors

One important value of the ROMT approach is viewing clients within their broader context. It is important to acknowledge that one's broader context may have a greater impact on one's mental health than one 50-minute MT session a week. Though research suggests that MT may be beneficial in helping individuals cope with stressors (Hanser, 2014), we must also acknowledge that some stressors may only be relieved through political and social change. For example, one participant disclosed they feared they were going to lose access to necessary medical technology and medication to manage their AD due to changes in accessing disability support. This issue in their broader context appeared to exacerbate anxiety. MT sessions can be beneficial as they support stress management and self-expression. However, particularly in the U.S. context, significant political changes are needed to mitigate the costs and limited access to healthcare for individuals living with ADs.

Limitations

While the limitations of the research study are reported elsewhere (Schwantes & Smith, 2026), there are also a number of limitations of the treatment approach and interventions which need to be considered. The amount of flexibility needed to work with individuals with AD may not be accessible to other clinicians who do not have the time to continually reschedule sessions and allow for frequently cancelled sessions. Having a flexible approach to treatment options may also be discomforting to some clients who need regular structure and repetition (Ala-Rouna, 2005). Some clients may feel overwhelmed with choices and may prefer the clinician to initially make those for them. Other clients may feel like they are doing the work of the clinician by determining the interventions used on a regular basis. Further, some clients may become stuck by using experiences they find to be safer and less confrontational.

The treatment period was also only 8 weeks and came at no cost to the participants. Individuals, who have significant health care costs and loss of income may not be able to access MT for private pay. Access to MT services may still be unavailable to larger groups of people. Allowing for the flexibility of clinical setting may be challenging to clients and music therapists. While some MT interventions work well in telehealth contexts (e.g., relaxation and song discussion), other interventions may be warranted for what the client needs (e.g., improvisation) but may be less effective in the telehealth space (Willhelm & Wilhelm, 2022).

Most of the participants in this study identified music as a health resource prior to beginning their participation. We recommend that therapists consider the clients' relationships to music as a part of determining their fit for working from an ROMT perspective. Some clients may need a more directive approach with psychoeducation about the value of music and MT as an effective approach to holistic care.

Further research is needed to develop appropriate MT interventions and ways of working with clients who have complex medical needs (such as those with ADs) as well as the accompanying mood disorders that are often exacerbated by chronic health conditions. While we believe this report provides the opportunity for more dialogue in MT, more research, clinical practice, and theory development is warranted.

Conclusion

ADs are an under-researched population in the field of MT, even though there are many individuals throughout the world who are facing the challenges of living with an AD. Since many individuals with AD face ongoing challenges of managing symptoms and a decrease in quality of life, they need targeted treatment and support to manage their disease, particularly when they are navigating mood disorders in addition to having an AD. MT may be a viable treatment option when combined with usual care. We recommend that music therapists consider using an ROMT approach to provide opportunities for agency and choice within a predictable and structured framework. Additional research and clinical work are needed to further develop how MT might best support individuals with ADs.

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Sylvia Grace Smith, MT-BC, is a board-certified music therapist based in Roanoke, Virginia. She holds both a master's and a bachelor's degree in music therapy from Appalachian State University, along with a certificate in expressive arts therapy. Grace's clinical experience includes work with children, adolescents, and adults in acute mental health settings, adults living with autoimmune disease, and adults receiving general

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Grace is dedicated to advancing the field of music therapy through education, research, and clinical practice. Her research focuses on adults living with autoimmune disease and co-occurring depression and anxiety. She frequently presents at professional conferences on the applications of music therapy with individuals living with autoimmune disease. Her recent presentations include the World Art Therapy Festival in Prague, Czechia (September 2025) and the 11th Nordic Music Therapy Conference in Aalborg, Denmark (June 2024). Grace is also an advanced trainee in the Bonny Method of Guided Imagery and Music through the Appalachian GIM Institute.

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