COMPARATIVE EFFECTS OF REBT AND MUSIC THERAPY ON HOSPITALIZED DEPRESSED PATIENTS

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ABSTRACT
The study examined the comparative effects of REBT and Music Therapy on depression. Ten (10) clinically depressed inmates of the Psychiatric Rehabilitation Centre Obosi in Anambra State served as the participants in the study. 8(80%) were males while 2(20%) were females. The ages of the participants ranged from 18 to 64 years with a mean age of 41.7 and standard deviation of 15.9. Two instruments were used for the study: the self Rating Depression Scale (SDS) developed by Zung (1965), and a Sony DVD player, made in Japan and the musical compact disc. The design is pretest-posttest within subject experimental design. Based on the design, matched T-test statistics was used for hypothesis I and II, while for hypothesis III independent T-test statistics was applied. The first hypothesis which stated that music therapy will significantly lower depression among patients was upheld at P< .01 level of significance, the second hypothesis which stated that Rational Emotive Behaviour Therapy will significantly lower depression among patients was also upheld at P< .01 level of significance, and The third hypothesis which stated that depressed patients who received Rational Emotive Behaviour Therapy will show significantly lower depression when compared with those that receive Music Therapy was rejected at P> .01 level of significance. It is recommended that the potentials of music therapy be further explored since it holds promise for an affordable and dependable treatment modality.

Key Words: *REBT; Music Therapy; Hospitalized; Depressed Patients.*

INTRODUCTION

Depression can be seen as a state of mood, as a special symptom manifesting itself in many different mental disorders, as a syndrome measured by depression rating scales, and as a clinical diagnosis operationalized in diagnostic classification (Lehtinen and Joukamma 1994). It is an illness that involves the body, mood and thoughts and that affect the way a person eats, sleeps, feels about him or herself, and thinks about things. (www.medterms.com/script/main/art.asb).

Kinds of depression are distinguished by their prevalent features, duration, and severity of symptoms. Most prevalent kinds of depression are defined by the Diagnostic and Statistical

Manual of Mental Disorders (DSM), an American Psychiatric Association publication which describes the standard criteria for different types of psychiatric disorders. A common criterion is that their symptoms either cause significant distress or impair one's functioning (eg, work, school, relationships). Also these depressive symptoms are not caused by a medical condition or substances (eg, medication, drug). The following three distinct kinds of depression are described in the DSM.

a. **Major Depression**, known as depressive disorder in the DSM-IV-TR: is a mood disorder distinguished by the occurrence of one or more major depressive episodes. Symptoms occur as a result of the disorder and not from the effects of a substance, medical conditions, or loss of a loved one within the previous 2 months.

Emotional symptoms: Two primary symptoms of major depression are depressed mood and anhedonia, or loss of interest and pleasure in activities. In order for clients to be diagnosed with major depression, one of these symptoms must be present most of the day, nearly every day, for at least 2 weeks. Clients may describe their mood as depressed, sad, empty, or numb. They may report difficulty experiencing pleasure or satisfaction from their usual activities, including eating and sex. Feelings of sadness may be accompanied by frequent crying. Anxiety, irritability, or anger may also be present. Clients may report feelings of loneliness, helplessness, or hopelessness. The affect of a person with depression is often flat and constricted, with minimal expression.

Cognitive symptoms: cognitive criteria for major depression include the diminished ability to think, concentrate or make decisions and excessive focus on self-worthlessness and guilt. Clients may be unable to make decisions about routine concerns, such as what clothing to put on in the morning or what to buy at the grocery store. Recurrent thoughts of death are often evident, including thoughts of suicide, death from natural causes, or existential thoughts about dying. Clients ruminate about past deeds and their negative view of themselves and the world. Clients with severe depression can become delusional with fixed beliefs that cannot be changed by logic, focusing on persecution, punishment, nihilism (belief that existence is senseless and useless), or somatic concerns.

Behavioural Symptoms: Behavioural symptoms that are criteria for major depression are significant weight loss or gain or change in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, and fatigue. Weight gain or weight loss is considered to be significant when it represents 5% change in body weight in one month. Sometimes the weight change is not apparent but the client reports a major change in appetite. Sleep disturbances are common, and the clients report not being able to sleep or sleeping too much. Psychomotor agitation is evident when the client appears to be restless, paces, fidgets, or is

irritable. With psychomotor retardation, the client appears to be slowed down in movement and in speech. Persons with depression may appear listless and disheveled. They may not carefully attend to their distress, appearance, or hygiene. They may exhibit a stooped posture and make little eye contact.

Social symptoms: To diagnose major depression, the convergence of symptoms must cause personal distress and significant impairment in social and occupational functioning. Clients may have problem at their job, including inability to organize, begin and complete their work. While some are able to function at work with relatively little impairment, this often comes at great personal and family expense as their energy for social interaction is depleted. Family members began to feel confused, angry, guilty, abandoned, and sad.

b. **Dysthymic Disorder:** it differs from major depression because it is a chronic, low-level depression. To receive this diagnosis, the client must have had depressed mood and at least three of the following symptoms for most of the day, nearly every day, for at least 2 years (one year for children and adolescents): poor appetite or overeating, insomnia and hypersomnia, low energy, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. There cannot have been a manic or hypomanic episode. The client may have experienced an episode of major depression before the onset of dysthymia, provided there were at least 6 months with no signs or symptoms of depression. After 2 years of dysthymia, the client may be diagnosed with major depression superimposed with dysthymia if symptoms increase in severity. The dysthymia disorder is not due to the effects of a substance or medical condition. Psychotic features are usually not present in this disorder.

c. **Manic depression (now known as bipolar disorder)** – This kind of depression includes periods of mania and depression. Cycling between these two states can be rapid or only mania can be present without any depressive episodes. A manic episode consists of a persistent elevated or irritable mood that is extreme which lasts for at least one week. At least three (four if only irritable mood) other features are also present: inflated self esteem or self importance, decreased need for sleep, more talkative than usual - compelled to keep talking, experiencing racing thoughts and flight of ideas, easily distracted, increase in goal-oriented activity (social, work, school, sexual) or excessive movement, excessive involvement in potentially risky pleasurable behaviour (eg. Overspending, careless sexual activity, unwise business investments). Symptoms can be severe enough to warrant hospitalization to prevent harm to self or others or include psychotic features (eg. Hallucinations, delusions).

CAUSES OF DEPRESSION

Various theories have been presented to explain the development of depression and other mood disorders. Each theoretical perspective helps to explain some aspect of mood

disorders, but none fully accounts for their development hence the exact cause remains uncertain. Many researchers and clinicians support the premise that mood disorders have multi-causal origins, in which biological, psychological, social, and cognitive factors converge to promote the development of these conditions. Others contend that specific types of mood disorders may be related more to certain, specific etiologic factors. It seems most plausible that depressive disorders have a combination of predisposing factors: genetic and biological, environmental, and psychological factors.

THEORETICAL BACKGROUND

The study is anchored on the behavioural and cognitive perspectives in tandem with therapeutic modalities being studied. The behavioural perspective has nothing to do with internal unconscious conflicts, repression, or problems with object representations. Rather, emphasis is on dysfunctional or unhelpful behaviours, so depression is learned, and because depression is learned, behavioural psychologists suggest that it can be unlearned.

Lewinson (1974), argued that depression is caused by a combination of stressors in a person's environment, and a lack of personal skills. More specifically, the environmental stressors cause a person to receive a low rate of positive reinforcement. Positive reinforcement occurs when people do something they find pleasurable and rewarding. According to learning theory, receiving positive reinforcement increases the chances that people will repeat the sort of actions they had taken that resulted in the reinforcement. In other words, people will tend to repeat those behaviours that get reinforced.

Lewinson posited that depressed people are precisely those people who do not know how to cope with the fact that they are no longer receiving positive reinforcements like they were before. For example, a child who has newly moved to a new home and has consequently lost touch with prior friends might not have social skills necessary to easily make new friends and could become depressed. Similarly, a man who has been fired from his job and encounters difficulty finding a new job might become depressed.

In addition, depressed people typically have a heightened state of self-awareness about their lack of coping skills that often leads them to self-criticize and withdraw from other people. For instance, depressed people may avoid social functions and get even less positive reinforcement than before. To make matters worse, some depressed people become positively reinforced for acting depressed when family members and social networks take pity on them and provide them with special support because they are "sick". Research however, suggests that Lewinsohn's theory explains the development of depression for some individuals, but not for all.

COGNITIVE THEORY OF DEPRESSION

Cognitive theories rose to prominence in response to the early behaviourists' failure to take thoughts and feelings seriously. Cognitive theorists suggest that depression results from maladaptive, faulty, or irrational cognitions taking the form of distorted thoughts and judgments. Depressive cognition can be learned socially (observationally) as is the case when children in a dysfunctional family watch their parents fail to successfully cope with stressful experiences or traumatic events; or depressive cognitions can result from a lack of experience that would facilitate the development of adaptive coping skills.

According to cognitive theory, depressed people think differently from non-depressed people, and it is this difference in thinking that causes them to become depressed. For instance, depressed people tend to view themselves, their environment, and the future in a negative, pessimistic light. As a result depressed people tend to misinterpret facts in negative ways and blame themselves for any misfortune that occurs. This negative thinking and judgment style functions as a negative bias, it makes it easy for depressed people to perceive situations as being much worse than they really are, and increase the risk that such people will develop depressive symptoms in response to stressful situations.
Different cognitive behavioural theorists have developed their own unique twist on the cognitive way of thinking.

AARON BECK'S COGNITIVE THEORY OF DEPRESSION

According to Beck, (1963), negative thoughts generated by dysfunctional beliefs are typically the primary cause of depressive symptoms. A direct relationship occurs between the amount and severity of someone's negative thoughts and the severity of their depressive symptoms. In other words, the more negative thoughts one experience, the more depressed they will become. Beck also suggests that there are three (3) main dysfunctional belief themes (schemas) that dominate depressed people's thinking:

- I am defective or inadequate
- All of my experiences result in defeats or failures and
- The future is helpless

Together, these three themes are described as the "negative cognitive triad". When these beliefs are present in someone's cognition, depression is very likely to occur.

Beyond the negative content of dysfunctional thoughts, these beliefs can also warp and shape what one pays attention to. According to Beck, depressed people pay selective attention to aspects to their environment that confirm what they already know and do so even when evidence to the contrary is right before them. This failure to pay attention properly is known as "faulty information processing". Particular failure of processing are very characteristic of the depressed mind. For instance, depressed people will tend to demonstrate selective attention to information which matches their negative expectations, and selective inattention

to information that contradicts those expectations. Faced with a mostly positive performance review, depressed people will manage to find and focus in on the one negative comment that keeps the review from being perfect. They tend to magnify the importance and meaning placed on negative events. All of these maneuvers, which happen quite unconsciously, function to help maintain a depressed person's core negative schemas in the face of contradictory evidence, and allow them to remain feeling hopeless about the future even when the evidence suggest that things will get better.

ALBERT ELLIS COGNITIVE THEORY OF DEPRESSION.

According to Ellis (1956), depressed people's irrational beliefs tend to take the form of absolute statements. Ellis describes three (3) main irrational beliefs typical of depressive thinking.

- "I must be completely competent in everything I do, or I am worthless".
- "Others must treat me considerately, or they are absolutely terrible"
- "The world should always give me happiness, or I will die".

Because of these sorts of beliefs, depressed people make unqualified demands on others and, or convince themselves that they have overwhelming needs that must be fulfilled. Ellis referred to this tendency towards absolutism in depressive thinking as "Musterbation".

Ellis also noted the presence of information processing biases in depressed people's cognitions. Like Beck, he noted that depressed people tend to ignore positive information and engage in overgeneralization, which occurs when people assume that because some local and isolated event had turned out badly, that this means all events will turn out badly. For instance depressed people may refuse to see that they have at least a few friend (ignoring the positive); or they might dwell on, and blow out of proportion the hurts they have suffered (exaggerating the negative). Other depressed people may convince themselves that nobody loves them, or that they always mess up (overgeneralization).

Depression is widespread; across nations and races. A national survey of the mental health of Australians was carried out in 2007. This survey asked people about a range of symptoms of depression and other health problems. A special computer program was used to make a diagnosis based on the answers provided. Shown below are the percentage of people found to be affected.

Percentage of Australians age 16 years or over affected by depressive disorders:

Type of disorder	Percentage affected in previous 12 months	Percentage affected at anytime in life
Major depressive episode	4.1%	11.6%
Dysthmia	1.3%	1.9%
Bipolar	1.8%	2.9%
Any depressive disorder	6.2%	15.0%

Similarly, Abasiubong F, Obembe A, and Ekpo M, (2006) carried out a research in Lagos, Nigeria to determine the General Health Questionnaire (GHQ) score of mothers of children with learning disability. To identify sociodemographic variables and to assess anxiety and depression in them.

Using structured questionnaires between March and May 2002, 106 mothers of children with learning disability in Mentally Handicapped Home for children in Lagos, Nigeria were assessed and compared with mothers of normal healthy children in Lagos. The mean age of the participants was 40.0±6.6 years. Mothers of participants (26.4%) compared with mother of normal healthy children (9.9%) had a high GHQ score and high levels of anxiety (25.5%) and depression (10.4%). Marital difficulties were associated with learning disability.

Atindanbila and Abasimi, (2011), in a study examined the prevalence of depression of students at the University of Ghana, and the coping strategies they use. A sample of 312 students were drawn from Legon and Accra city campuses of the University of Ghana through stratified sampling. Manova, Anova, T-test and Regression Analysis were used to analyse the result which revealed that students had mild depression in them. Females had more signs of depression while level 400 students had the least signs. The commonly used strategy was the cognitive.

Chang MY, Chen CH, Huang KF, (2008) conducted a research to examine the effects of music therapy on stress, anxiety and depression in Taiwanese pregnant women. Two hundred and thirty-six (236) pregnant women were randomly assigned to music therapy (n = 116) and control (n = 120) groups. The music therapy group received two weeks of music intervention. The control group received only general prenatal care. Their psychological health was assessed using three self-report measures. Perceived Stress Scale (PSS), State Scale of the state-Trait Anxiety Inventory (S-STAI) and Endinburgh Postnatal Depression Scale (EPDS). In a paired tests, the music therapy group showed significant decrease in PSS, S-STAI and EPDS after two weeks.

Research Questions

1. Will depressed patients who receive music therapy show significantly lower depression?
2. Will depressed patients who receive Rational Emotive Behaviour Therapy show significantly lower depression?
3. Will depressed patients who receive Rational Emotive Behaviour Therapy show significantly lower depression when compared with those that receive Music Therapy?

Hypotheses

1. Music Therapy will significantly reduce depression among patients
2. Rational Emotive Behaviour Therapy will significantly reduce depression among patients.
3. Depressed patients who receive Rational Emotive Behaviour Therapy will show significantly lower depression when compared with those that receive music therapy

Method

The methods are presented under the subheadings: Participants, Instruments, Procedure, Design and Statistics.

Participants

Ten (10) clinically depressed patients from Psychiatric Rehabilitation Centre Obosi in Anambra State served as the participants in the study. 8(80%) were males while 2(20%) were females. The participants were selected based on the hospital diagnosis which is based on DSM-IV-TR revised. The ages of the participants ranged from 18 to 64 years with a mean age of 41.7 and standard deviation of 15.9.

Instruments

Two instruments were used for the study: the self Rating Depression Scale (SDS) and a Sony DVD player, made in Japan. The SDS is a 20 – item inventory designed to assess the cognitive, affective, psychomotor, somatic and social interpersonal dimensions of depression. The normative cut off points established by Zung (1965) for categorizing depressed and normal people are: 50-59 = mild depression, 60-69 = moderate depression, 70-80 = severe depression. For Nigerian samples, the norms or mean scores obtained by Obiora (1995) with a population of secondary school students are M(n = 100) 48.77, and F(n = 100) 47.87. The questionnaire was then vetted for face, content and construct validity by a clinical psychologist.

The reliability was determined prior to the main study through a pilot study, using 5 depressed patients of Psychiatric Rehabilitation Centre Obosi. A Crombach alpha coefficient

using test retest reliability method was obtained as r = 0.98. This indicated that the instrument has high internal consistency; hence, it was adopted for the study.

The scoring was based on four point response pattern (1) some or a little of the time (2) some of the time (3) Good part of the time (4) Most or all of the time. The scoring has no reverse item. Based on this each respondent was expected to obtain a score within the range of 47 and 100.

Procedure

The SDS was administered to the participants to determine their level of depression prior to treatment. This served as a pretest measure. It was administered to the respondents individually after establishing adequate rapport with them. After the administration of the pretest, the participants were assigned to two groups through the Fishbowl Random Sampling Technique. This was a simple random sample technique involving the participants picking a folded paper of "Yes" or "No" from a bowl. Those who picked "Yes" were labeled group A while those who picked "No" became labeled group B. The group A was given Music therapy while group B was on the REBT. The five participants of the pilot study were not included in either of the study groups.

The group A was administered Music therapy three times in a week for 45 minutes in each session. This lasted for 8 weeks, a total number of 24 sessions. Group B members were administered REBT for the same duration. The researchers chose to use folk music because of the locality of the study. The original works of two minstrels of Anambra State Origin, were selected for the study: (1) Morocco Mmaduka "Asili' 98" (SSAS 042) and (2) Ozoemena Nwansugbe "Tribute to Chief Osita Osadebe" (MEL 018). The post-test was taken after two months by re-administration of the SDS.

Design and Statistics

The research is experimental. The design is pretest-posttest within subject experimental design. Based on the design, matched T-test statistics was used for hypothesis I and II, while for hypothesis III independent T-test statistics was applied.

Results

The results are presented in the order in which the hypotheses were tested.

Table 1: *Summary table of matched t-test statistic on the effect of music therapy.*

Pair 1	Mean	N	Std. Deviation	Mt	df	Sig. (2 - tailed)
Pre-test	52.00	5	1.41	6.78	4	.002
Post-test	39.80	5	3.35			

The above table indicated that the first hypothesis was confirmed at t(4) = 6.78, P<.01 level of significant. This means that music therapy significantly reduced depression among the patients.

Table 2: *Summary table of Matched t-test on the effect of REBT.*

Pair 1	Mean	N	Std. Deviation	Mt	df	Sig. (2 - tailed)
Pre-test	56.60	5	7.06	10.38	4	.000
Post-test	36.20	5	3.19			

The above table also indicated that the second hypothesis was accepted at t(4)=10.38, P<.01 level of significant. This means that REBT significantly reduced depression among patients.

Table 3: *Summary table of independent T-test on the influence of the therapies (MUSIC & REBT) on depression.*

Type of therapy	N	Mean	Std. Deviation	T	df	Sig. (2 - tailed)	Mean difference
Post-test (Music)	5	39.80	3.35	1.74	8	.120	3.60
Post-test (REBT)	5	36.20	3.19	1.74	7.98	.120	3.60

The table three above indicated that the third hypothesis was rejected at t(8) = 1.74, P>.01 level of significant. This means that REBT had no significant advantage over music therapy among participants.

DISCUSSION AND CONCLUSION

The study examined the comparative effects of REBT and Music Therapy on depression. This was ascertained from the three hypotheses formulated. The first hypothesis which stated that music therapy will significantly lower depression among patients was upheld at P< .01 level of significance. This shows that music therapy reduced depression among patients. This finding is supported by the finding of Chang MY et al (2008) who reported that two weeks of music therapy reduced stress, anxiety and depression in Taiwanese pregnant women. Another very significant effect of music therapy reported by Ezenwa (2012) that classical music decreased systolic and diastolic blood pressure of the essential hypertension

patients. The positive outcome could be as a result of the psychoneural effect of music which could increase the level of certain neurotransmitters, especially Norepinephrine and Serotonin which are believed to be the two monoamines that are most important in depressive conditions (Elhuwegi 2004). Another possibility is that the lyrics of the minstrel's songs had messages and themes related to value system and beliefs that had positive cognitive implications on the depressives thereby elevating their moods.

The second hypothesis which stated that Rational Emotive Behaviour Therapy will significantly lower depression among patients was also upheld at P< .01 level of significance. This indicates that REBT brought about reduction of depression among patients. The effectiveness of REBT in treating adverse emotional states has been reported by many authors. Obi-Nwosu (2007) reported resounding success in treating anxiety among caesarean section patients, while Egbochukwu et al (2008) reported that REBT significantly reduced anxiety among secondary school students. The positive outcome could be due to cognitive restructuring of the distorted thoughts of clients that made them to get depressed, since the patients were encouraged to develop optimistic thought patterns that require essentially three things, recognizing self-talks for what it is, dealing with negative messages, and enhancing the positives for the greater goals of individual person. This helped the patients to do better evaluation for their problems (activating events) and the options available to them, and then make better/rational decisions. Another plausible explanation is that the behavioural component of REBT assisted the clients. The behavioural component which involved at least one hour daily exercise schedule as part of the homework increased the overall activity of the clients and possibly helped to remove their thoughts from things that could be bothering them at that point thereby improving their overall well-being.

The third hypothesis which stated that depressed patients who received Rational Emotive Behaviour Therapy will show significantly lower depression when compared with those that receive Music Therapy was rejected at P> .01 level of significance. This strongly suggested that both treatment modalities were equally effective in reducing depression among patients. This finding is supported by the first and second hypotheses and earlier findings. However, from the mean difference of their post test scores, it shows that REBT had some degree of therapeutic advantage over music therapy among the depressed patients but the difference was not significant. The efficiency could be because both therapeutic modalities seem to posses both cognitive and behavioural components. Indeed, minstrel's songs which has messages could have strong cognitive implications while the entire music as a whole produce nodding and muscular movements in responding which are relevant muscular movements that could be likened to exercise, hence mimicking the effect of REBT (cognitive and behavioural components).

The little difference observed could be because the patients were taught a self helping and

constructive rational way of thinking, emoting and behaving or that more sessions of music therapy are required to meet the level of efficiency of REBT. This view is supported by the study reported by Okafor (2009) in which musical buzz was found to be effective in the reduction of anxiety among nurses. Background music was played throughout their working hours in the offices and units for a period of one month.

Indeed, the foregoing results evidently suggest that REBT and Music Therapy could be very good non-pharmacological tools in the hands of clinicians for controlling patients' psychological problems

CONCLUSION

The study examined the comparative effects of REBT and Music Therapy on depression. Three hypotheses were tested. (I) Music Therapy will significantly lower the depression among patients. (II) Rational Emotive Behaviour Therapy will significantly lower depression among patients. (III) Depressed patient who received Rational Emotive Bebaviour Therapy will show significantly lower depression than those who receive music therapy.

The result shows that both treatment modalities reduce depression among the depressed patients and that REBT has more influence than music therapy but the difference is not significant.

Based on the outcome of the research, the researchers conclude that the study will be useful to those in medical and clinical psychology settings and even private persons. This may contribute in better understanding and treatment of depression in our society. Also. it will make people understand that REBT and Music Therapy are not only beneficial to their cognitive processes and relaxation respectively but also to control the psychological state for holistic mental health.

Limitation of the study

The factor that mostly limits the result obtained in this research work was the little number of participants that makes generalization of result difficult. Secondly, local music was used.

Recommendation for further research

1. The influence of age and gender was not considered in this research. Future research should subdivide the age range and gender difference to know how these treatment modalities work across age and gender.

2. In the application of music as therapeutic resource for depressed patients, the factor of musical preference depending on the music genres and generational gaps must be

considered and built into the research design. It could become a threat to internal validity of a research of this nature since different people react differently to various kinds of musical composition.

Recommendations

1. It is recommended that music therapy be incorporated as part of regular therapeutic approaches in psychiatric and rehabilitation centres since it is effective, as well as relatively affordable for both clinicians and patients.
2. REBT should also be more widely applied because literature has shown that its effect lasts long.
3. Music therapy should be included in the curriculum of psychology students since it has been found effective in the treatment of psychopathology.

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