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# Current Music Therapy Practice with Adolescents with Emotional and Behavioral Disorders in the United States: A Survey of the Profession

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# CURRENT MUSIC THERAPY PRACTICE WITH ADOLESCENTS WITH EMOTIONAL AND BEHAVIORAL DISORDERS IN THE UNITED STATES: A SURVEY OF THE PROFESSION

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# CURRENT MUSIC THERAPY PRACTICE WITH ADOLESCENTS WITH EMOTIONAL AND BEHAVIORAL DISORDERS IN THE UNITED STATES: A SURVEY OF THE PROFESSION

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The purpose of this study was to survey Board Certified Music Therapists in the US to examine (a) the demographics of the music therapists working with this population in a non-school setting, (b) assessments used by the music therapists, (c) goals for clients, and (d) treatment methods used in the treatment of adolescents with emotional and/or behavioral disorders. The participants in this study were board certified music therapists working with emotional and/or behavioral impairments outside of the school setting. Of the total of 111 surveys sent to music therapists who possibly met the inclusion criteria, 27 were returned (N=27). The findings from this study were compared to the findings from a recent study by Polutnik investigating the role of music therapy with children with EBD in school settings. The results indicate that there are many similarities between music therapy with EBD populations inside and outside of the school setting, along with some differences. The findings further reveal that there are a variety of treatment considerations for music therapists working with the EBD population in both schools and other settings.

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# CHAPTER I

# INTRODUCTION

## Problem Statement

Over the past decade, there has been a shift in therapeutic focus from deviant adults to therapeutic prevention and counseling with adolescents with emotional and behavioral disorders (EBD). This shift forced therapists to re-evaluate current practice, and to develop more effective means of reaching and working with this population. Because of the flexibility and non-threatening approach of Music Therapy, it is often one of the treatment modalities used with adolescents diagnosed with EBD. However, there has been little research conducted as to how music therapy is implemented with the population. The purpose of this study is to describe the current status of music therapy with adolescents with emotional and behavioral disorders (EBD).

## Rational for Research

Although there is substantial research supporting the use of music therapy with children and adults in the extant literature, relatively few studies were found that describe the efficacy of music therapy for adolescents (Aldridge, 1996). A 2001 doctoral dissertation by Yeaw addressed this issue by conducting a review of literature to provide evidence for the efficacy of music therapy treatment with children. The author concluded that although research in music therapy has traditionally focused on

adult populations, there is a growing body of evidence that music therapy is being recognized as a developmentally appropriate treatment for children and adolescents.

The small amount of literature that does focus on music therapy with adolescents indicates that music therapy is an effective treatment modality. Although there are many articles that describe specific interventions and techniques used to treat this population, a cohesive presentation describing the efficacy of music therapy with adolescents with emotional and behavioral impairments was not found. It was the hope of this author that by describing the music therapy goals, objectives, and trends in the work being done with adolescents with emotional disturbance, a more complete description of current music therapy practice with adolescents could be developed.

Polutnik's 2010 survey of music therapists working with children with emotional and behavioral disorders in school settings served as the basis for the current research study. However, a major difference in the present study is that only music therapists who work with *adolescents* with emotional and behavioral disorders in treatment settings *outside of schools* were surveyed. It is hoped that the results obtained from surveying music therapists who work with adolescents with emotional and behavioral disorders in non-school settings will help to (a) identify current trends in music therapy clinical practice with adolescents with emotional and behavioral disorders and (b) determine if the treatment methodologies are the same as in school settings. The research objectives for this survey study include; 1) determining the demographic information of music therapists who are working with adolescents with emotional and behavioral disorders (e.g. age, gender, degrees earned, experience, etc.)

in non-school settings, 2) determining which music therapy philosophical orientations are most frequently reported by music therapists working with adolescents with emotional and behavioral impairments in these settings, 3) determining what specific music therapy interventions are being used with adolescents with emotional and behavioral impairments, 4) determining the goals and objectives music therapists are most often focusing on, 5) determining which interventions music therapists practicing with this population in clinical settings report to be the most effective and the least effective when working with this population, 6) determining the behaviors typically observed in adolescents with emotional and behavioral disorders, 7) and comparing the responses of music therapists working in clinical settings to previous findings of music therapists working in school settings.

## Research Questions

The research presented is based on a descriptive survey study with the results presented in a descriptive format to provide the reader with a clearer understanding of current trends in the music therapy practice of treating adolescents with emotional and behavioral impairment. This study attempts to describe the current scope of practice in treating adolescents by answering the following questions:

R1) What are the demographic characteristics of music therapists who work with adolescents with emotional and behavioral disorders (EBD) in non-school settings?

R2) Which music therapy philosophical orientations are most frequently used by music therapists in non-school settings with adolescents identified as having EBD?

R3) How do music therapists working with adolescents with EBD in non-school settings assess their clients strengths and limitations?

R4) What are common symptoms and diagnoses associated with adolescents with EBD?

R5) What are the behaviors typically observed by music therapists in the non-school settings with adolescents with EBD?

R6) What are the common goal areas focused on by music therapists in non-school settings with adolescent clients identified as having EBD?

R7) What specific music therapy interventions are most frequently used by music therapists in non-school settings with adolescents with EBD?

R8)Which interventions do music therapists in non-school settings report to be the most effective and the least effective when working with adolescents with EBD?

R9) How are music therapists evaluating the progress of adolescents with EBD?

R10) What is the structure of music therapy sessions with adolescents with EBD?

R11) What are the similarities and differences between music therapists working with adolescents with EBD in school settings versus outside of school settings concerning the previous research questions.

## Definition of Terms

Clinical Settings (non-school) included in this study were Hospitals, Private Practice (outside of the educational setting), Juvenile Detention Centers, Psychiatric Hospitals, Group Homes, and Rehabilitation Centers.

*Emotional disturbance:* The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association, (2000) classifies emotional and behavioral problems. The DSM-IV offers the following broad categories of behavioral disorders:

*Conduct disorder*: Students may seek attention, are disruptive and act out.

*Socialized aggression*: Students join a subculture group of peers who are openly disrespectful to their peers, teachers, and parents. Delinquency, truancy, and dropping out of school are common.

*Attention problems*: Immaturity: These students may have attention deficit disorders, are easily distractible and have poor concentration. They may have the tendency to be impulsive and may not think about the consequences of their actions.

*Anxiety/Withdrawal*: These students are self-conscious, reticent, and unsure of themselves. They typically have low self-esteem and withdraw from immediate activities. They are also anxious and frequently depressed.

*Psychotic behavior*: This student displays more bizarre behaviors than others do. They may hallucinate, may deal in a fantasy world, and may talk in gibberish.

*Motor Excess*: Students with motor excess are hyperactive. They cannot sit still nor listen to others nor keep their attention focused.

The Individuals with Disabilities Education Act (IDEA, 2004) uses the term emotional disturbance to describe students with emotional or behavioral impairments. IDEA defines emotional disturbance as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:

(a) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

(b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(c) Inappropriate types of behavior or feelings under normal circumstances.

(d) A general pervasive mood of unhappiness or depression.

(e) A tendency to develop physical symptoms or fears associated with personal or school problems.

Due to criticism of this definition as excluding adolescents with strictly behavioral disabilities, the National Mental Health and Special Education Coalition developed a definition that aims to address the various behaviors exhibited by adolescents and children meeting the criteria for emotional disturbance (Smith, 1997). They divide emotional or behavioral disorders into three groups that are characterized by; externalizing behaviors, internalizing behaviors, and low incidence disorders. Externalizing behaviors constitute an acting-out style that could be described as aggressive, impulsive, coercive, and noncompliant. Internalizing behaviors can be described as withdrawn, lonely, depressed, and anxious, and low incidence behaviors occur very infrequently but are quite serious when they do occur (Gresham et al., 1999). For the purpose of this study, emotional and behavioral impairment will be used to describe adolescents exhibiting any or all of aforementioned categories or behaviors.

*Adolescent:* The World Health Organization (WHO) defines adolescence as the period of life between 10 and 19 years of age.

## Summary

The methodology for this study is based on a 2010 study by Polutnik describing school based music therapy practice in the treatment of adolescents with emotional and behavioral disorders. In surveying existing research, the Polutnik study was the only study found that examined the current trends in music therapy with adolescents with emotional and behavioral impairments. However, this study was

limited to the school setting and did not address the work done outside of the school setting with this population. This research project surveyed professionally credentialed music therapists in the United States regarding the type and frequency of interventions used, the demographics of therapist and client, and the relationship of various aspects of music therapy with emotionally disturbed adolescents in clinical settings.

# CHAPTER II

## Review of Literature

### Emotional and Behavioral Impairment Development and Statistics

During adolescence, children are vulnerable to developing emotional and behavioral disorders due to a number of biological, interpersonal, cognitive, and environmental changes, and the occurrence of increasing numbers of stressful life events. At this stage of development, there is a significant change in the physical and emotional state of adolescents due to puberty. Because of the physical, social, and hormonal changes that occur, adolescents are vulnerable to emotional disturbance. At this point in life, adolescents begin to develop abstract thought, which can both positively and negatively impact emotional and behavioral well being. As the adolescent develops, there is also an increased identification with peers, and a shift in autonomy from parental figures. Along with this autonomy, there are transitions in school and activities. It is also common at this stage in life for an adolescent to experience the loss of a close relationship through friendships, intimate relationships, and loss of significant personal through death, relocation, and divorce. Considering the many physical, emotional, psychological, and biological changes that accompany adolescence, it is easy to see why emotional impairment is often observed in this life stage (Schonert-Reichl & Muller, 1996). Because emotional and behavioral disorders can occur for many different reasons, many different treatments have been employed to address them.

The goal of a study by Mark and Buck (2006) was to characterize the population of youths with serious emotional disturbance by using a nationally representative household survey. The authors reference Friedman, Katz-Levy, and Manderscheid's (1996) research indicating that there are six million to nine million youths and adolescents in the United States with serious emotional disturbance, representing 9 to 13 percent of all youths. This information was gathered from smaller epidemiological surveys. The prevalence rates of emotional and behavior impairments are higher in related studies with estimates range from 17.6 to 22 % (Costello, et al., 1996) in one study, and 16 % in another (Roberts, et. al., 1998). Mark and Buck note that child mental disorders persist into adulthood with 74% of 21 year olds with mental disorders had prior problems. In a study by, Costello, Egger and Angold, (2006) a re-analysis of community studies examined the prevalence of children and adolescents with emotional impairments. They note that in 2006, the median prevalence estimate of functionally impairing child and adolescent psychiatric disorders is 12%, and that there is evidence that many, if not most, lifetime psychiatric disorders will first appear in childhood or adolescence.

## Music Therapy with Emotionally and Behaviorally Impaired Adolescents

*Music* is defined as vocal, instrumental, or mechanical sounds having rhythm, melody, or harmony by Merriam-Webster dictionary (2010). It is the auditory and temporal characteristics of music that contribute to the uniqueness of music therapy as a treatment modality. The structure of music and its capacity to create organized forms

are also important. The major elements of music; rhythm, melody, harmony, tempo, and volume can be used to produce change in the client directed at achieving nonmusical goals. Nordoff and Robins (1977) identified the *music child* as an important aspect of the efficacy of music therapy. The theory of the *music child* is based on the belief that all children have an inborn musicality and the capacity, regardless of pathology, to respond to musical experiences. In studying the effects of music therapy in the special education setting, Pellitteri (2000) believes that music therapy is unique because it is transdisciplinary and can effect positive change in many identified areas. He notes that in terms of psychological change, music therapy utilizes the inherent structure in songs, which can reinforce a sense of internal order in the child, evidenced by adherence to the beat of the music. He also notes that the group setting in music therapy is ideal for facilitating socialization and interpersonal interactions for children with special needs. Although there are many articles demonstrating the efficacy of specific music therapy techniques, a cohesive presentation of what interventions and methods are currently being implemented to address the needs of adolescents with emotional and behavioral disorders was not found.

Keen (2004) used a pre and post test method to measure the efficacy of music as a tool in therapy. He notes that traditional treatment methods with young people often include cognitive behavioral approaches combined with other traditional psychotherapy tools. Although these methods can be effective with some clients, troubled adolescents often lack a solid communication base, creating a block to

successful treatment. Music was found to be successful in helping adolescents engage in the therapeutic process with minimized resistance as they related to the music and the therapist became a safe and trusted adult. Using various techniques such as song discussion, listening, writing lyrics, composing music, and performing music, the author states that the adolescents were able to engage in therapy with minimized resistance using the music as a means of relating to the therapist.

In what appears to be the first comprehensive meta-analysis on the effects of music therapy for children and adolescents with psychopathology, Gold, Wigram, and Voracek (2004) reviewed eleven articles published in journals from the US, Austria, Germany, and the UK. One of the main research goals was to identify how the music therapy approach influences the efficacy of treatment. The authors note that even though there are at least 230 different approaches to treating psychopathology, only a few have been empirically tested for efficacy. The results indicated that active music making helped the subjects to focus and sustain attention. The research also suggests that eclectic approaches to music therapy, where techniques from different models or theories are mixed, are particularly effective. These findings are an indication that music therapists should have a flexible attitude and match the music therapy techniques to the individual client's needs, as opposed to a fixed treatment regimen. The authors also note that effects were larger when overt behavior rather than subjective experience was used as an outcome measure.

McIntyre (2007) conducted a study with the goal of facilitating change through the use of music in students' behavior with particular emphasis on their social

interactions and their classroom behavior and academic progress. All participants were male and were identified as having emotional and/or behavioral impairments. The outcomes for the student participants were to develop new skills (both musical and non-musical); to instigate appropriate interaction with others in the group; to experience group identity, cohesion and purpose; to communicate and express themselves through the use of musical instruments, voice, lyric writing and lyric analysis; to expand their capacity to respond, relate and communicate; to develop greater self esteem and self awareness; to enjoy musical experience and expression; and to use music to help facilitate self regulation of impulsive or inappropriate behavior within session time and school time. Various music making interventions were introduced to the group including group improvisation via a drum circle, individual improvisation via the piano, structured music making e.g. arrangements and an introduction to computer composition via music composition software. It was observed that the participants were more willing and able to engage in the music making when familiar and contemporary music was utilized in the sessions.

McIntyre (2007) found that the adolescents with emotional and behavioral impairments showed improvements in their behavior, attitude, academic achievements and social interactions after receiving music therapy. These positive changes were reflected in the Nordoff-Robbins Scales of Assessment, the teacher evaluations and the observations made by the therapists. Some of these changes included: an observable difference in the quality of listening to the therapists and listening to each other during music making; an increase in the length of time they were able to maintain focus and

concentration during an improvisation and during a session, resistive behavior decreased significantly during the sessions, a change in school room behavior developed after music therapy sessions, positive attitudes towards their own education began to emerge, a stronger sense of "self" became evident, improvement in classroom relationships, motivation to improve their academic results occurred, self-expression and a development of creativity in music occurred, group participation and respect for each other significantly developed, and the boys began to experience the fun aspects of playing and making music as an individual and as a group. The data from the Nordoff-Robbins Evaluation Scales indicated a change in resistiveness and a change in the ability to relate to the therapist and others in the group.

McIntyre's conclusions indicate the need for more research into the effects of music therapy on adolescents and children with behavioral and emotional impairment so the best clinical interventions can be conducted with adolescents and families who are experiencing these behaviors. She believes that creating an evidence base in music therapy for this client group could assist music therapy clinicians in establishing best practices in mental health care. She also states that new measuring tools need to be developed and tested to ensure their efficacy.

An important aspect of music therapy research includes recording the clients' response to the treatment. One method of acquiring data on the efficacy of treatment is by measuring the client's physiological response to music. Field, Martinez, and Nawrocki (1998) investigated the effects of music on mood state and right frontal EEG activation associated with chronic depression. The authors compared adolescent

females diagnosed with chronic depression listening to rock music for twenty three minutes to a control group where adolescents with the same diagnosis sat in silence for twenty three minutes. EEG was recorded during baseline, music, and post music for three minutes each, and saliva samples were collected before and after the session to determine the effects of the music on cortisol levels. Although the behavior and self-report data showed no changes during or after the music sessions, EEG and cortisol levels were significantly affected by music. This data suggests that music may have a strong effect on lessening depression and anxiety.

## Music Therapy Approaches and Techniques

Music therapy is a unique modality because there are many different elements in music that contribute to its efficacy in treatment. In an observational study ,Gold, Wigram, and Voracek (2007) acknowledge that although music therapy has been deemed an appropriate treatment modality, there is little empirical research as to specifically what elements of music therapy influence its effectiveness in clinical situations. The researchers conducted a study to explore how different approaches to music therapy influence treatment outcomes. They determined that children and adolescents in music therapy exhibit more positive change when discipline specific music therapy techniques, such as improvisation and verbal reflection of the music, are used instead of other, less specific techniques such as free play. Also, the authors noted that there was a significant association between techniques and age. Verbal communication became more important with increased age, and the use of songs

decreased as children's ages progressed between 3-14 years, but played an important role again with adolescents aged 15-19 years. Songs were also more often used in treatment sessions with females than males. Gold, et al. believe the most important implication for clinical work is that, "music therapists should be aware of their method's specific strengths and limitations" (p. 582). The authors state that there are many case studies advocating the music therapy techniques that have led to therapeutic change. The findings from this study supported the specificity of the effects of music within music therapy. However, their findings also suggested that not all clients may be ready to use music in the therapeutic setting. Also, in making the case that more research is needed on the specific elements of music therapy, the authors state, "the findings suggest that the appropriate use of specific techniques does matter... Many approaches, including qualitative as well as quantitative methods, will be appropriate in further exploring why, for which clients, and with what success music therapists use their specific and non-specific techniques" (p. 589). This study indicates a need for more research into the use of music therapy with adolescents with Emotional and Behavioral Disorders.

The majority of studies describing the use of music therapy in treating adolescents with emotional and behavioral disorders provide support for the inclusion of this treatment method. Some of the studies have isolated and tested specific elements and methodologies within music therapy. In their pilot study, Watkins and Rickson (2003) investigated the effectiveness of music therapy services in promoting prosocial behaviors in aggressive adolescent boys with social, emotional, and learning

difficulties. The activities in this research included bringing self selected music, having a personalized song in which the clients were asked to greet each other and shake hands, active rhythm-based activities, the opportunity to experience and care for musical instruments, and group song writing activities.

The findings from this study suggest that music therapy may help to increase adolescents' awareness of the feelings of others and assist in the development of positive relationship with peers. Also, the specific elements of rhythmic activities may facilitate internal organization and help with impulse control. The authors also noted that for adolescents with ADHD an individualized and highly structured treatment might be more effective because they may become overly aroused in a creative music therapy group. The authors further state that while there seems to be evidence that group music therapy is beneficial with adolescents, there is, "a paucity of recent music therapy literature relating to the use of music therapy with adolescents who have social and emotional difficulties" (p. 2).

In a related study, Coons and Montello (1998) evaluated the effects of active rhythm-based music therapy versus passive listening-based groups on adolescents with emotional, learning and behavioral disorders. In the study, there was overall improvement observed in both groups. However, one group did show an increase in hostility problems during the treatment (active therapy) and returned to baseline during the control (passive therapy). The authors propose that this may be due the lack of structure in the treatment approach. They indicated that adolescents with a more "fragile ego" may benefit more from approaches that provide more stability.

In a study by Rickson (2006), 90 adolescent boys who were enrolled in a residential education facility for students with intellectual, social, and emotional deficits received music therapy services to address the motor impulsivity associated with ADHD. Most of the students involved in the study had comorbid diagnoses including Oppositional Defiant Disorders, Obsessive Compulsive Disorder, Post Traumatic Stress Disorder, Mood Disorder, Fetal Alcohol Syndrome, and Intermittent Explosive Disorder. The independent variables included; 1) instructional sessions based on behavioral and developmental theories that included direct teaching and modeling of specific beat and rhythm tasks and 2) improvisation sessions which focused on a humanistic approach to therapy, with the therapist relying on the music to promote growth and development. It was hoped that through this process, the adolescents would develop increased confidence, self-esteem, self-awareness, and awareness of others' needs.

The results of Rickson's study revealed that there was not a statistically significant difference between the impact of instructional and improvisational music therapy approaches on students' level of motor impulsivity. However, teachers and social workers cited other benefits to improvisational music therapy. There was an increase in anxious/shy behaviors for each group during the instructional music therapy treatment and a decrease during the period of their improvisational music therapy. The social workers also noted a reduction in emotional liability and psychosomatic symptoms for the clients during the improvisational sessions. The group that began with the improvisational sessions tended to have difficulty adjusting to the instructional

section of treatment. These findings indicate that it may be beneficial to begin music therapy sessions with high levels of structure, specifically for adolescents with emotional impairments. Although the main focus of this study was to evaluate different music therapy approaches on the level of motor impulsivity, there are clear implications as to the importance of approach when working with adolescents with emotional disturbance (2006).

In a study by Tervo (2001), music therapy with adolescents was explored. The author believes that adolescent music therapy aims to promote adolescent growth and development and that a variety of musical experiences and a firm and reliable therapeutic relationship are important aspects of reaching this goal. He feels that music therapy is especially useful when it is given in conjunction with psychotherapy and divided adolescent music therapy into three stages; interest, learning and improvisation. According to Tervo, the main goal of music therapy is to listen to, and above all, play, the type of music the adolescents themselves choose. To summarize, the author noted key aspects of importance in adolescent music therapy including musical interventions, therapeutic relationship, collaboration between therapeutic disciplines, and music preference.

The literature suggests that certain forms and models of treatment may work better for some adolescents than others. For example, in the Gold et al (2004) described previously, behavioral models of music therapy showed smaller effects than other approaches. However, there appears to be a gap in the literature concerning which specific models of music therapy and specific interventions are currently being

used to address the needs of adolescents with emotional and behavioral disturbance. Although there are several studies that address benefits of specific music therapy interventions used to treat adolescents with EBD, a study that determines the current trends in utilized interventions was not found.

## Specific Music Therapy Interventions with Emotionally and Behaviorally Impaired Adolescents

As health care in the US is becoming increasingly evidenced based, there is a growing need to identify and describe the benefits of music therapy techniques that are used to treat adolescents with emotional and behavioral disorders. There have been articles published that look directly at specific music therapy interventions being employed to treat adolescents with Emotional and Behavioral Disorders.

Robb (2003) addressed the process of designing music therapy interventions by developing a model of music therapy for adolescents and children that draws from research, theory, and clinical practice. Her contextual support model of music therapy seeks to explain how music functions to create supportive environments and, in turn, promotes active coping behaviors. She provides suggestions as to how to use the model as a guidepost for developing music therapy interventions. The model focuses on creating supportive environments, providing order and predictability, and fostering feelings of security in children and adolescents through the use of music therapy interventions. The author notes that, additional research is necessary to draw clearer relationships between specific music interventions and changes in behavior. This paper serves as a precursor to this process by exposing the interventions that are currently

used with adolescents with Emotional and Behavioral Disorders outside of the school setting.

Several articles were found in the extant literature that looked at specific music based interventions and their effectiveness with adolescents. One such approach that has been described in a number of publications is song writing. The song writing process can be a valuable tool when working with adolescents because it provides both verbal and non-verbal expressive opportunities. For example, Dalton and Krout (2006) described the development and implementation of the Grief Song-Writing Process (GSWP). The process began with a thematic analysis of 123 songs previously written by bereaved adolescents in individual music therapy sessions. All of these songs expressed concerns regarding the death of a loved one and how the client was coping. Next, existing grief models were compared with the thematic songs and a model was developed that included grief process areas. These included understanding, feeling, remembering, integrating, and growing. Then, a GSWP protocol was developed and implemented, where adolescents created music and wrote original lyrics which focused on each of the grief process areas. The authors believe that GSWP allowed the clients to creatively address the grief process and to discuss their issues related to the loved one's death in a safe environment.

Song-writing was also the focus of a study by McFerran, Baker, Patton, and Sawyer (2006). The authors summarize that the most common goals for this population include promoting an increased sense of mastery over emotional expression, to facilitate greater personal autonomy and understanding of relationship

patterns that may inhibit self-esteem, and to provide opportunities experiment with alternative interpersonal behaviors in a creative and safe environment. They note that the psychodynamic approach to therapy is most commonly used with adolescents with anorexia by creative arts therapists, but a cognitive behavioral approach can also used successfully. The authors found that although engaging adolescents with eating disorders is often difficult, the high participation rate in the song -writing process used in this study confirmed that is was both appealing and relevant to adolescents with anorexia. They also noted that song-writing was able to reveal information that had not been disclosed to other members of the inter-disciplinary team.

As professionals in other disciplines search for effective strategies to address the needs of adolescents with emotional disorders, there is evidence in the literature that some are employing therapeutic techniques that involve music. Decarlo and Hockman (2003) describe how social workers used Rap Music as a medium to communicate with their adolescent clientele and to support pro-social skills development. Three adolescent groups were tested: violent offenders, status offenders, and a control group of high school students with no criminal history. The study was conducted using lyric analysis as the basis for therapy. It was concluded that adolescent clientele preferred this method over traditional therapy. The authors attribute this finding to adolescents possibly feeling this form of therapy was more relevant to their lives than other forms of treatment.

In the Decarlo and Hockman (2003) article, the authors include a list of essential standards for the facilitator of a RAP therapy group which centered on

structuring and skills of the leader. These include defining the purpose of the group, teaching concepts, establishing guidelines, and group organization. Also, the authors believe that the RAP therapy leaders need to be able to schedule sessions, select locations, set lengths for sessions and select members appropriately. They also list important qualities for the RAP therapy leaders to have are such as trustworthiness, authoritativeness, interactiveness, and cultural competence. This article demonstrates an eagerness of social workers to understand the impact that music has on adolescents and demonstrates the need for further explanation of the benefits of music therapy for this population.

Grief counseling refers to a specific form of therapy, or a focus in general counseling with the goal of helping the individual grieve and address personal loss in a healthy manner. Specific tasks of grief counseling include emotional expression about the loss, accepting the loss, adjusting to life after the loss, and coping with the changes within oneself and the world after the loss (Encyclopedia of Mental Illness, 2010). Hilliard (2007) evaluated and compared the effects of Orff-based music therapy, social work, and control groups on behavioral problems and grief symptoms of bereaved school-aged children. In this study, Hilliard references Shamrock's definition of the Orff method as a process that guides children through several phases of music development. The design of Hilliard's study included Experimental Group 1 - 8 weekly sessions of Orff-based music therapy, Experimental Group 2 - 8 weekly sessions of social work interventions, and a control group - no sessions after the pretest until the completion of the study. The results indicate that the control group

did not show improvement in their behaviors or grief symptoms, the social work group showed improvement in their behavior, but not their grief symptoms, and the music therapy clients showed improvement in both behavior and grief symptoms. The authors stated that the Orff-based method was successful because the children in the group were able to express themselves non-verbally through improvisation.

This present study was conducted to investigate the current use of music therapy with adolescents with EBD receiving services outside of the school setting. It is the hope of this author that this study will add to the body of knowledge concerning music therapy with this population and will help to elucidate the current trends in the field.

# CHAPTER III

## METHOD

The focus of this study is to investigate the use of music therapy with adolescents with emotional and behavioral disorders being treated outside of the school setting. The survey instrument developed by Polutnik (2010) was used as a basis for a survey and was designed to gather information about music therapy interventions and assessments, goals and objectives, and frequency of specific interventions found in treating adolescents with EBD. The primary research questions for the study were:

R1) What are the demographic characteristics of music therapists who work with adolescents with emotional and behavioral disorders (EBD) in non-school settings?

R2) Which music therapy philosophical orientations are most frequently used by music therapists in non-school settings with adolescents identified as having EBD?

R3) How do music therapists working with adolescents with EBD in non-school settings assess their clients strengths and limitations?

R4) How are music therapists evaluating the progress of adolescents with EBD?

R5) What are common symptoms and diagnoses associated with adolescents with EBD?

R6) What are the behaviors typically observed by music therapists in the non-school settings with adolescents with EBD?

R7) What are the common goal areas focused on by music therapists in non-school settings with adolescent clients identified as having EBD?

R8) What specific music therapy interventions are most frequently used by music therapists in non-school settings with adolescents with EBD?

R9) Which interventions do music therapists in non-school settings report to be the most effective and the least effective when working with adolescents with EBD?

R10) What is the structure of music therapy sessions with adolescents with EBD?

R11) What are the similarities and differences between music therapists working with adolescents with EBD in school settings versus outside of school settings concerning the previous research questions.

Participants

A list of possible participants was identified by contacting Certification Board for Music Therapists (CBMT) and the American Music Therapy Association (AMTA). The researcher contacted the American Music Therapy Association to request a listing of email addresses of all AMTA professional members who either worked with clients identified as having EBD or in child/adolescent treatment centers. CBMT was asked to provide a list of board certified music therapists grouped by employment. Both lists were then cross referenced to include the maximum number of Music Therapists

working with adolescents with emotional and behavioral disorders, which totaled 114 music therapists. Two surveys were not delivered due to the email addresses that were no longer valid, and one address was for a duplicate recipient, bringing the total number of surveys sent to music therapists to 111. Subjects for this study were recruited to participate in the survey if they met the following criteria; 1) Have worked with emotionally and/or behaviorally impaired adolescents within the past year in a non-school setting, 2) Must be currently board certified, and 3) Must have a minimum of 1 year of experience at the professional level. All professionals who listed a school setting as their primary place of employment were excused from participating in the study and not included in the data analysis. Because the addresses were obtained from the AMTA and CBMT membership lists, it is possible that some music therapists meeting this criteria were not included in the study if they did not have current email addresses on the lists. Because it was impossible to determine the actual number of music therapists who would meet the criteria to participate in this study, the cross referenced lists were used as a means of gathering the largest sample of known music therapists working with adolescents with EBD outside of the school setting.

Through the use of an online survey organization (surveymonkey.com), music therapists who possibly met the inclusionary requirements received a recruitment e-mail with a link to the letter of consent and the survey instrument (Appendix 3). The letter of consent indicated how they were chosen to receive the survey, their prospective involvement, and a brief description of the research study. In addition, the

letter of consent informed participants that by completing the survey they had provided their consent. All recruitment e-mails were distributed at the same time.

## Research Design

This research was a descriptive study based on a survey study conducted by Kathryn Polutnik (2010). The survey tool that was used to collect data in Polutnik's study was modified for the purpose of this study to address professionals providing music therapy services to adolescents with emotional and behavioral impairments in clinical settings (outside of the school setting). The questions address many aspects of working with adolescents with EBD including; behaviors most commonly seen by music therapists when working in this population, the specific goal areas addressed in a music therapy session, the interventions used to meet these goals, and the assessment tools utilized. The findings from this research will be reported in a descriptive fashion resulting in a framework of practice for both music therapy professionals and other professionals working with this population.

A. Survey Design- The survey is divided into four sections:

(i) *Demographics*:
(ii) *Assessment*
*(iii) Goal Area*
*(iv) Treatment Methods*

B. Data Collection Plans: Data was collected through the use of an on-line survey where participants chose the response that best reflects their practice. Participants were given a detailed rationale prior to seeing the study that served as a description of the study and an explanation of how their responses would be collected.

It was explained that the Survey was created using Surveymonkey.com and would include an electronic signature indicating permission to use survey responses in study. The information collected in this study did not provide any identifying information. Although names and email addresses were collected to identify participants, they could not be linked to the completed surveys once they were submitted online.

## Data Analysis

The data was analyzed by the researcher, reporting results in a narrative and descriptive nature. The results of the study were analyzed and the data is represented graphically. The data from this survey was then compared to the data from the Polutnik study to determine areas of commonality and differences between school-based and non-school based music therapy services for adolescents with emotional and behavioral disorders.

## Limitations and Assumptions

The most obvious limitation of this study was the small sample size. There were 27 surveys completed out of 111 email invitations sent to music therapists, for a return rate of 23%. Since it was impossible to know the total number of music therapists that would meet the inclusion criteria, the actual return rate may have been substantially higher. Because music therapists were identified to participate in this study through AMTA and CBMT membership, eligible professionals who were not current or active members of these organizations were not solicited to participate. If

the email addresses of the AMTA and CBMT members were not current or accurate, potential respondents could have been overlooked as well. It was also assumed that participants would have a working knowledge of diagnostic and clinical terms used in the survey instrument.

# CHAPTER IV

# RESULTS

One hundred and eleven music therapists were sent an invitation to participate in this study. Of those 111 music therapists, 27 partook in the research (N=27). This is a response rate of 23%. Of the twenty seven returned surveys, there were two surveys that were less than halfway completed, and various questions were skipped by respondents; however, all survey questions that were answered were included in the data analysis.

What are the demographic characteristics of music therapists who work with adolescents with emotional and behavioral disorders (EBD) in non-school settings?

The first section of the survey aimed to gather demographic information of music therapists working with adolescents with emotional and behavioral disorders. The majority of the participants (77.8%) were female with male participants representing 22.2% of the total responses received. (see Figure 1). In 2004, the ratio of females to males in the AMTA membership was 88:12 (AMTA, 2005), and estimated to be 80:20 by Edwards and Hadley in 2007. However, the AMTA 2010 Member Sourcebook reported a slight decrease in the ratio of female to male music therapist, with the ratio of 87:13 (AMTA Member Sourcebook, 2010). The participants in this study reflected a similar ratio to the total AMTA membership ratio, although there were 10% more male participants.

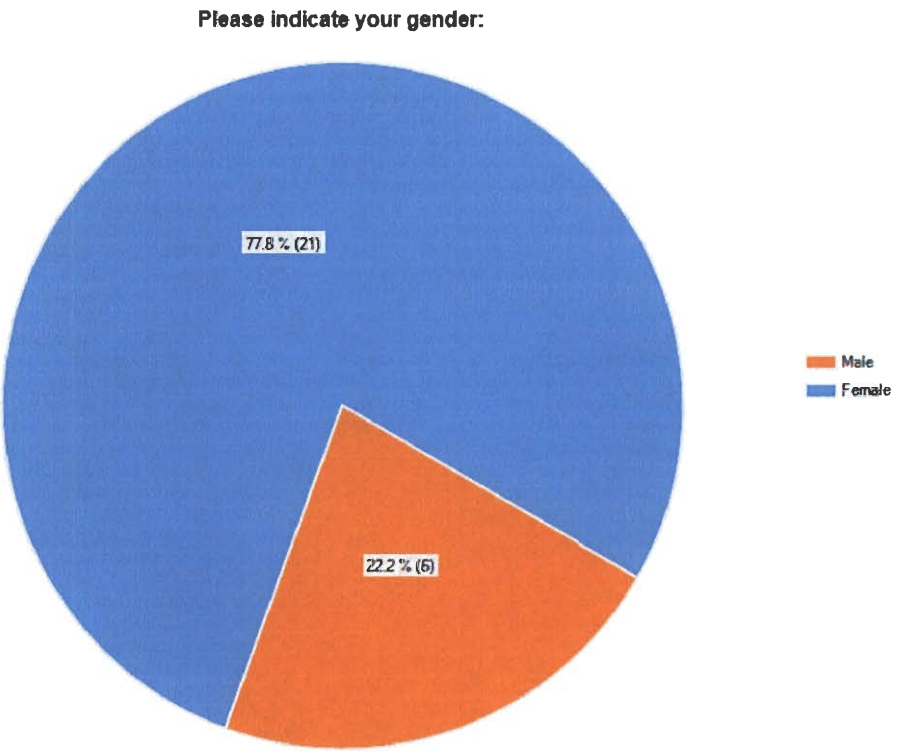



Figure 1

Gender Distribution of Survey Participants

Although there was a broad age range among the respondents, two-thirds of the participants were between the ages of 25 years and 34 years of age. The remaining one third of the respondents were fairly evenly distributed among the other age groups with the exception of the 35-39 category (see Figure 2).

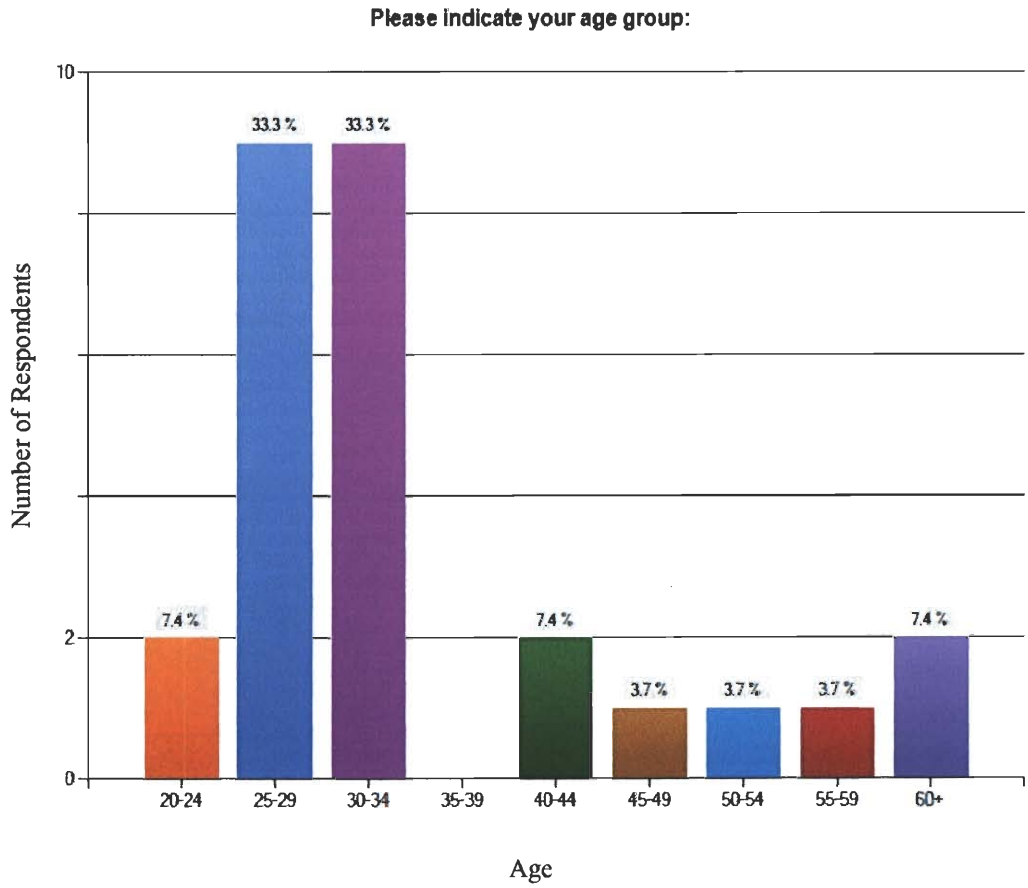



Figure 2

Age of Participants

As shown in Figure 3, each music therapy region was represented in this study by at least one music therapist. The majority of respondents were from the Mid-Atlantic Region, followed by the Great Lakes Region. The Midwestern, Southeastern and Western region were each represented by two music therapists and the Southwestern and New England regions were represented by only one music therapist each.

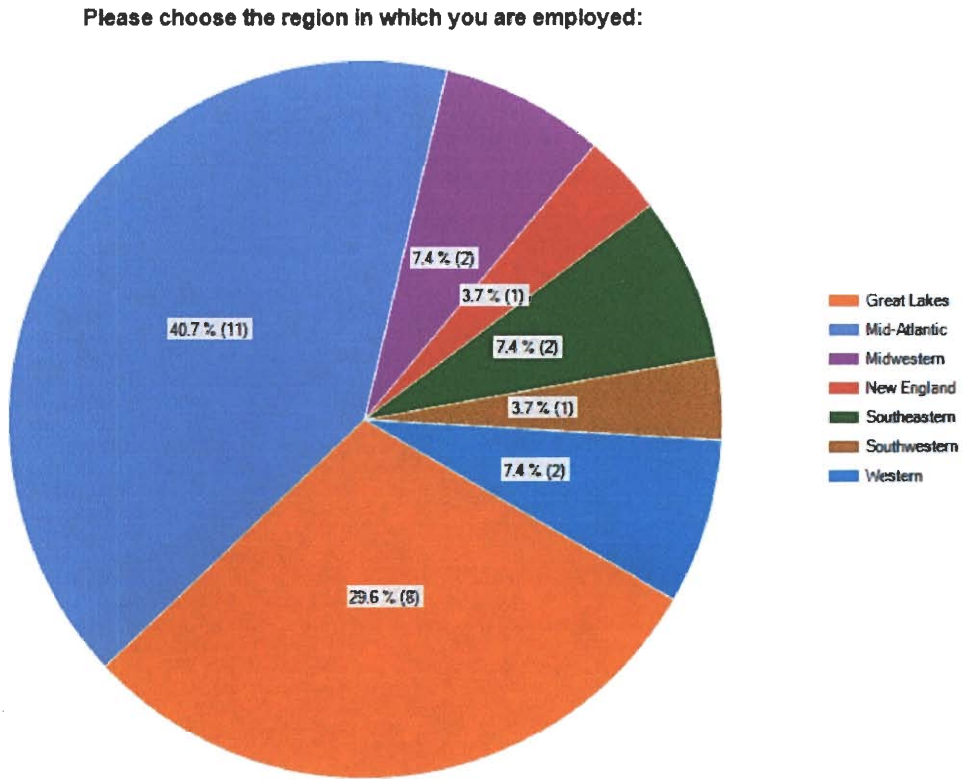



Figure 3

Regions Represented by Research Participants

Slightly over half of the participants in this study had been credentialed music therapists for five years or less. Almost one quarter of the participants had been credentialed therapists for 6-10 years. The remaining participants represented a wide range of experience (see Figure 4).

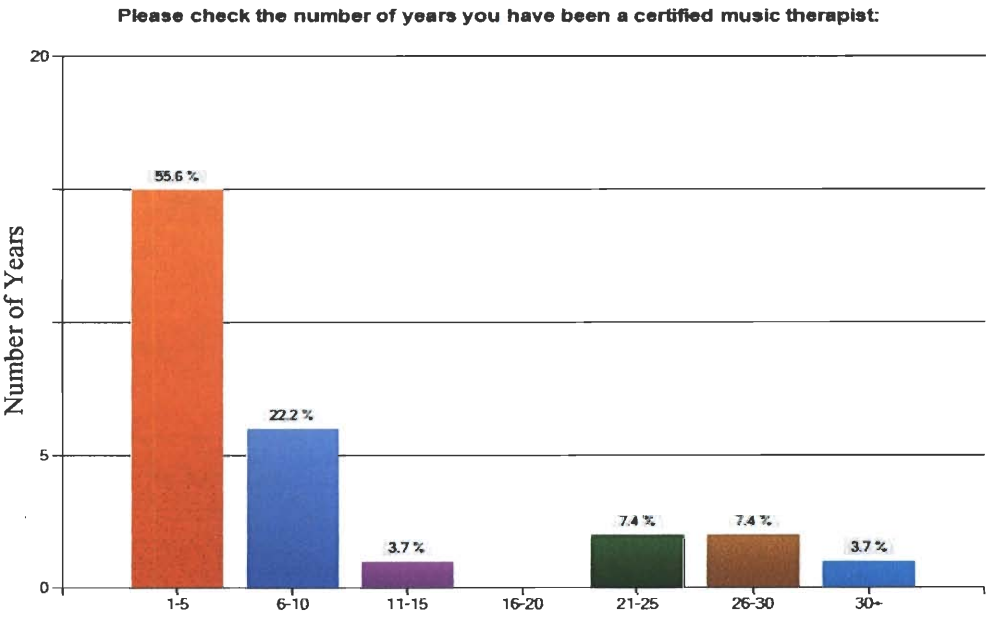



Figure 4

Number of Years Respondents Have Been A Certified Music Therapist

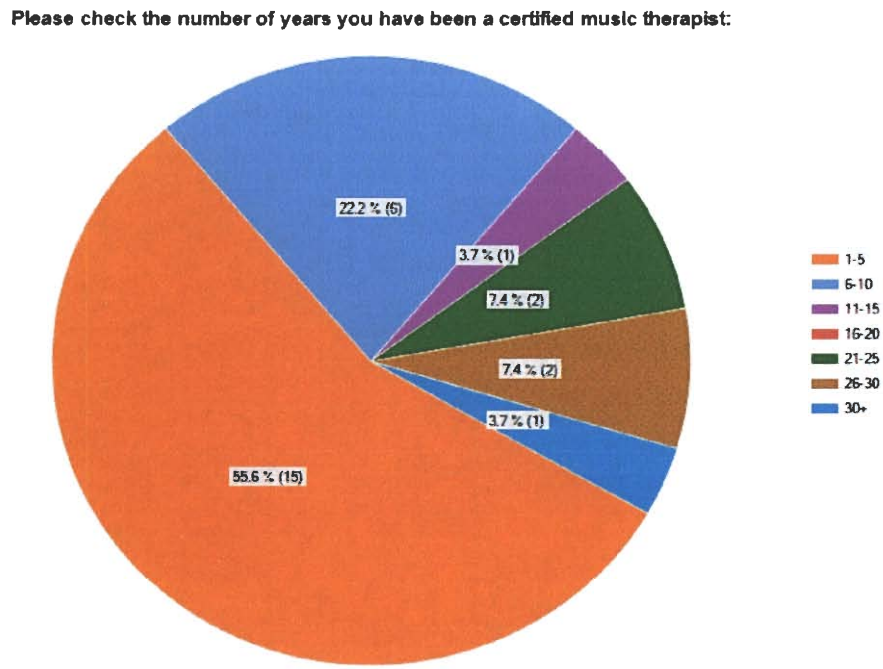



Figure 5

Experience Working With Adolescents With EBD

When asked about their years of experience with this population, sixty-seven percent reported that they had worked with adolescents with emotional and behavioral impairments for five years or less. This would seem to indicate that some of the music therapists surveyed may have shifted to positions serving this population during their years of professional practice. Nearly fifteen percent of respondents have worked with this population for 6 to 10 years. The remaining eighteen percent of the music therapists have worked with adolescents with EBD for 11 to 25 years, with 7.4 percent representing twenty one to twenty five years of experience (see Figure 5).

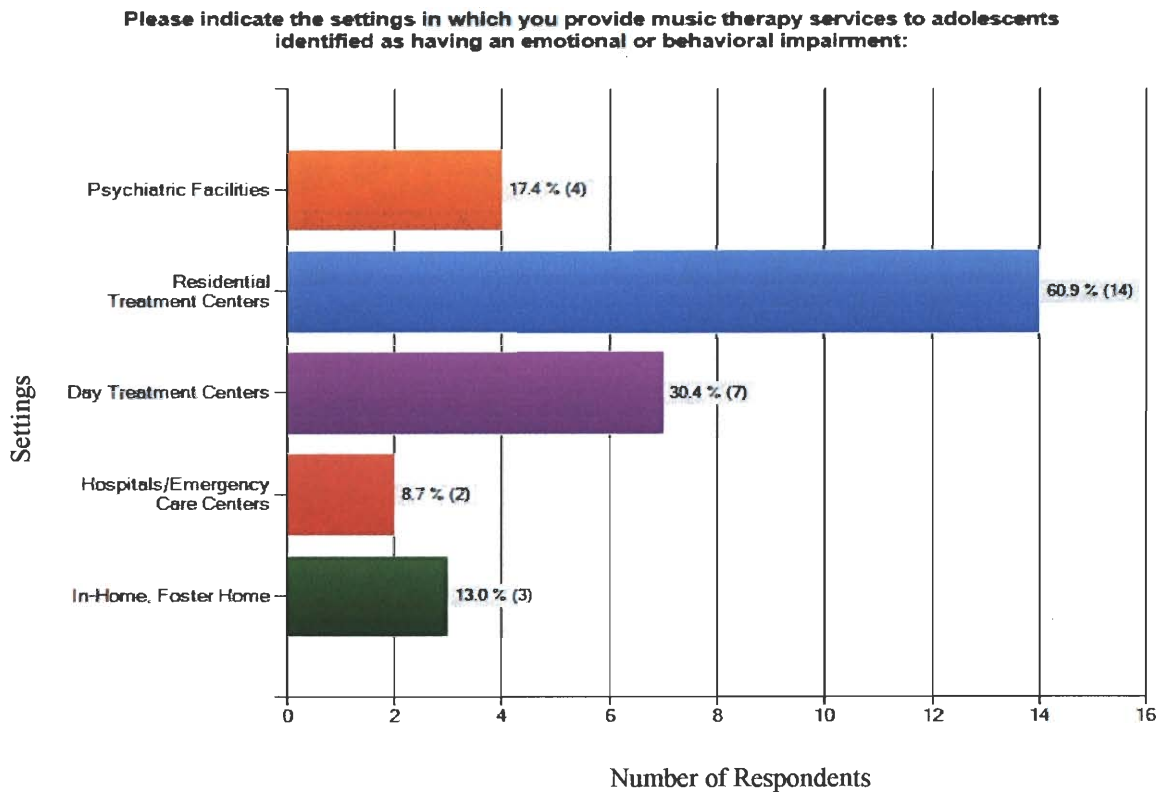



Figure 6

Settings Where MT is Provided to Adolescents with EBD

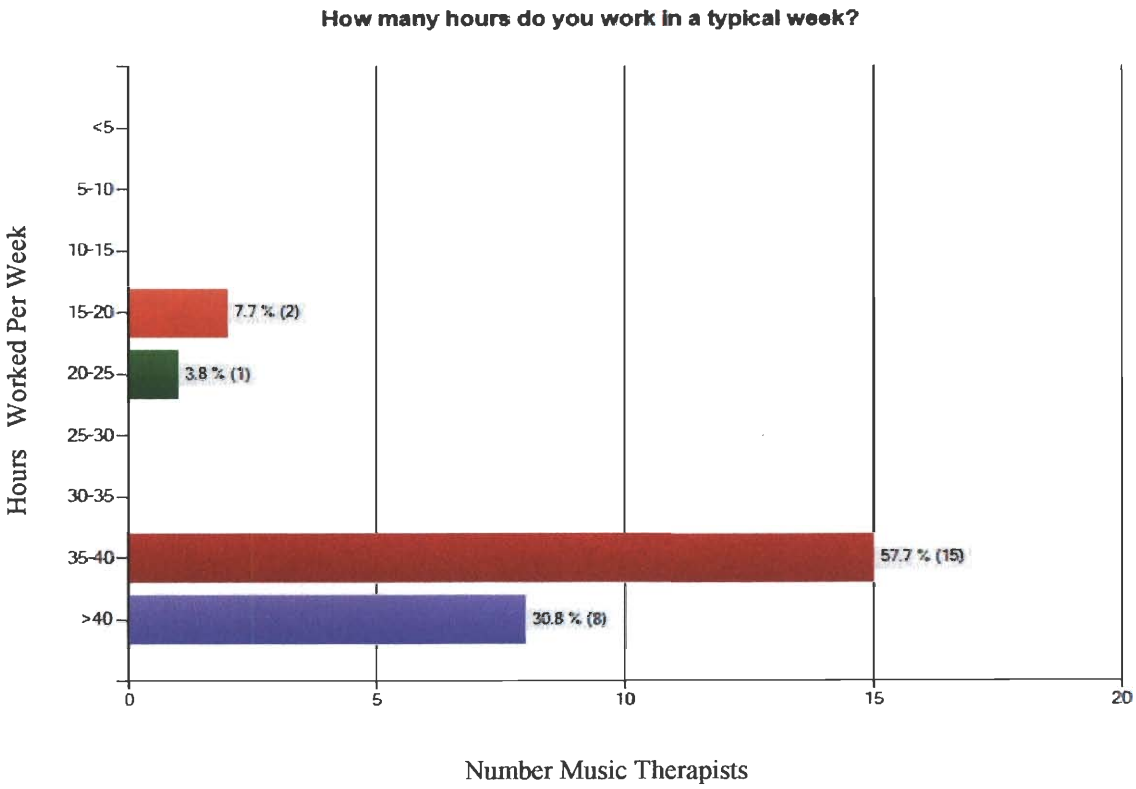



Figure 7

Hours Worked In a Typical Week

The participants in this study indicated that they worked in a variety of settings with adolescents with emotional and behavioral impairments. The vast majority of respondents (61%) provided services for this population in residential treatment centers followed by 30% who listed day treatment centers as their work setting. Psychiatric centers were the third most common settings for treatment, followed by in-

home and foster care treatment and the least common being in hospitals and emergency care centers at 8.7 percent (see Figure 6).

The vast majority of music therapists responding to this survey reported that they worked a minimum of thirty five to forty hours per week. This statistic includes 30.8% that reported working more than forty hours per week. A much smaller percentage, 11.5%, reported working between 15 to 25 hours per week (Figure 7).

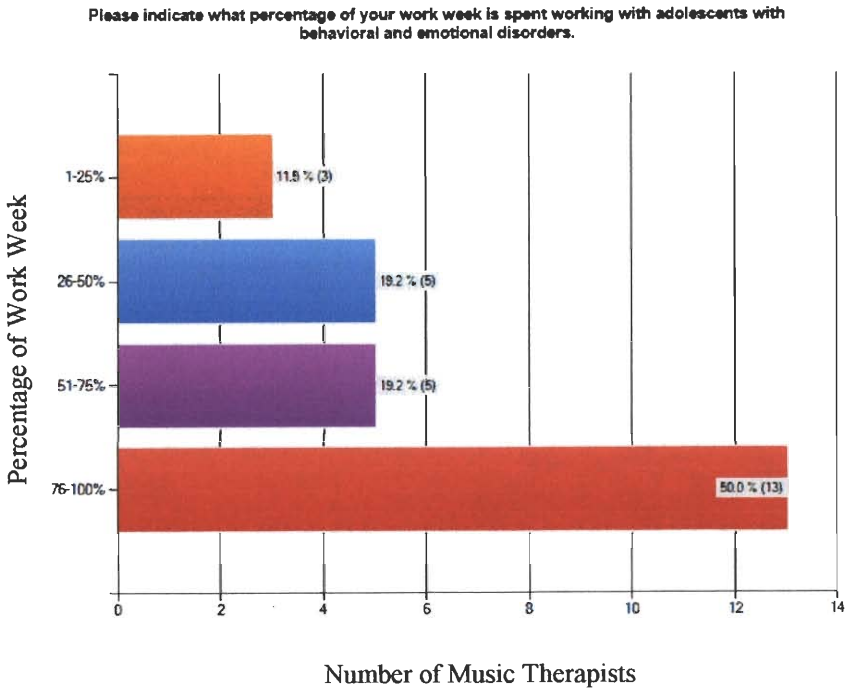



Figure 8

Percentage of Work Week Spent With Adolescents with EBD

Fifty percent of the respondents in this survey stated that they spend 76-100% of their work week treating adolescents with behavioral and emotional disorders. Thirty eight percent of music therapists spend twenty-six to seventy five percent of

their workweek with this population. The smallest percentage, 12%, spend 25% or less of their week with adolescents with emotional and behavioral disorders (See Figure 8).

Which music therapy philosophical orientations are most frequently used by music therapists in non-school settings with adolescents identified as having EBD?

Based on their responses to the survey, the philosophical approaches used by the music therapists were diverse (see Figure 9). The largest percentage (41.7%) of participants described their general approach to music therapy with emotionally and behaviorally impaired adolescents as Cognitive-Behavioral. The next most frequently chosen theoretical approach was humanistic, with 37.5% stating that this is their general approach to music therapy with this clientele. Behavioral approaches, Nordoff-Robbins, and the Bonny Method of Guided Imagery were collectively chosen by the remaining 20.8% of participants as their general approach. None of the music therapists surveyed chose the analytic or phenomenological approaches.

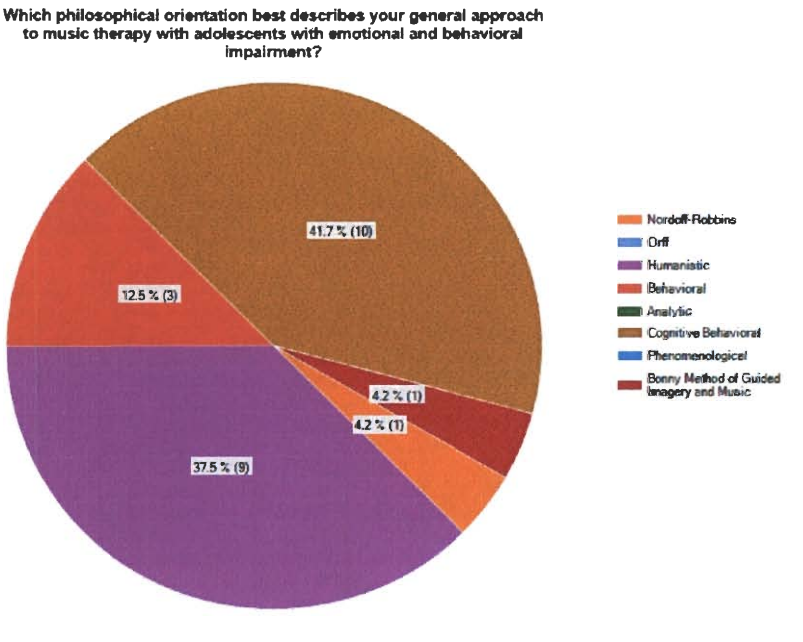



Figure 9

Philosophical Approach Used To Treat Adolescents with EBD

The professionals surveyed in this study conduct both group and individual sessions at a fairly even rate. The following graph shows the number of music therapists that use group and individual sessions when treating adolescents with emotional and behavioral impairments (See Figure 10).

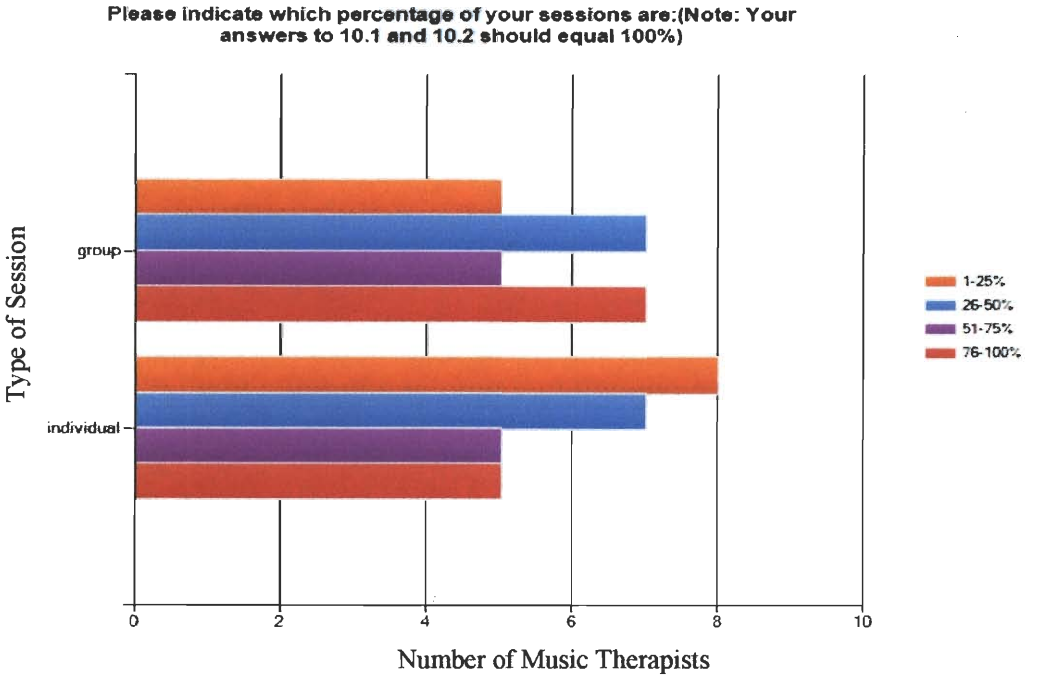



Figure 10

Group vs. Individual Sessions

Figure 11 shows the typical number of adolescents that attend music therapy groups. The music therapists working with groups of adolescents indicated that 6 to 9 group members was the most common number of participants, but the group size varied.

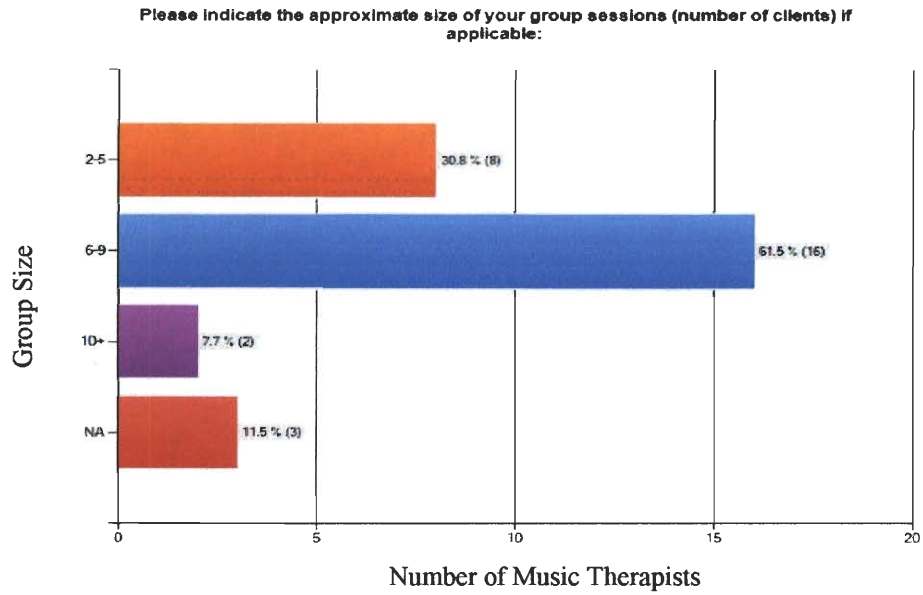



Figure 11

Number of Participants in Group Sessions

How do music therapists working with adolescents with EBD in non-school settings assess their client's strengths and limitations?

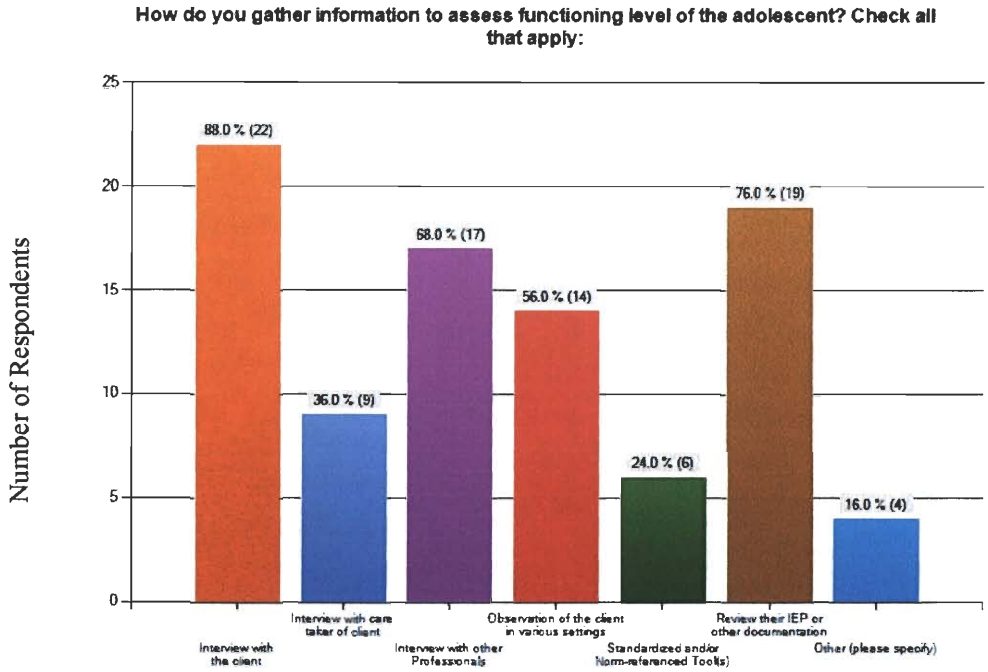
An important aspect of describing the current trends in music therapy with adolescents with emotional and behavioral impairment is examining the assessment process being used with this population. Participants in this study were asked to answer a number of questions regarding the assessment process and tools they use to gather information about their clients with emotional and behavioral impairments. From the data received, it appears that clinicians use a number of different methods to gain information as to the functioning level of their clients (see Figure 12). Eighty-eight percent of participants indicated that they use interviews with the clients to gain information about their functioning level. More than 75% of survey participants use

the client's IEP or other form of documentation as a means of obtaining information about their clients. Sixty-eight percent of the music therapists surveyed have the opportunity to gain information from other professionals seen by their clients, and use this as a means of gathering information for their assessment. Many of the professionals also indicated that they observe their clients in various settings. As the majority of the survey participants see their clients in residential treatment centers and day treatment centers, there would be more opportunities for this sort of observation than in private practice and music therapy clinics, which were chosen by only two participants. Almost one quarter of participants identified standardized tests that they use to assess their clients, or assessments not listed, such as diagnostic assessments, medical/physical charts, music therapy group assessments, and musical assessments. All of the following standardized and norm referenced tools were written into the survey by the music therapists as additional information on this survey question:

- Ohio Scales, which measure children's and adolescents problem severity, functioning, hopefulness and satisfaction with mental health treatment (Ohio Department of Mental Health)
- Psychological assessments administered by psychologists
- Weschler Tests and Weschler Tests for Children - The Wechsler tests are the most common individually administered IQ tests. They currently include the WISC-IV (age 6-16 years), the WAIS-IV (age 16-89 years), and the WPPSI-III (age 2.5 - 7 years) (Rich, 2011).

- Trauma Symptom Checklist for Children (TSCC) which evaluates posttraumatic symptomatology in children and adolescents (Briere, 2011).
- Child Behavior Checklist (CBC(L)) which is a device use by parents or other individuals to rate a child's problem behaviors and competencies, or to measure a child's change in behavior over time or following a treatment (Violence Institute of New Jersey, 2006).
- A Teacher's Report Form (TRF) which obtains teacher's reports of children's academic performance, adaptive functioning, and behavioral/emotional problems (Violence Institute of New Jersey, 2008).
- A Youth Self Report (YSR) provides self-ratings for 20 competence and problem items paralleling those of the Child Behavior Checklist (CBCL)/Ages 6-18. The YSR also includes open-ended responses to items covering physical problems, concerns, and strengths. Youths rate themselves for how true each item is now or was within the past six months (Violence Institute of New Jersey, 2002).
- The Child and Adolescent Functioning Assessment Scale (CAFAS) which is used to assess youth's day-to-day functioning across critical life domains and for determining whether a youth's functioning improves over time (Functional Assessment Systems, 2011).

- PTSD Index for DSM IV (Adolescent version) –a series of self and parent report instruments to screen both for exposure to traumatic events and for all DSM IV PTSD symptoms in school age children and adolescents who report traumatic stress experiences. The instrument measures traumatic bereavement. The instrument is meant to serve as a brief screening tool to provide information regarding trauma exposure and PTSD symptoms. (Rodriguez et al, 1999).
- Clinician Administered PTSD Scale - The CAPS is a 30-item structured interview that corresponds to the DSM-IV criteria for PTSD. The CAPS can be used to make a current (past month) or lifetime diagnosis of PTSD or to assess symptoms over the past week. The questions target the impact of symptoms on social and occupational functioning, improvement in symptoms since a previous CAPS administration, overall response validity, overall PTSD severity, and frequency and intensity of five associated symptoms-guilt over acts, survivor guilt, gaps in awareness, depersonalization, and derealization (Blake et. al 1995).




Methods of Gathering Information

Figure 12

Means of Gathering Information About Client's Functioning Level

How are music therapists evaluating the progress of adolescents with EBD?

The majority of the music therapists surveyed reported using some form of assessment tool to track the progress of their clients (See Figure 13).

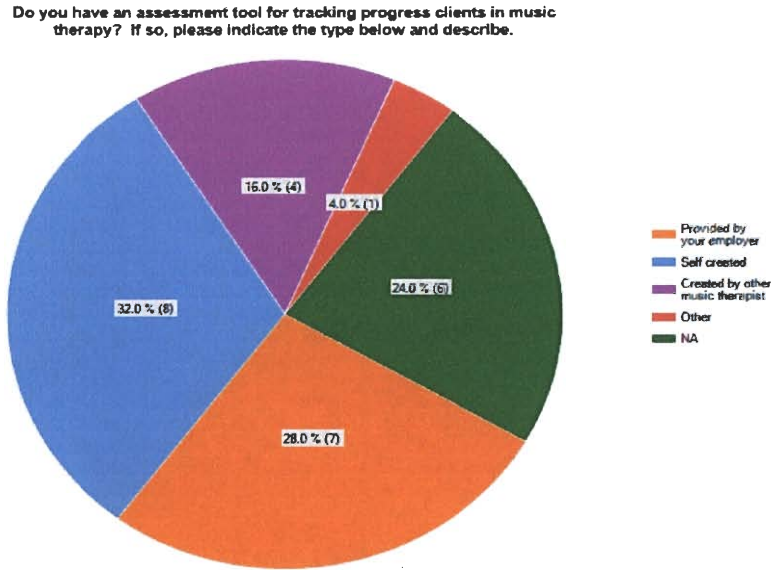



Figure 13

Assessment Tool Used to Track Progress

Almost 1/3 of the respondents use a self made assessment tool to measure their client's progress. Slightly less than that (28%) use a progress tracking method provided by their employer, and 16% use a tool created by another music therapist. One-quarter of the music therapists surveyed identified this question as "not applicable" to their practice with emotionally and behaviorally impaired adolescents. One respondent stated, "I am required to write Medicaid notes which act as progress notes for music therapy as well."

What are common symptoms and diagnoses associated with adolescents with EBD?

Because it is a broad diagnosis, without a single definition, EBD can be difficult to define. This research aimed to determine some of the common symptoms and diagnoses associated with adolescents with EBD. There are many common symptoms and diagnoses seen among adolescents with emotional and behavioral impairments. Among the music therapist's surveyed, attention problems, oppositional defiant disorder, and socialized aggression were the most commonly witnessed co-occurring issues. Conduct disorder, immaturity and anxiety or withdrawal were also identified as commonly witnessed but at a less common rate than the aforementioned symptoms. The participants in this study were less likely to see psychotic symptoms and motor excess, but they have been seen by some of the music therapists completing this survey (See Figure 14).

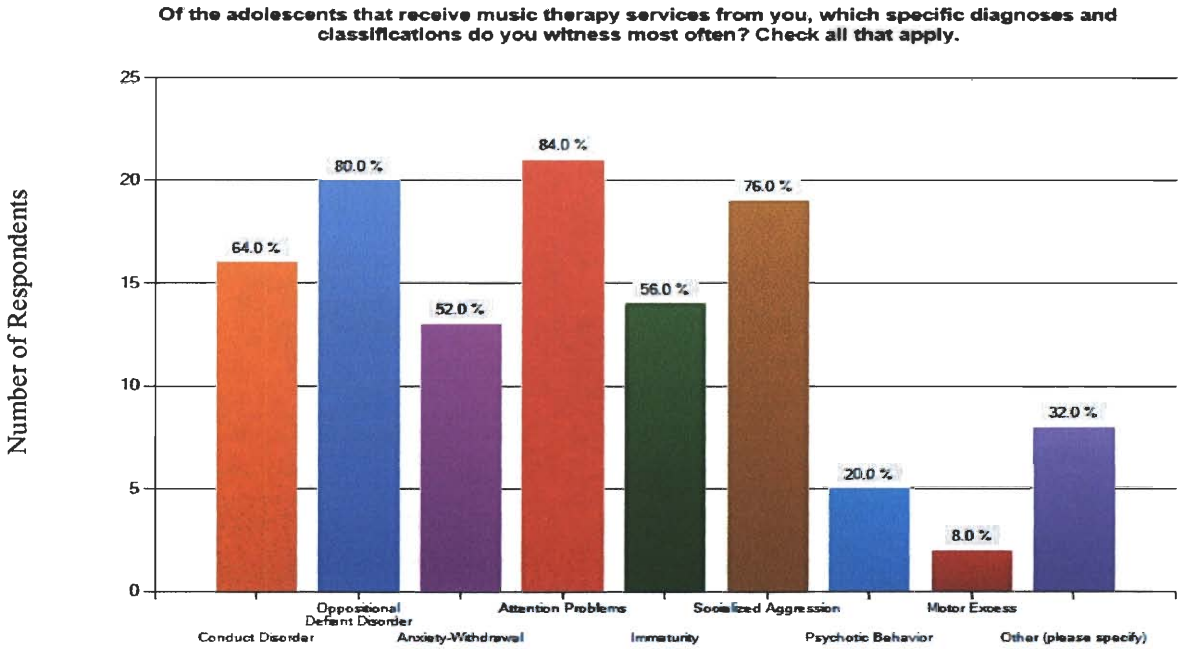



Figure 14

Cooccurring Diagnoses in Adolescents with EBD

The music therapists listed the following disorders or symptoms as also occurring in the adolescents they see with emotional and behavioral impairment; Depression, Bipolar Disorder, Substance Abuse, Attachment Disorders, Post Traumatic Stress Disorder, Anti- Social Personality Disorder, Borderline Personality Disorder, Paranoid Personality Disorder, Asperger's Syndrome, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and Mood Disorders, Autism, Mental Retardation and Developmental Delay.

Adolescents with emotional and behavioral impairment often have comorbid diagnoses. These can include personality disorders, biological conditions, cognitive

impairments and developmental delays. The music therapists surveyed identified all of these areas as comorbid conditions they have seen in their work with this population (See Figure 15).

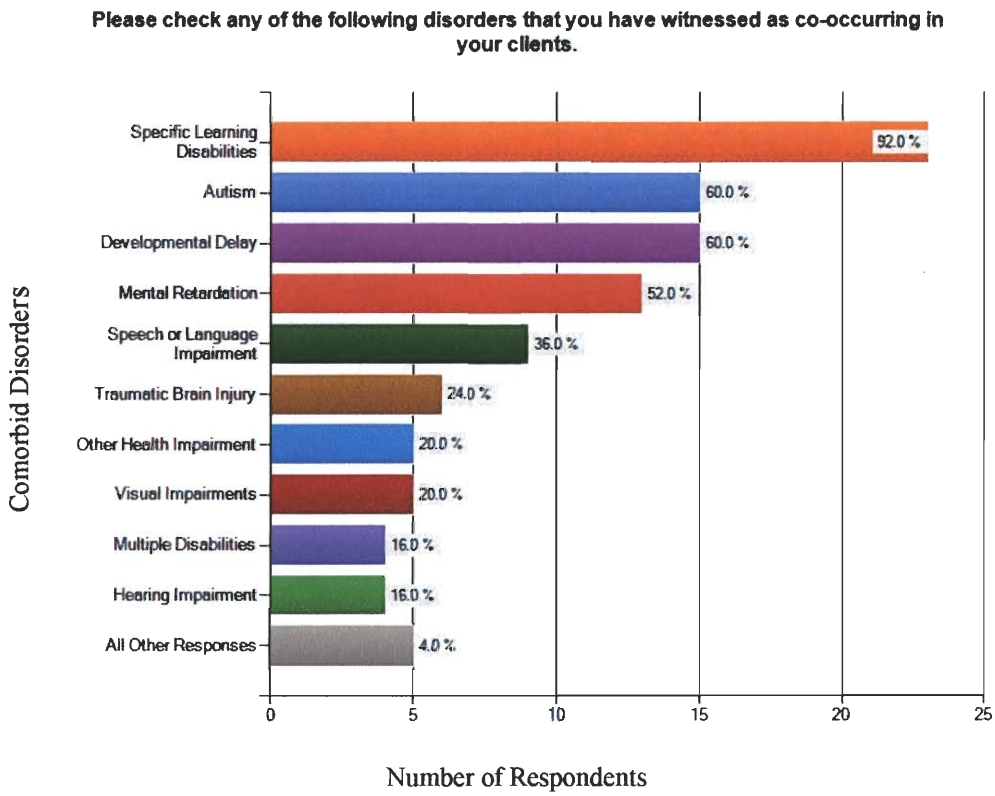



Figure 15

Comorbid Disorders

What are the behaviors typically observed by music therapists in the non-school settings with adolescents with EBD?

The following tables represent the participants experience with behaviors exhibited by adolescents with emotional and behavioral impairment:

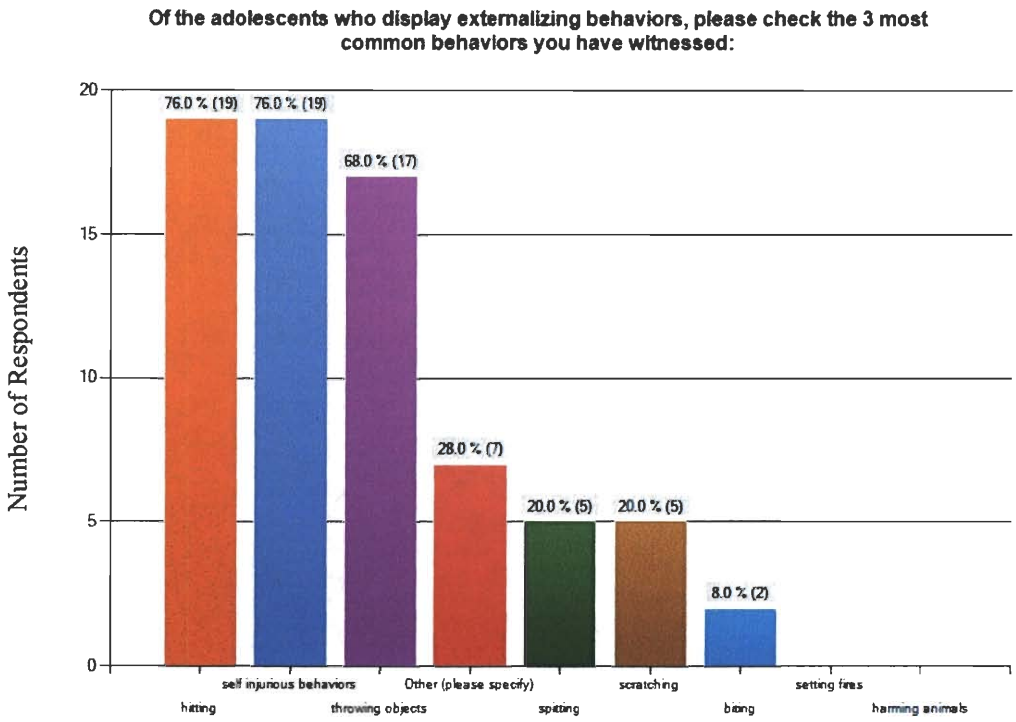



Figure 16

Externalizing Behaviors Demonstrated by Adolescents with EBD

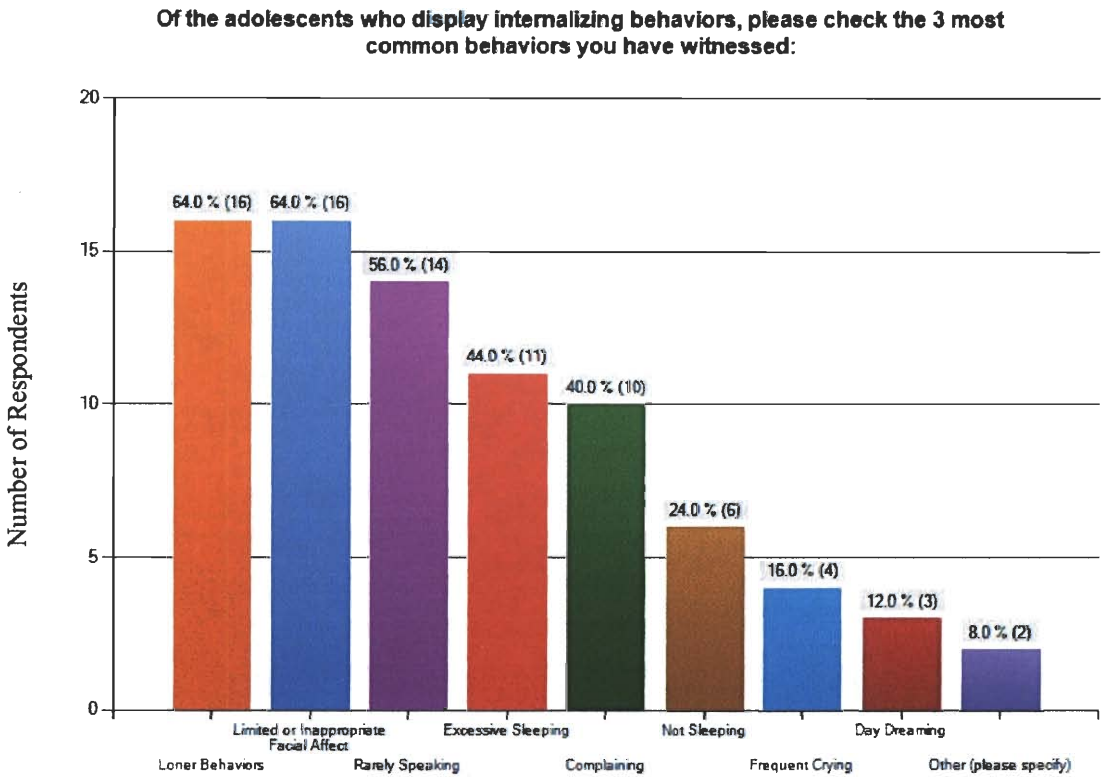



Figure 17

Internalizing Behaviors Demonstrated by Adolescents with EBD

The most common externalizing behaviors seen by the music therapists surveyed were self injurious behaviors, hitting, and throwing objects (see Figure 16). The most commonly observed internalized behaviors are loner behaviors, limited, or inappropriate facial affect, and clients that rarely speak (see Figure 17). Additional responses for externalizing behaviors included verbal aggression and for external behaviors, one participant recognized "head covering," as an additional behavior.

What are the common goal areas focused on by music therapists in non-school settings with adolescent clients identified as having EBD?

The music therapists surveyed in this study all identified socialization as a goal area they address in their work with adolescents with emotional and behavioral impairment. Affective goals and cognitive goals were also identified by 87.5% of the participants as goal areas they work towards with their clients (See Figure 18).

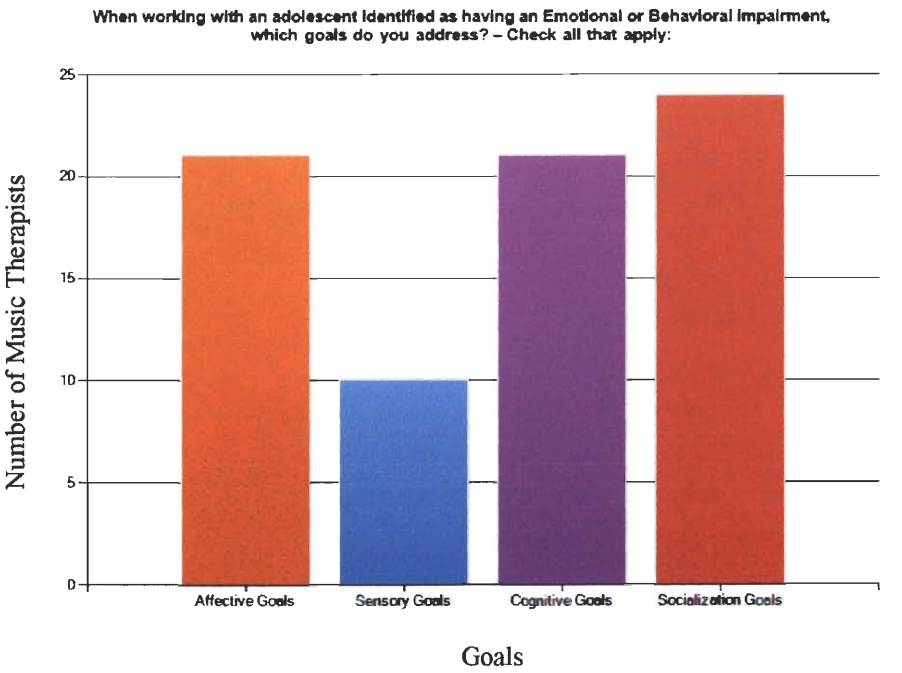



Figure 18

Types of Goals Addressed with Adolescents with EBD

In order to address these goals, music therapists use objectives to measure the client's progress. The participants were asked to list an objective they have written for an adolescent with emotional or behavioral impairments. Table 1 displays the objectives that were listed by participants in this study.

| Social Skills | Emotional Expression | Coping Skills | Self-Esteem |
|---|---|---|---|
| Client will increase positive peer interactions. (add criteria) | Given participation in emotion exploration, Client A will participate in group discussion centered on feelings 3 out of 4 sessions. | Client will learn and demonstrate 3 anger management techniques during a group session | Increase positive comments about self |
| Client will exemplify turn-taking behavior 75% of the time while playing the keyboard with a peer partner. | A will verbally identify his current emotion and play that emotion through the use of a musical instrument once per session. | Client X will utilize a self-soothing technique (that includes deep breathing and safe place imagery) when he is emotionally overwhelmed 80% of the time in the milieu to address coping skills. | |
| Patient will demonstrate 3 non-verbal cues while leading a drum improvisation experience | Youth will write 1 rap song that reflects his rationale behind his feelings of anger and how he plans to cope with anger in a positive way. | Client will learn three ways to decrease and cope with generalized anxiety. | |
| Client will show increased social skills in group and individual therapy sessions. | Express anger in an age appropriate manner | | |
| Client will keep hands and feet to themselves during group | | | |
| During an entire session, client will display 2 or less instances blatant disregard (doing exactly opposite of what the therapist verbally asked the client) to the therapist. | | | |

Table 1

Categorized Objectives Written For Adolescents with EBD

This question was skipped by nine participants, two participants selected "NA," and two responses were not included due to the objective containing the descriptor, "student." While it is unclear why two participants chose to answer, "NA," it could be that these participants do not write objectives for their clients. Table 1 classifies the responses into the following groups: social skills, emotional expression, coping skills and self-esteem. Based on the responses in this research, social skills objectives are the most commonly addressed treatment area by music therapists working with adolescents with EBD.

What specific music therapy interventions are most frequently used by music therapists in non-school settings with adolescents with EBD?

The music therapists surveyed indicated that they use a wide variety of interventions with emotional and behaviorally impaired adolescents. The following graph (see Figure 19) displays the distribution of music therapists that use each specific intervention listed in this survey.

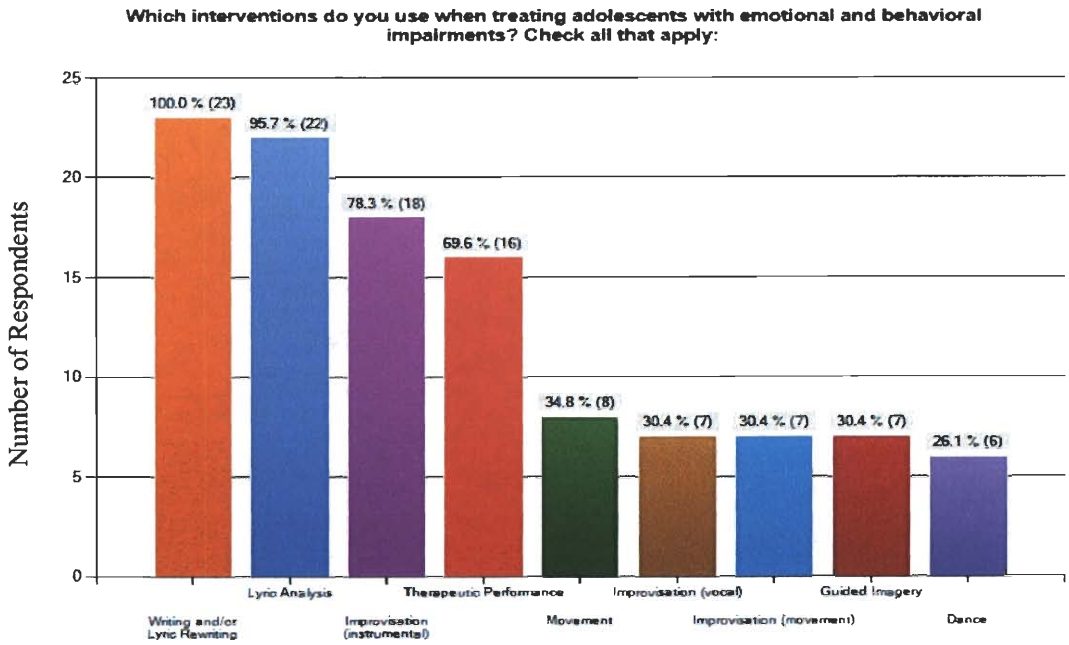



Figure 19

Interventions Used by Music Therapist to Treat Adolescents with EBD

Five music therapists identified other music therapy interventions they use with adolescents with emotional and behavioral impairments. These include; cognitive games, playing an instrument, music and relaxation (not guided imagery), ensemble work not specifically for performance, Music Executive Function Training, Musical Attention Control Training, Music Psychotherapy and Counseling, and art and music experiences. All of the music therapists surveyed use writing and/or lyrics writing, and more than 95% use lyric analysis. Dance was the least likely to be used, with movement and movement improvisation chosen by only one and two music therapists respectively. The responses to this question shows the broad range of interventions

that music therapists are currently using with adolescents with emotional and behavioral impairment.

Which interventions do music therapists in non-school settings report to be the most effective and the least effective when working with adolescents with EBD?

When asked to rank these interventions, with 1 being the most effective, and 9 being the least effective, the results were as followed (from most effective to least effect) Writing and/or Lyric Rewriting, Improvisation – instrumental, Lyric Analysis, Therapeutic Performance, Movement, Guided Imagery, Improvisation – Vocal, Dance, and Improvisation – Movement (See Figure 20). This question was skipped by five respondents. The information displayed in this chart shows the average rankings by the remaining participants.

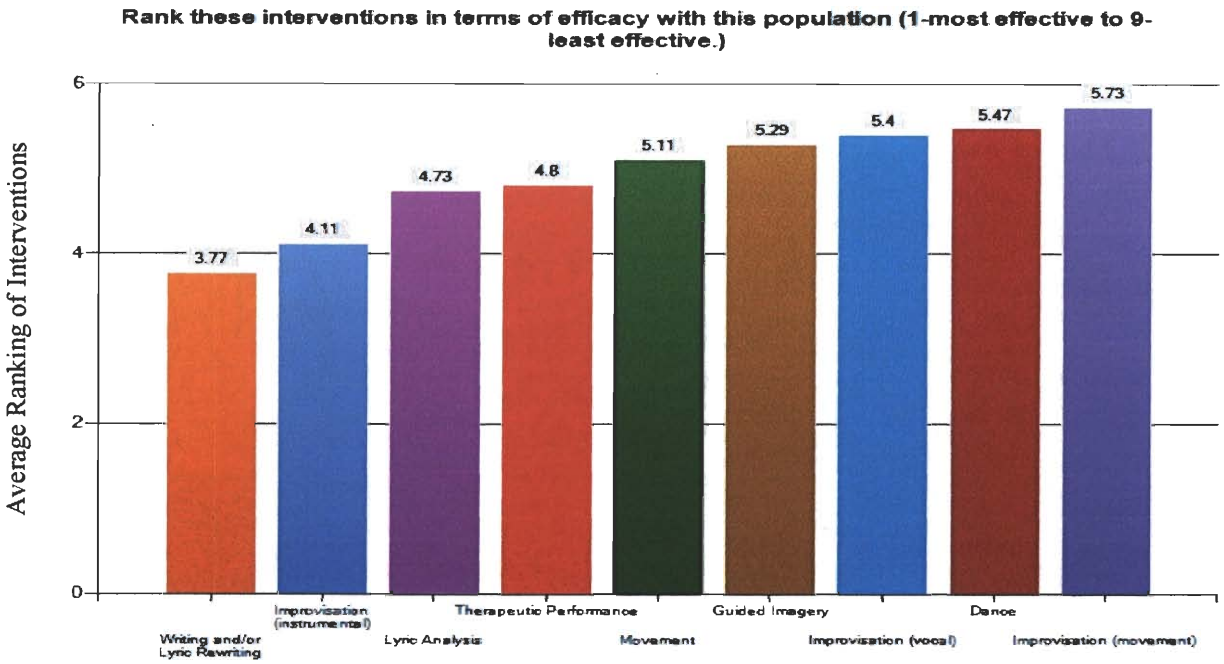



Figure 20

Perceived Efficacy of Interventions

What is the structure of music therapy sessions with adolescents with EBD?

Along with many interventions, many of the music therapists reported that they use live and recorded music when working with adolescents with emotional and behavioral impairments. A smaller percentage reported using only live music and an even smaller percentage report using only recorded music. One music therapist stated that he/she used a recording studio in sessions (see Figure 21).

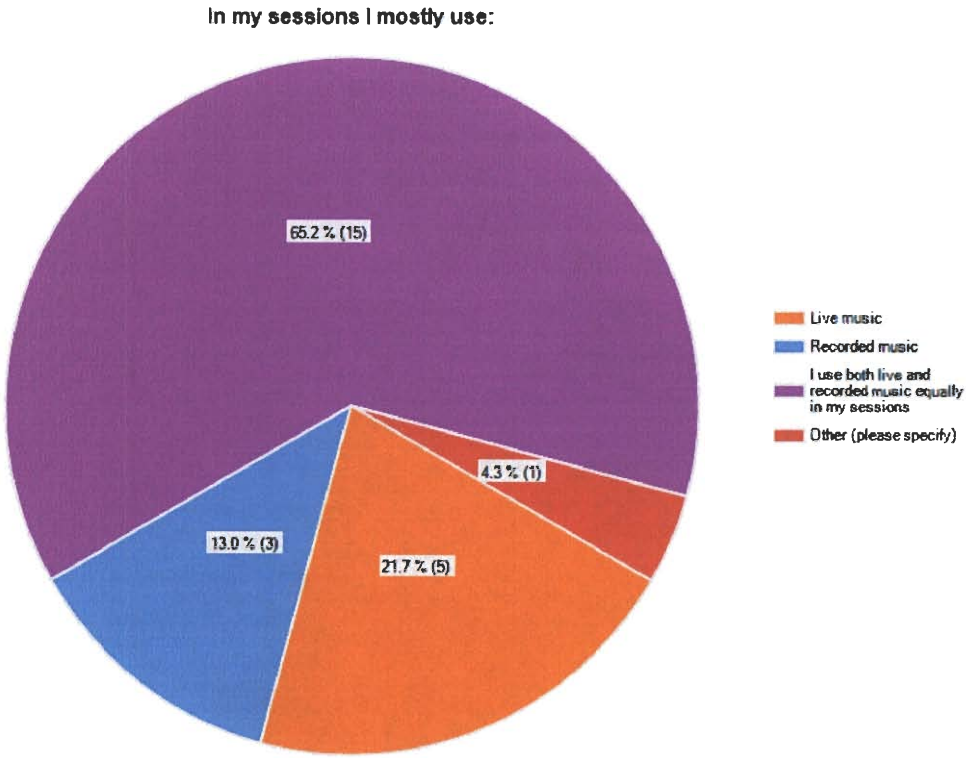



Figure 21

Live Versus Recorded Music

Figure 22 depicts the amount of time the survey respondents reported they spend treating client in individual versus group settings. Based on the results of this study, more clinicians spend at least 50% of their time running group sessions than individual sessions. Individual sessions are less frequent, with 60% of survey participants spending less than 50% of their clinical time with individual clients.

The participants that run group sessions indicate that the most common group size is 6 to 9 clients. A group size of 2 to 6 clients is the second most common, and groups of more than 10 were run by the smallest percentage of participants. Approximately 12% of respondents selected NA, indicating that they did not run

group music therapy sessions with adolescents with Emotional or Behavioral Disorders.

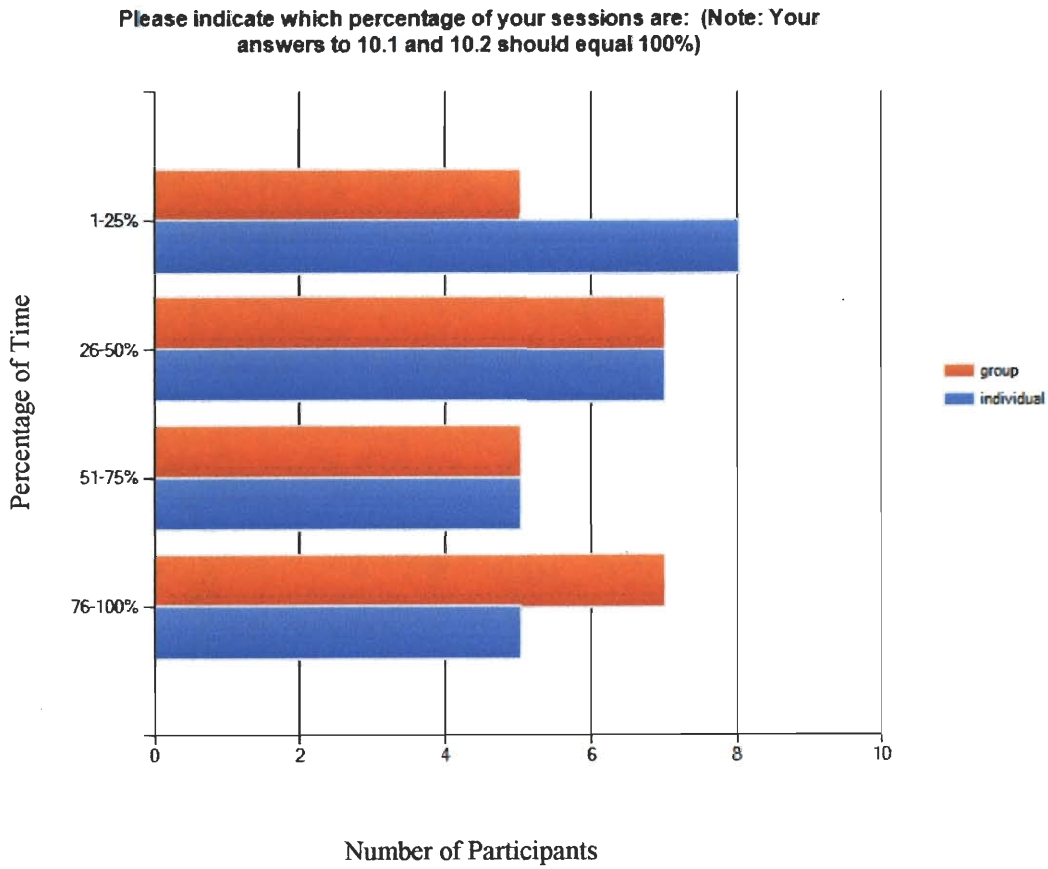



Figure 22

Amount of Time Spent in Individual Sessions Versus Group Sessions

What are the similarities and differences between music therapists working with adolescents with EBD in school settings versus outside of school settings concerning the previous research questions?

In order to address this research question, the results of an unpublished study by Pulutnik (2011) was the basis for comparison. It is important to note that Polutnik's study does not focus solely on adolescent clients, but includes any child in the school setting. The Polutnik study yielded a larger sample size with N=46, compared to N=27 in this study. In both studies, the majority of respondents indicated that they had been working as music therapists for a short time (1-5 years) and may have limited experience with this population. There is a larger percentage (66.7%) of music therapists working outside of schools with 5 years or less experience working with this population, than in the school setting (32.6%).

One area of discord between music therapists working in school settings with adolescents with EBD and music therapists working outside of the school setting is the method of assessing the clients. In the school setting, the methods of formulating an assessment were as follows:

| Assessment | Count |
|---|---|
| Review student IEP | 40 |
| Interview with classroom teacher | 38 |
| Observe student in various settings | 37 |
| Interview with parents | 24 |
| Interview with student | 22 |
| Other | 14 |
| Utilize a check list | 13 |
| Interview peers | 5 |

Table 2

Assessment Formulation (Polutnik 2010)

Outside of the classroom environment, music therapists most commonly gather information from an interview with the client. They often review the IEP, interview professionals, and observe the student as well (See Figure 10). A high percentage (69%) of music therapists working with clients with EBD in the school setting use a self-created assessment tool, while only 32% of the music therapists surveyed outside of the school setting used a self created assessment tool. According to these findings, it is more common for an employer in a facility outside of the school setting to provide an assessment tool (28%) than for a music therapist to use one created by a school (24%).

Among the music therapists working in the school settings, attention problems and immaturity (77%), oppositional defiant disorders (72%), conduct disorders (52%), and socialized aggression (48%) were the most commonly observed behaviors and classifications observed in students with EBD. This was also the case in clients with EBD outside of the school settings, however, the percentages of each was higher. (See Figure 12.)

When comparing the externalizing and internalizing behaviors displayed by clients with EBD in school settings versus other settings, there are many similarities. This surveys excluded "tantrums" as a selection for externalizing behaviors due to age differences within the music therapists clientele, but the following behaviors were the next three most common external behaviors for EBD clients in school and the three most common with adolescents outside of the school setting: Hitting, Throwing Objects, and Self Injurious Behavior. Due to the developmental differences between some school-aged children and some adolescents, the internalizing behaviors listed in this study were slightly different than the Pulutnik study. The following tables display the results of the two studies concerning internalizing behaviors.

| **Polutnik Study** | | **Current Study** | |
|---|---|---|---|
| Diagnosis | Percentage | Diagnosis | Percentage |
| Poor facial affect | 66% | Limited/Inappropriate Facial Affect | 64% |
| Rarely Speaking | 66% | Loner Behavior | 64% |
| Complaining | 55% | Rarely Speaking | 56% |
| Frequent Crying | 39% | Excessive Sleeping | 44% |
| Playing Alone | 32% | Complaining | 40% |
| Sleeping During School | 12% | Not Seeping | 24% |
| Daydreaming | 11% | Frequent Crying | 16% |
| Other | 4% | Daydreaming | 12% |
| Other | 8% | | |

Table 3

Internalizing Behavior Comparison

As shown in the table, the internalizing behaviors presented by adolescents outside of the school setting, and children with EBD inside the school setting are comparable both in nature and rate.

It has been shown that children and adolescents diagnosed with EBD often have a co-occurring diagnosis. The music therapists working with children and adolescents with EBD in both this study and the Polutnik study indicated that professionals in both settings are confronting similar comorbidity issues. Specific learning disabilities, speech or language impairment, autism and developmental delay were all in the top five diagnoses commonly seen by respondents in both studies. It is interesting that 92% of music therapists working outside of the school setting noted that they worked with clients with EBD and a specific learning disability, while only 75% noted seeing this in the school setting.

The music therapists surveyed in both the Polutnik study and this study indicated that socialization goals are the most commonly addressed, followed by cognitive goals, affective goals, and sensory goals. While Polutnik found that socialization goals were particularly prevalent with elementary aged students, this goal area was indicated by 100% of the participants (who work solely with adolescents) in the present study. Polutnik points out that Imagery Goals were more prevalent with high school aged clients in the school setting.

Due to the various behaviors, levels of functioning and comorbid diagnosis of children and adolescent with EBD, various music therapy interventions can be implemented to address different treatment areas. Table 4 displays the interventions used by the participants in Polutnik's study (2010) and the participants in the current study. The interventions are ranked according to the number of music therapists that reported using the intervention with adolescents with EBD.

| Polutnik's Study | Current Study |
|---|---|
| 1. Instrument Play | 1. Writing and/or Lyric Rewriting |
| 2. Movement | 2. Lyric Analysis |
| 3. Singing | 3. Improvisation - Instrumental |
| 4. Improvisation | 4. Therapeutic Performance |
| 5. Music Listening | 5. Movement |
| 6. Composition | 6. Improvisation-Vocal<br>Improvisation-Movement<br>Guided Imagery |
| 7. Other | 7. Other |

Table 4

Comparison of Music Therapy Interventions in Polutnik Study vs. Current Study

There were clear differences between the interventions most commonly used by music therapists in the school system and those working elsewhere with adolescents with EBD. Music therapists working with adolescents with EBD outside of the school setting appear to use more cognitive approaches, using lyric analysis and song writing approaches to address treatment goals. Perhaps due to the broader age range, instrument play and movement appear to be more commonly employed in the school setting. Vocal improvisation, improvisation using movement, and guided imagery were used by the same number of music therapists in the current study. Improvisation was a broad category in the Polutnik study, without signifying vocal, instrumental, or movement, but still ranked only 4$^{th}$ of the interventions.

# CHAPTER V

# DISCUSSION

It is hoped that the information gathered in this study will give a clearer view of the music therapy practices used in the treatment of adolescents with emotional and behavioral disorders and also serve as a comparison between music therapy in the school setting versus other settings serving clients with EBD.

## Overview and Interpretation of Results

The goal of this study was to describe the current practice of music therapy with adolescents with emotional and behavioral disorders outside of the classroom environment. The survey tool was divided into four areas; demographics, assessment, goal areas, and treatment methods. The survey results indicate:

1. Music therapists working with this population tend to have limited experience (less than 5 years).
2. Music therapists confront a variety of behaviors and diagnoses when working with adolescents with EBD.
3. There is consistency between professionals regarding the treatment needs of this clientele.
4. Music therapists working with this population use a variety of music therapy interventions to address treatment goals and objectives.

5. There are many commonalities between music therapists working with adolescents with EBD outside of the school setting and music therapists working with school aged children in the school setting.

Demographics

The participants primarily had less than 5 years of experience, with the majority residing in the Great Lakes Region and the Mid Atlantic Region. It is possible that a larger sample size, and a more diverse participant pool, would generate more reliable results. The majority of the music therapists that participated in this study were female (77.8%) and between the ages of 25 and 34 years (66.6%). Although it seems a disproportionate number of females, it is comparable to the current ratio of male and female members of the American Music Therapy Association (AMTA Member Sourcebook, 2010). Over half of the participants had only 1 to 5 years of experience. It is possible that this is due to a high level of burnout for music therapists working with this population. In a study of the burnout rate of music therapists, Vega (2010) concluded that music therapists have a higher burnout rate than other mental health workers. According to the author one possible explanation for this finding is that the other mental health workers, such as psychiatrists and psychologists, are more likely to have advanced degrees and because of this, experience less burnout. It is unknown what level of education the participants in the present study had, but the majority of respondents were between the ages of 25-34 years old with five years or less of experience as music therapists. It is possible that if music therapists experience a

higher rate of burn out than other mental health workers, fewer music therapists gain extensive experience in one position. According to Rupert and Morgan (2005), clinicians that deal with more negative behaviors from clients are at a higher risk for burn out. As evidenced by the responses to the survey question regarding internal and external behavior, music therapists working with this population are exposed to a high frequency and broad spectrum of negative client behavior. Rupert and Morgan also point out that women appear to be at a greater risk for burn out. As the majority of music therapists that participated in this study were female, burn out may contribute to the majority of participants having fewer than 5 years of experience with this population.

The vast majority (approximately 80%) of music therapists that participated in this study identified two philosophical orientations to describe their approach to music therapy with this population. The humanistic approach was selected by 37.5% of respondents, while slightly more, 41.7% selected the cognitive behavioral approach. It is notable that none of the therapists who responded to the survey selected Analytical Music Therapy, Phenomenological Music Therapy, or the Orff approach. It is possible that respondents were not familiar with some of the theoretical approaches and the responses may have been different if there had been a brief explanation of each provided with the survey. Also, the term, "analytic approach to music therapy," may have been a better description than, "Analytic Approach," as many music therapists are not using the Analytic Approach to treatment but may use some of the methods associated with this general approach. In a study by Gold, Voracek, and Wigram

(2004), the authors suggest that, "eclectic approaches to music therapy, where techniques from different models or theories are mixed, are particularly effective" (p. 1059). The respondents in this survey were not given the option of selecting more than one approach, which may not reflect the true nature of the therapeutic process.

## Assessment

In terms of initial assessments, the music therapists surveyed reported using a variety of tools, methods and resources to gather information about their clients. The most common methods for assessment included interviewing the client, reviewing their IEP and other forms of documentation and interviewing other professionals. Many therapists also stated that they used standardized assessments such as the Ohio Scales and the TSCC, but they are not as common as more subjective and observational methods. It is interesting that music therapists in this study reported using assessment tools that are not specific to music therapy. It is unclear if they use these standardized assessments in conjunction with music therapy assessment tools, or as an independent assessment tool. This is significant in that as evidenced based practice becomes the expectation, there may be a requirement for more measurable assessment tools to be utilized. When assessing progress throughout treatment, 32% of the respondents stated that they created their own tools for recording data concerning goals and objects, while 24% said they did not have a tool to record progress. The employers provided 28% of the music therapists with a tool to track progress and 16% use a tool created by another music therapist. This aspect of documentation is an area that varies

greatly between therapists. Some music therapists appear to be using tools to measure progress in music therapy created by professionals that may or may not be music therapists, some are using their own, and some appear to not be using any. Consistency in tracking progress could potentially lead to a clearer understanding of the effectiveness of specific interventions with this clientele.

Music therapists working with adolescents with emotional and behavioral impairments have the unique challenge of addressing internal and external behaviors as well as a high frequency of comorbid disorders. This challenge is reflected in the information gathered from this survey. A minimum of 16% of the respondents have seen each of the disorders listed in the survey as co-occurring in the adolescents they see. This includes developmental delays, cognitive disorders, mood and thought disorders, and social and behavioral disorders. Behaviors range from negative and withdrawn to positive and aggressive. With this wide range of manifestations of emotional and behavioral impairments, music therapists working with this population are required to use a variety of approaches and techniques.

## Goal Areas

In a study by Laymon et al (2002), five categories of perceived benefits in using music therapy to treat emotionally disturbed children and adolescents are identified; affective functioning, communication, social dysfunction, cognitive dysfunction, and musical responses. All of the music therapists participating in this study reported addressing social skills goals with their clients with EBD. Affective

goals and cognitive goals are addressed by the majority of therapists and about 40% address sensory goals. This population of clients spans a wide range of severity, abilities and diagnoses. The music therapists in this survey have witnessed a broad range of positive and negative behaviors as well as various diagnoses. However, the objectives addressed by the music therapists surveyed were fairly consistent including; social skills, emotional expression, coping skills, self-esteem, When asked to give examples of objectives they have used with their clients, a third of the responses centered around social skills and communication, while the remainder, with the exception of 1 response, focused on coping skills and processing emotion. It is interesting to note that while all of the respondents reported focusing on social skills and not all reported working on affective goals, the objectives submitted address affective goals over social skills goals by almost 2:1. Also, although the majority of respondents report addressing cognitive goals, this was not reflected in the objectives provided by the therapists.

Treatment Methods

The respondents of this survey felt that lyric writing and re-writing, lyric analysis and instrumental improvisation are the most effective treatment approaches when working with adolescents with emotional and behavioral impairment. They indicated that these are the techniques that they are using most often as well. According to a study by Baker and Bor (2008), a preference for heavy metal music and rap music correlate with a range of antisocial and other problem behaviors.

Adolescents with emotional and behavioral impairments often display antisocial and problem behaviors, indicating that the clients seen by the music therapists responding to this survey may have an increased preference for these genres. The majority of therapists are using a combination of live and recorded music when working with this population, but more therapists report using exclusively live music than recorded music. This was somewhat surprising considering the types of music that have continued to gain popularity with teenagers since the 1980's include rap, hip hop, and rock music, which are all heavily electronic based.

There were weaknesses in the survey instrument that may have affected the results. There were some questions that may have required further definition, clarification, and the option for alternative answers. For instance, when asking for information regarding philosophical orientations and diagnoses, it may have been beneficial to include a short description of the selections. Also, the list of goal areas was developed from the Polutnik study. Allowing for an option to fill in treatment goals, as opposed to choosing from only Sensory, Affective, Cognitive and Socialization Goals, may have given the respondents the opportunity to more clearly describe their treatment for adolescents with EBD. The options for externalizing behaviors, internalizing behaviors and co-occurring and comorbid diagnosis was also developed from the Polutnik study, though they were modified to reflect the nature of behaviors found in adolescents.

## Comparison to Polutnik Study

Although the client populations in the Polutnik study and the current study were slightly different, the results from the music therapists responding to both surveys indicate that the music therapy practice with adolescents with EBD outside of the school setting and school-aged children within the school setting with EBD is fairly consistent. Music therapists working with both populations indicate that they focus on mainly the same goals, and observe similar internal and external behaviors as well as co-occurring diagnoses. The main differences reported by music therapists are the specific interventions being used to treat similar goal areas, and the assessment tool being used to gather information. Music therapists outside of the school setting report using self created assessment tools, assessment tools created by their employers, and assessment tools created by other music therapists. These methods were also used by teachers in the school settings at a similar rate. The major difference between the in school music therapists and the music therapists in other settings, is that the music therapists outside of the school settings report using various standardized assessment tools.

## Implications and Clinical Applications

This research aimed to describe the music therapy practices being employed with adolescents with EBD. It is a follow up study to Kathryn Polutnik's 2010 study entitled, *Music Therapy for Children with Emotional and Behavioral Disorders in the School Setting: A Survey Study.* The findings from the present study demonstrate that

there are a variety of techniques and philosophies employed to treat adolescents with emotional and behavioral impairment. Although the sample size was small, there was diversity in some responses, as well as continuity in others. As evidenced based practice becomes increasingly important in our field, it will become necessary to clearly assess and define the needs of our clients and determine the most effective and efficient way to address those needs. It is possible that further research in this area could lead to a more developed description of music therapy services offered to this population. The data gained from this survey study addresses the demographics, assessment methods, goal areas, and treatment methods of music therapists working with adolescents with emotional and behavioral disorders. Although this study does lend support to Polutnik's research, it is evident that more research would be valuable to refine assessment tools and to aide music therapists working with population to meet the vast needs of clients with emotional and behavioral impairment.

# CHAPTER VI

# CONCLUSION

Although there were limitations to this study, it yielded interesting information regarding the music therapy treatment currently provided to adolescents with emotional and behavioral impairments. It is clear from the results of this study that music therapists are addressing a wide range of needs with the population and that there is a high level of cohesion between the professionals providing music therapy services to this population both in school settings and outside of academic institutions.

## Recommendations for Further Research

More research is necessary to further explore the music therapy practice with adolescents with EBD outside of the school setting. According to Gold, Wigram, and Voracek, "the findings suggest that the appropriate use of specific techniques does matter... Many approaches, including qualitative as well as quantitative methods, will be appropriate in further exploring why, for which clients, and with what success music therapists use their specific and non-specific techniques" (p. 589). As evidenced by this research, music therapists working with adolescents with EBD are using a wide variety of techniques and interventions and the perceived effectiveness is consistent between therapists. It would be beneficial to explore the reasons why some techniques are more beneficial than others and to evaluate the differences when examining the same techniques with different populations.

One interesting finding of this study is that there is variation concerning the assessment process. Music therapists are using their own assessment tools, tools created by other music therapists, standardized educational and psychological assessments, and in some cases, no assessment is being completed by the music therapist. This suggests that there may be a need for an assessment tool specifically designed for working with adolescents with EBD.

It may also be beneficial to conduct a longitudinal study concerning burnout rates of music therapists specifically with adolescents with EBD to determine if this has an effect on the relatively low amount of experience reported by the music therapists in both this research and the Polutnik study.

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Appendix A
Survey Consent Form

My name is Melinda K. Murray, MT-BC. I am a graduate student in the Music Therapy Program at Western Michigan University. I am conducting a survey as part of the required Master's Thesis. It has been determined through the use of the AMTA sourcebook and through communication with the AMTA and CBMT that you may be eligible to complete this survey. If you meet the following criteria, please take a few minutes to complete this short survey concerning music therapy with adolescents with emotional and behavioral impairments.

1. Have worked with emotionally and/or behaviorally impaired adolescents within the past year.
2. Must be currently board certified.
3. Must have a minimum of 1 year of experience at the professional level.

The survey involves answering some general demographics questions and some questions about your music therapy practices with adolescents identified with emotional and behavioral disorders. The survey takes about 15 minutes to complete. The purpose of the survey is to explore the current trends in music therapy with this population. Your participation is completely voluntary, and your responses will be completely anonymous. The data I collect will be analyzed at the group level only. You do not have to answer any question you'd rather not answer. There are no consequences if you decide not to complete the survey.

If you agree to complete the survey, please click on the link at the bottom of this form. By filling out and returning this survey, you are consenting to participate in this study.

If you have any questions or concerns about this study, you may contact Melinda Murray, MT-BC at ***315.868.6123*** or ***269.337.4028***. You may also contact the chair of Human Subjects Institutional Review Board at 269-387-8293 or the vice president for research at 269-387-8298 with any concerns that you have.

This research project has been approved by the WMU Human Subjects Institutional Review Board (HSIRB). Do not participate in this study after 5/30/11.

The results of my project will be available after 5/30/11. If you would like a copy of the results of my project or have any questions, please contact me via Melinda.K.Murray@wmich.edu.

Please keep this letter for your records. Thank you for your participation.

Appendix B
Survey Instrument

**For answers to be included in the analysis process, the responding music therapist must:**

1. Have worked with emotionally and/or behaviorally impaired adolescents within the past year.
2. Must be currently board certified.
3. Must have a minimum of 1 year of experience at the professional level.

**Demographics:**

**1. Please indicate your gender:**

a. Male
b. Female

**2. Please indicate your age group**

a. 20-24
b. 25-29
c. 30-34
d. 35-39
e. 40-44
f. 45-49
g. 50-54
h. 55-59
i. 60+

**3. Please choose the region in which you are employed:**

a. Great Lakes
b. Mid-Atlantic
c. Midwestern
d. New England
e. Southeastern
f. Southwestern
g. Western

**4. Please check the number of years you have been a certified music therapist:**

a. 1-5
b. 6-10

c. 11-15
d. 16-20
e. 21-25
f. 26-30
g. 30+

**5. Please check the number of years you have had experience working with an adolescent identified as having an emotional or behavioral disorder:**

a. 1-5
b. 6-10
c. 11-15
d. 16-20
e. 21-25
f. 26-30
g. 30+

**6. Please indicate the settings in which you provide music therapy services to adolescents identified as having an emotional or behavioral impairment:**

a. Psychiatric Facilities
b. Residential Treatment Centers
c. Day Treatment Centers
d. Hospitals/Emergency Care Centers
e. In-Home, Foster Home
f. Other_____

**7. How many hours do you work in a typical week?**

a. <5
b. 5-10
c. 10-15
d. 15-20
e. 20-25
f. 25-30
g. 30-35
h. 35-40
i. >40

**8. Please indicate what percentage of your work week is spent working with adolescents with behavioral and emotional disorders.**

a. 1-25%
b. 26-50%

c. 51-75%
d. 76-100%

**9. Which philosophical orientation best describes your general approach to music therapy with adolescents with emotional and behavioral impairment?**

a. Nordoff-Robbins
b. Orff
c. Humanistic
d. Behavioral
e. Analytic
f. Cognitive Behavioral
g. Phenomenological
h. Bonny Method of Guided Imagery and Music
i. Other (Please Specify)

**10. Please indicate which percentage of your sessions are**:

1. Group:
    a. 1-25%
    b. 26-50%
    c. 51-75%
    d. 76-100%

2. Individual:
    a. 1-25%
    b. 26-50%
    c. 51-75%
    d. 76-100%

Note: 10.1 and 10.2. should equal 100% representing total client visits.

**11. Please indicate the approximate size of your group sessions (number of clients) if applicable**:

a. 2-5
b. 6-9
c. 10+
d. NA

**Assessment:**

**12. How do you gather information to assess functioning level of the adolescent? Check all that apply.**

-Interview with:

The client
Care taker of client
Other Professionals

-Observation of the client in various settings
-Stadardized and/or Norm-referenced Tool(s):
Please identify the Stadardized and/or Norm-referenced Tool(s):

_____
_____
_____

-Review their IEP or other documentation
-Other _____
-Other_____

**13. Do you have an assessment tool for tracking progress clients in music therapy? If so, please indicate the type below and describe.**

a. Provided by your employer_____
b. Self created_____
c. Created by other music therapist_____
d. Other_____

**14. Of the adolescents that receive music therapy services from you, which specific diagnoses and classifications do you witness most often? Check all that apply.**

a. Conduct Disorder
b. Oppositional Defiant Disorder
c. Anxiety-Withdrawal
d. Attention Problems, Immaturity
e. Socialized Aggression
f. Psychotic Behavior
g. Motor Excess
h. Other_____
i. Other_____

**15. Of the adolescents who display externalizing behaviors, please check the 3 most common behaviors you have witnessed:**

a. hitting
b. spitting
c. scratching

d. throwing objects
e. biting
f. setting fires
g. harming animals
h. self injurious behaviors
i. Other_____
j. Other_____

**16. Of the adolescents who display internalizing behaviors, please check the 3 most common behaviors you have witnessed:**

a. Loner Behaviors
b. Frequent Crying
c. Complaining
d. Rarely Speaking
e. Not Sleeping
f. Excessive Sleeping
g. Day Dreaming
h. Limited or Innapropriate Facial Affect
i. Other_____

**17. Please indicate the percentage of internalizing and externalizing behavior that you see in your adolescent clients with EBD.**

Internalizing:
a. 1-25%
b. 26-50%
c. 51-75%
d. 76-100%

Externalizing:
a. 1-25%
b. 26-50%
c. 51-75%
d. 76-100%

**18. Please check any of the following disorders that you have witnessed as co-occurring in your clients.**

a. Specific Learning Disabilities
b. Speech or Language Impairment
c. Mental Retardation
d. Traumatic Brain Injury
e. Other Health Impairment

f. Multiple Disabilities
g. Hearing Impairment
h. Autism
i. Orthopedic Impairment
j. Developmental Delay
k. Visual Impairments
l. Deafness
m. Blindness
n. Other_____

**Goal Areas**

**19. When working with an adolescent identified as having an Emotional or Behavioral impairment, which goals do you address? – Check all that apply:**

a. Affective Goals
b. Sensory Goals
c. Cognitive Goals
d. Socialization Goals

**20. Please give an example of one specific obective you have written for an adolescent with emotional or behavioral impairments.**

_____
_____
_____
_____

**Treatment Methods**

**21. Which interventions do you use when treating adolescents with emotional and behavioral impairments? Check all that apply:**

a. Writing and/or Lyric Rewriting
b. Improvisation (instrumental)
c. Improvisation (vocal)
d. Improvisation (movement)
e. Lyric Analysis
f. Guided Imagery
g. Therapeutic Performance

h. Movement
i. Dance
j. Other (please specify)

**22. Rank these interventions in terms of efficacy with this population (1 most effective to 7 least effective- If you do not use a specific intervention, check Not applicable.)**

a. Writing and/or Lyric Rewriting
- o NA

b. Improvisation (instrumental)
- o NA

c. Improvisation (vocal)
- o NA

d. Improvisation (movement)
- o NA

e. Lyric Analysis
- o NA

f. Guided Imagery
- o NA

g. Therapeutic Performance
- o NA

h. Movement
- o NA

i. Dance
- o NA

j. Other (please specify)

**22. In my sessions I mostly use:**

a. Live music
b. Recorded music
c. I use both live and recorded music equally in my sessions
d. Other (please specify)

Please use the space below to include any additional comments regarding your experience using music therapy to treat adolescents with emotional and behavioral impairment:

_____

_____

_____

_____

_____

_____

*Thank you for particpating in this survey.*

Appendix C
HSIRB Approval Letter

Date: May 9, 2011

To: Brian Wilson, Principal Investigator
Melinda Murray, Student Investigator for thesis

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 11-05-01

Thank you for submitting the requested revisions to your project. This letter will serve as confirmation that your research project titled "Current Music Therapy Practice with Adolescents with Emotional and Behavioral Impairment in the United States: A Survey of the Profession" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: May 9, 2012



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