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Music Therapy with High-Risk Youth: An Exploration of Current Practice

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MUSIC THERAPY WITH HIGH-RISK YOUTH: AN EXPLORATION OF CURRENT PRACTICE

by

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This study explored the practices of music therapists in the United States and Canada who had worked with high-risk youth within the previous ten years. High-risk youth were defined as those likely to experience a decline in global level of functioning due to one or more issues related to mental health, substance misuse, or other social, economic, or cultural disadvantages, including correctional system involvement, street-involvement, or unstable home environment. An online survey of credentialed music therapists was conducted to explore the areas of demographics, clinical practice and information-seeking. Music therapists working with high-risk youth were asked to identify the most common areas of need, treatment goals, assessment methods, and interventions used with this population. Participants also described an intervention considered highly effective in meeting the needs of high-risk youth. Synthesis and thematic analysis of these results, as well as examples of effective interventions are presented with discussion related to the implications for further research.

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CHAPTER 1

INTRODUCTION

Background

The music therapy and general health literature both reflect recognition of the effectiveness of therapeutic music interventions with youth populations. Studies published in peer-reviewed journals indicate that music therapists, social workers, and other health professionals understand the potential of music therapy as an effective agent for assisting youth with a diversity of needs (Baker & Jones, 2005; Currie, 2004; Dalton & Krout, 2005; Frank, 2005; Keen, 2004; Tervo, 2001). Music therapy is used in mental health, oncology, substance misuse, and bereavement programs for adolescents (McFerran-Skewes, 2004), and research published in the United States and Canada indicates that youth who are at-risk, aggressive, or juvenile offenders are also benefiting from music therapy programs (Buchanan, 2000; Gladfelter, 1992; Rickson & Watkins, 2003; Rio & Tenney, 2002; Wyatt, 2002). Programs targeted at meeting the needs of youth refugees and youth involved in gangs, as well as those experiencing schizophrenia, trauma, and body image issues are discussed in the global music therapy literature (Fouche & Torrence, 2005; Baker & Jones, 2005; Frank, 2005; Ruutel, 2004).

Authors of some of these studies use the terms "at-risk" or "high-risk" to describe their clientele (Buchanan, 2000; Nelson, 1997). While these terms are used without standard definition, they generally refer to youth who are served by mental health, substance use, street-involved, and correctional programs (Springer, Sale, Herman, Soledad, Kasim, & Nistler, 2004; Keating, Tomishina, Foster, & Alessandri, 2002; Ungar & Teram, 2000). Youth often align with more than one of these categories, making it

both impractical and illogical to separate them. Instead the term "high-risk youth" may be used as a general term to describe a cohort of youth that is distinct from the general population, and can be differentiated from those whose primary areas of need relate to developmental disabilities, learning disabilities, physical disabilities, or diseases.

Statement of the problem

No studies were found in the extant literature that sought to explore the state of current practice of music therapists with high-risk youth. Studies related to this clinical population in the music therapy literature evidence strong support for the application of music therapy with high-risk youth around the globe (Baker & Jones, 2005; Buchanan, 2000; Frank, 2005; Gardstrom, 2003; Rio & Tenney, 2002; Wyatt, 2002). However, the limited number and the scope of these studies may not reveal a comprehensive picture of either the music therapy services available to high-risk youth or the clinicians engaged in this area of practice. An exploratory study surveying music therapists is warranted in order to further inform clinicians, educators, students, researchers, and policy-makers, as well as youth and their care providers.

Rationale for research

A survey of current practices of music therapists in the United States and Canada with high-risk youth would provide a clearer picture of where and how music therapists are working with this population. Informing clinicians, educators, and students of current assessment and treatment practices could lead to more effective practice. Dissemination of survey results could aid in identifying future areas for research, contributing to the

establishment of standards of practice for music therapy with high-risk youth. Ultimately this information could strengthen the case for funding music therapy programs with this population. Learning about the information-seeking behavior of music therapists, achieved through exploring where clinicians search for information to guide them in their practice, could assist researchers in effectively disseminating information to music therapy clinicians, and in raising awareness of what resources are presently available.

The primary question for investigation in this study is: what are the current practices of music therapists with high-risk youth in the United States and Canada? The information sought in order to address this area of inquiry includes age, gender, years in practice, professional training, country of practice, primary clinical theoretical orientation, treatment settings, funding sources for positions, as well as practicum and internship experiences with high-risk youth. Also relevant to this investigation is information specific to clinical practice with high-risk youth, including areas of need, goals addressed, assessment methods, and treatment interventions, and information-seeking behavior. Finally, descriptions of interventions found to be highly effective with this population provide a context for understanding factors impacting therapeutic efficacy.

Definition of terms

Adolescence is derived from the Latin verb "adolescere," meaning "to grow up," thus implying growth, transition, and incompleteness as characteristics of adolescence (Bucholtz, 2001). G. Stanley Hall, "the father of adolescence," viewed this phase of life as a border zone between many dichotomous variables, including adult and child, sexual

and asexual, rational and emotional, civilized and savage, productive and unproductive (Lesko, 2001). Youth, adolescents, juveniles, and teens are terms that are often used interchangeably to describe people in the years or stage of life between childhood and adulthood (Mish, 1988). For the purposes of this study, the term youth will be used, to identify individuals whose chronological age ranges between twelve and eighteen.

Music therapy refers only to services delivered by a credentialed (accredited, certified, or registered) music therapist. The music therapists included in this study must maintain a professional credential in their country of practice, including Music Therapist Accredited (MTA) in Canada, and Music Therapist-Board Certified (MT-BC), Registered Music Therapist (RMT), or Certified Music Therapist (CMT) in the United States.

At-risk and high-risk are both terms used in the social sciences in the United States and Canada to describe youth. However, they are used without consistent definition, even within a given discipline. For instance, corrections, substance use, and mental health workers may have contrasting or conflicting conceptualizations of who is at-risk or for what they are at risk. Wotherspoon (2002) and Esters (2003) define at-risk youth in terms of risk for academic and social failure in and outside of school. Alternately, the focus of some professionals may be on youth at risk for juvenile delinquency or mental illness (Keating, et.al., 2002), for exhibiting antisocial behavior, for involvement with the juvenile justice system, or for school and life-long failure (Scott, Nelson, Liaupsin, Jolivette, Christle, & Riney, 2002). Similarly, high-risk youth has been used to refer specifically to young people likely to use substances (Springer, et. al., 2004).

In contrast, high-risk can describe a cohort of youth with multiple risk factors present in their lives, such as poverty, mental illness of parents or caregivers, physical abuse, sexual abuse, family violence, neglect, intellectual, physical, and mental health challenges (Ungar, 2000). Buchanan (2000) also conveys a more global view of teens at-risk, describing an individual as at-risk when "coping with extreme external stresses beyond the typical context of the adolescent's school and home" (p. 40).

Depending on the definition, virtually any youth could be considered at risk for some decline in functioning. The term high-risk youth can be used to identify a specific subset of the youth population who may be targeted for intervention by professionals. For this study the term high-risk youth has been selected to describe a population with a high incidence of co-occurring and inter-related psychosocial issues. High-risk youth are therefore defined as youth likely to experience a decline in global level of functioning due to one or more issues related to mental health, substance misuse, or other social, economic, or cultural disadvantages such as correctional system involvement, street-involvement, or unstable home environment. Excluded from this study are youth whose primary issue is related to a developmental disorder, including pervasive developmental disorders, learning disabilities, brain injury, or physical disability or illness.

Summary

A survey of music therapists can assist in identifying demographic information, common treatment issues, assessment and treatment practices, effective interventions, and information-seeking behavior. This can benefit the music therapy profession through assisting students who are preparing to enter the field, educators in training programs,

clinicians developing their practices, and researchers working toward identifying standards of practice. Ultimately it is the youth of the United States and Canada who can benefit from clinicians possessing a deeper understanding of how music therapists can engage in effective practice with high-risk youth.

CHAPTER 2

CONTEXT FOR THE STUDY

The selection of this research topic was driven by the researcher's interest and clinical experience with high-risk youth in music therapy settings and other professional contexts. The review of the extant literature, survey design, and analysis of the results were all undertaken with intention of informing and improving the researcher's own clinical practice, as well as sharing this information with others in the field.

Literature related to music therapy practice is published through a variety of sources, including dissertations, theses, and peer-reviewed journals in the fields of music therapy, creative arts therapies, social work, counseling, and psychology. In recent years, several studies have been published relating to music in therapy with youth who can be categorized as high-risk (Baker & Jones, 2005; Currie, 2004; Fouche & Torrence, 2005; Frank, 2003; Gardstrom, 2003; McFerran-Skewes, 2004; Rio & Tenney, 2002; Tervo, 2001). These sources can provide a foundation for understanding the specific populations with whom clinicians work, as well as the assessment methods selected, the interventions used, and factors contributing to therapeutic effectiveness.

Subpopulations of high-risk youth identified in the literature include youth who are juvenile offenders (Rio & Tenney, 2002), using substances (McFerran-Skewes, 2004), gang-involved (Fouche & Torrence, 2002), refugees (Baker & Jones, 2005), and experiencing mental health issues (Gardstrom, 2003). Assessment methods, such as rating scales (Baker-Jones, 2005), review of records (Tervo, 2001), and instrumental improvisation (Frank, 2003; Gardstrom, 2003) are presented, as well as interventions

including song sharing, songwriting (McFerran-Skewes, 2004), and improvisation (Fouch & Torrence, 2005; Frank, 2003; Gardstrom, 2003).

In order to obtain a more comprehensive picture of music therapy practice with high-risk youth, a survey of music therapists in the United States and Canada was developed. Demographic information regarding the profile of music therapists was available in publications from the American Music Therapy Association (Member Sourcebook, 2006) and the Canadian Association for Music Therapy (Membership Directory, 2006). Survey questions concerning the demographics of music therapists practicing with high-risk youth were designed for comparison with this existing data. Information presented in the extant literature relating to music therapy practice with high-risk youth served as a basis for the survey questions related to clinical practice. The researcher's clinical experience in music therapy practice with high-risk youth guided the qualitative exploration of effective practice with this population.

Historical context

To place this study in the context of past and present systems of care, a brief historical overview of the treatment of high-risk adolescents will be provided. Similarities in mental health reform movements as well as differences in the development of health care systems of the United States and Canada will be reviewed. Finally, present day influences on policy and standards of practice will be introduced.

Deviance and institutionalization

The term deviant is used to label behaviors in violation of social norms (deviance, American Heritage Dictionary). Those individuals exhibiting deviant behaviors may be

subjected to extreme measures of social control, including involuntary confinement. Physical confinement in asylums and jails has been imposed by Western society on individuals identified as deviant for over seven centuries (Shorter, 1997). Mental health issues, homelessness, substance use, and other social, economic, and cultural factors may place a person outside the norms of society and subject them to management through confinement or other treatment. This has applied not only to adults, but also to thousands of youth in the United States and Canada over the last century.

In 1904 there were 93,000 children living in institutions and another 25,000 identified as juvenile delinquents in the United States alone (Richardson, 1989). Over a century later in the United States, over 90,000 youth were detained on a given day in 2006 (National Center for Juvenile Justice, 2006). A similar statistic in Canada reveals that on given day in 2003 over 2,000 youth were detained in their correctional facilities (Calverley, 2004).

In 2001, over 4 million U.S. youth (ages twelve through seventeen) accessed mental health services, with over 300,000 being admitted overnight to a hospital (Substance Abuse and Mental Health Services Administration, 2001). In Canada in 2002, 18.4% of youth ages fifteen through twenty-four (approximately 760,000) were determined to have at least one measured mental health or substance dependence disorder (Statistics Canada, 2002). Only 9.2% of these youth (approximately 380,000) had contact with services and support for these issues (Statistics Canada, 2002).

Therapeutic care

Policy-makers in Western society have long struggled to provide therapeutic care, versus institutionalization without treatment, for individuals with mental illnesses.

History shows cycles of progress and regression in the treatment of those with deviant behavior, as policy-makers, clinicians, advocates, and clients have gradually recognized the benefits of therapeutic care over confinement without treatment.

Institutionalization for those with mental illness is recorded as early as 1403 when the Priory of St. Mary of Bethlehem, later to be called "Bedlam," opened in England. This same facility would not close until 1948. For centuries, asylums in urban areas housed the insane in abhorrent conditions, while in the countryside, records tell of the inhumane treatment of youth and adults, chained in stables and homes (Shorter, 1997).

A significant movement away from custodial care was initiated in the late 18th century by Reil. He both coined the term "Psychiaterie," and promoted the idea that mental illness is caused by a combination of heredity and brain dysfunction. Others who contributed to this transformation include Battie, Chiarugi, and Pinel, who brought forth the ideas that asylums should be places of treatment and that the milieu itself can be therapeutic. This era gave rise to moral, or mental, therapy in which productive activity and doctor-patient relationships were valued (Shorter, 1997).

Meanwhile, across the Atlantic Ocean, 17th and 18th centuries saw Massachusetts towns granting permission to lock children up in rooms or small buildings (Shorter, 1997). In the 19th century desperately needed reforms began to emerge. Shortly before his death in 1812, Benjamin Rush published "Diseases of the Mind." A practitioner ahead of his time, he recommended that exercise, occupational therapy, productive work, reading, and music be used in the treatment of mental disorders. He also emphasized the importance of physician and attendee attitudes toward patients, citing in particular the

treatment of patients with dignity, truthfulness, sincerity, respect, and sympathy (Farr, 1994).

In 1841 Dorothea Dix began to investigate conditions in the jails and almshouses of the United States and Canada, finding children, youth, and adults with mental illnesses in cages, closets, stalls, pens, chained, naked, and beaten with rods (Goldman, 1990; Rypins, 1948). Dix's advocacy led to monumental changes in legislation and the building of numerous institutions for the humane treatment of those with mental illness.

However, as the turn of the 20th century approached, these progressive institutions founded in the United States were deteriorating and overcrowded with patients who were abused by unqualified staff (Thompson, 1994). Care was seemingly reverting toward a custodial approach, a dark contrast to the enlightened views of therapeutic care developed in Europe in the previous century.

The lagging mental hygiene reform movement was provided with a much-needed catalyst in 1908 when Clifford Beers published an eloquent and detailed autobiographical account of the abusive treatment he received in American institutions for the insane (Pratt, 1947). Beers advocacy led to the establishment of the U.S. National Committee for Mental Hygiene (Beers, 1968), and by 1920 the Canadian National Committee for Mental Hygiene had been founded to address similar issues to those found in America (The Mental Hygiene Movement, 1929). Once again therapeutic approaches began to gain the attention of policy-makers and consequently, funding to make changes. These cycles of progress and regression in the treatment of those with mental illness continued well into the twentieth century.

During World War II in the United States, conscientious objectors were assigned to work mental hospitals (Pratt, 1947). These pacifists continued to progress the mental hygiene movement, playing an important role in exposing the conditions of institutions, leading to investigations at state and national levels. As the reality of the conditions for the mentally ill became evident to the public and policy-makers in the 1950's, the process of deinstitutionalization was initiated (Pratt).

Priorities shifted in the 1960's, and funding was provided for Community Mental Health Centers by the United States federal government. Services included inpatient, outpatient, emergency, and partial hospitalization care, as well as consultation and education. Later, diagnostics, rehabilitation, research and evaluation were incorporated. In 1968 provision was made for alcohol and narcotics addictions treatment. Finally in 1970 services for children were mandated, and in 1975 the aged, follow-up treatment, screening, and transitional housing received attention (Thompson, 1994).

Canadian and U.S. policy

The mental hygiene movements of the United States and Canada followed similar courses. Custodial care was replaced by mental health treatment in large institutions, later giving way to deinstitutionalization and community-based care. Watson (1996) stated that the effects of this social policy change were still posing a struggle for Canadian clinicians who were attempting to provide psychiatric care, food, clothing, and shelter to those in need. At that time, forty percent of homeless individuals in Canada were reportedly living with a mental illness. While there are parallels between the mental hygiene movements in the United States and Canada, differences are evident. Richardson

(1989) discusses discrepancies and proposes an interesting theory regarding these two health care systems.

Richardson (1989) states that in the United States equal opportunity and individualism are culturally central ideals. Health care services provided by the government intend only to cover the basic needs of those deemed unable to provide for themselves. In contrast, Canada's monarchical history has resulted in a cultural sense of duty to care for the masses. Canadian social policy developed to include basic, comprehensive public health services for all Canadians beginning in 1966 (Richardson 1989). In 2005, the National center for Health Statistics reported that seventeen percent of Americans were without any form of medical insurance coverage. These contrasting systems of care result in a Canadian view of health care as a right and an American perception of health care as a privilege.

Current issues in youth care

As care for high-risk youth is examined, it is important to consider that a "generation" of youth, ages 12 through 18, completes a cycle every seven years. The social context for youth issues is constantly changing. Government policies, clinical trends in service provision, and shifting cultural norms and ideals all exert influence on care.

Silliman (2004) notes recent and significant progress in youth development practice, moving away from problem-oriented prevention and toward personal and interpersonal skill development, as well as trends toward science-based practice. However, he remarks that cuts in funding serve as a "major threat to youth development" (Silliman, p. 12).

An illustration of a significant change in youth mental health services over one youth generation is described by Pottick, McAlpine, and Andelman (2000), who state that between 1988 and 1995, psychiatric inpatient care for children and adolescents was greatly impacted by the managed care systems in the United States, resulting in increased discharges and decreased lengths of stay. A more recent change in policy in the United States relates to funding for abstinence only sexual health education (Santelli, Ott, Lyon, Rogers, Summers & Schleifer, 2006). These researchers report that since 1996 the federal government has funded programs with the exclusive purpose of promoting abstinence outside of marriage, and prohibiting the dissemination of information on contraception, sexual orientation, and gender identity. This shift in governmental policy has resulted in a distinct educational change for today's youth versus the youth of ten years ago.

Substance use of youth in North America is also a rapidly evolving area. Watkins, Ellickson, Vaiana, and Hiromoto (2006) highlight the importance of providing counselors and youth with accurate information about the changing trends in youth substance use, specifically the rise in use of ecstasy, methamphetamine (crystal meth), cough and cold medication, prescription opiates and stimulants, and "date rape" drugs. Friedman (2006) discusses the impact of direct-to-consumer advertising of prescription medications, as a factor influencing the non-medical use of prescription drugs among youth. The advertising dollars spent increased from $1.8 billion in 1999 to $4.2 billion in 2004 in the United States, contributing to youth perceptions of prescription drugs as safe and as a normal part of life (Friedman).

Friedman (2006) also notes that anti-drug advertising campaigns have been effective in the United States in reducing youth rates of substance use, with statistics

showing drops in alcohol, cigarette, cocaine, and ecstasy usage. However, the federal government has provided inconsistent financial support to these efforts, at one point cutting the budget for anti-drug advertising programs by one third, and dedicating 80% of the remaining resources to advertising while reducing funding to outreach and web-based programs (Teinowitz, 2003).

Finally, one of the major differences in youth culture today versus even five years ago is internet usage. The Pew Internet & American Life Project (2006) reported that in 2004 87% of youth ages 12 through 18 used the internet. Eleven million teens were online daily in 2004 versus seven million in 2000. Youth in 2004 were "more likely to play games online, make purchases, get news, and seek health information" (p.3). There are definite differences in the ways the youth of the 21st century seek information and interact with others. Services to youth who are in the "net generation," with no memory of life before the internet, should be studied as a unique phenomenon, especially in light of the many other changes that have occurred in the health care and social service systems in the last decade.

Catalysts for change

Changes in the systems of care involving mental health services have been initiated on several levels. Policy-makers, researchers, clinicians, advocates, and clients have all demonstrated the ability to effect social policy. Politicians have the power to advance or thwart mental health reform (Rypins, 1948). Clinicians in the field influence policy through quality research and the establishment of standards of practice. Clients and advocates who tell the stories of those unjustly treated garner support for change. Policy-makers, clinicians, advocates, and clients make up a system that can remain

stagnant, regress, or make progress in the treatment of those whose behavior is considered deviant by society.

Review of literature

Literature related to the concepts of adolescence and high-risk youth can provide a foundation for understanding present day treatment of this population. Review of the applications of creative arts therapies, specifically music therapy, with this population is necessary in order to ground the methodology for this investigation.

High-risk youth

Youth who deviate from the accepted norms of society in navigating this transitional period of their lives may find themselves in conflict with parents, teachers, health providers, or law enforcement officials. Conflicts with these adults may lead to youth being awarded many labels, including deviant, offender, drop-out, and mentally ill. The question of how society is attempting to identify and meet the needs of the youth who are not fitting within its limits has been addressed by many researchers (Clark, 1998; Eggert, Thompson, Herting, & Nicholas, 2000; Lamb, 1982; Ungar & Teram, 2000).

Lamb (1982) identified a category of youth: those with chronic mental illnesses who were searching for independence. He referred to these youth as "the new drifters," for they were unwilling to enter the mental health system in part because it demanded that they accept a label as a psychiatric patient. Much has been written in the two decades following this publication about methods for working with similar groups of youth, whether termed "drifters" (Lamb), "at-risk" (Eggert, Thompson, Herting, & Nicholas, 2000), "high-risk" (Ungar & Teram, 2000), or "offenders" (Clark, 1998). Merely the idea

of having to accept a label can serve as a significant barrier to seeking help for high-risk youth.

Articles in the extant literature indicate that when youth who experience multiple challenges are engaged in treatment, they can benefit greatly from positive relationships with adult helpers (Clark, 1998; Eggert, et al, 2000; Lamb, 1982; Ungar & Teram, 2000). A common theme presented in the writings of these authors is that youth must be empowered though strengths-based approaches (Clark; Eggert, et al; Lamb; Ungar & Teram). Focusing on the strengths of youth and entering into a solution-building partnership is key in building self-esteem and resilience (Clark). Strengths-based treatment needs to be culturally relevant and to incorporate prevention, risk-factor reduction, and life skills components. Recognition of the power of the peer group and finding a way to give youth a voice in their community is essential (Ungar & Teram). It is emphasized that youth who are witnesses of violence, survivors of abuse and neglect, experiencing mental illness, and using substances, all have the capacity for resilience and the need for acceptance (Ungar & Teram).

Therapeutic relationships

Therapeutic relationships with youth have a significant impact on treatment outcomes (Nabors, Weist, Reynolds, Tashman, & Jackson, 1999; Karver, Handelsman, Fields, & Bickman, 2006) and termination of therapy (Garcia & Weisz, 2002). Garcia and Weisz (2002) surveyed parents of 344 youth who had ended treatment through community mental health clinics. They found that "therapeutic relationship problems" (Garcia & Weisz, p. 442) was the factor with the greatest influence on treatment

termination. Other factors included practical problems, appointment problems, time constraints, money issues, and the perception that treatment was not needed.

Nabors, et al. (1999) examined youth satisfaction with school-based mental health care. The youth surveyed indicated that, "they valued the therapeutic relationship, 'catharsis' associated with therapy and skills they learned during therapy sessions" (p. 233). In this study, level of clinician training was found to positively influence youth satisfaction with treatment.

Karver, et al. (2005) addressed this issue of the effects of therapeutic relationships on treatment outcomes through a meta-analysis of 49 youth treatment studies. The analysis showed strong relationships between some of the variables identified and treatment outcomes.

> Therapist direct influence skills and the therapeutic relationship with the youth had moderate to large relationships with treatment outcomes. Counselor interpersonal skills, parent willingness to participate in treatment, youth willingness to participate in treatment, client participation in treatment, and parent participation in treatment were all moderately related to treatment outcomes. (p. 58)

One factor found to have no significant relationship to treatment outcomes was therapist self-disclosure.

Health professionals can take a proactive role in helping youth as they face innumerable challenges in Western society. The development of the therapeutic relationship is paramount in effecting positive outcomes. Once this is achieved, encouraging youth to identify and utilize their strengths in a solution-focused manner, while accepting their rejection of or identification with society's labels, has the potential to foster their natural resilience. This resilience may be a necessary element in facing the challenges of their personal circumstances. Music and other arts therapists have the

potential to foster the natural creative strengths of youth, connecting through familiar, motivating, and rewarding media.

Creative arts therapies for youth

Creative arts therapists often play the dual role of clinician-researcher, as evidenced through the growing body of literature that is descriptive of effective clinical practice with high-risk youth. Numerous authors address the application of a range of creative arts therapies with high-risk youth, a cross-section of which is presented in this section.

Physical, sexual, mental, emotional, social, and psychological sources of tension affect all youth. According to Emunah (1990), for some youth these tensions may lead to crime, substance use, threatening behavior, or suicide attempts. Creative arts, including visual art (Block, Harris & Laing, 2005; Buckland & Bennett, 1995; Wallace-DiGarbo & Hill, 2006; Wexler, 2002), movement (Marvasti & Florentine, 2004; Milkman, 2001; Teachout, 1998), drama (Bradley, Deighton, & Selby, 2004; Rousseau, Lacroix, Alain, Benoit, Moran, Rojus, & Bourassa, 2005; Sanders, 2004), video (Gardano, 1994; Schofield & Rogers, 2004; Tosone, Resenthal, & McVeigh, 2005), and music (Bird, 2006; Currie, 2004; Dalton & Krout, 2005; Frank, 2005; Hendricks & Bradley, 2005, Keen, 2004; Leitschuh & Brotoms, 1991; Nelson, 1997; A Reitman, personal communication, August 20, 2007; Wyatt, 2002) have been demonstrated as effective means of working with high-risk youth who are experiencing a diversity of psychosocial issues.

Emunah (1990) discussed using a heightened sense of creativity present in adolescence as a vehicle for expressing inner turmoil. Similarly, Buckland and Bennett's

(1995) therapeutic work with visual art focuses on the positive, creative abilities of youth who are hospitalized with chronic illnesses. Rousseau, et al. (2005) reports on the use of playback theatre and forum theatre in a program for new immigrants and refugees in a secondary school. Facilitators of this program strove to identify and channel both the strengths and idealism of youth in their processes. Other themes presented by these authors regarding creative arts therapies with youth include the advantages of creative process in promoting emotional expression, self-esteem, active participation, group cohesion, and a safe place for both verbal and nonverbal self-expression.

Two music therapists highlighted the effectiveness of integrating music with other arts and media in work with high-risk youth in a recent conference presentation (Bird, 2006) and telephone interview (A. Reitman, personal communication, August 20, 2007). Bird presented examples of poetry, visual art, lyrics, and music created by street-involved youth in a series of community-based programs in Vancouver, BC. Reitman shared his experience working with various youth populations, which resulted in the development of a group therapy model for "music video therapy." In this process, youth were involved in creating lyrics, raps, songs, musical accompaniment, storyboards, drama improvisation, recording music, or acting in and filming original music videos that addressed issues relevant to treatment. The multi-media approaches of these two clinicians represent innovation and integration of a multitude of therapeutic tools.

High-risk youth and the music therapy literature

In order to gain further insight into current music therapy practice with high-risk youth populations and to gather information necessary for designing a survey instrument, a comprehensive review of relevant literature was undertaken. This review of the

collective music therapy, allied health, social work, psychology, psychiatry, and counseling literature revealed nearly forty studies relating to the use of music with youth who meet this study's definition of high-risk. The earliest study found was published in 1969, with fifteen articles and one dissertation dated since the year 2000, reporting on the use of music interventions by trained music therapists or other counselors in the treatment of high-risk youth. The databases searched included: RILM Abstracts of Music Literature, PsycINFO, PsycARTICLES, ProQuest Dissertations & Theses, ProQuest Research Library, Wilson Select Plus, CINAHL, Social Sciences Abstracts, and MEDLINE.

Eighteen of these publications appeared in peer-reviewed music therapy journals from the United States and Canada, four were published in music therapy journals and forums from outside North America, one was a master's thesis, and two were doctoral dissertations. The remaining fourteen articles represent the work of both music therapists and other counselors, published in peer-reviewed, non-music therapy journals. When examining the country of publication, it was found that seventy percent of the articles published prior to 2000 were found in music therapy journals from the United States and Canada, as compared to twenty-five percent of articles published between 2000 through 2005.

Recently there has been an increasing number of high-risk youth music therapy articles published, especially in general counseling sources and in non-North American music therapy sources. Thirty-seven studies related directly to clinical practice provide insight into the methods therapists are using to meet the needs of high-risk youth. They represent long-term and short-term programs for both individuals and groups. The

majority of studies focus solely on group music therapy, with the remainder discussing individual therapy, mixed group and individual therapy, assessment, and family therapy. In addition to these publications, one clinician survey (Cassity & Cassity, 1994) and one meta-analysis (Gold, Voracek, & Wigram, 2004) in the area of psychiatric music therapy with children and youth were reviewed.

Treatment settings. The settings for the investigations were primarily hospital and residential treatment programs. Others included community-based programs, school programs, private practice, and one study conducted at a university laboratory. Since 2000 there has been a decrease in reports from hospital-based studies, with increases in school (Currie, 2004, Dalton & Krout, 2995; Jones, Baker & Day, 2004), private practice (Hendricks & Bradley, 2005; Keen, 2004), and community-based studies (Buchanan, 2000, McFerran-Skewes, 2004; Fouche & Torrence, 2005).

Subpopulations and areas of need. The specific populations identified in these publications as meeting the criteria for high-risk youth include: at-risk (Buchanan, 2000; Fouche & Torrence, 2005), offenders (Gardstrom, 1987; Gladfelter, 1992; Nelson, 1997; Rio & Tenney, 2002; Wyatt, 2002), refugees (Baker & Jones, 2005; Jones, Baker & Day, 2004), poor body image (Ruutel, 2004), bereavement (Dalton & Krout, 2005), abuse and trauma (Clendenon-Wallen, 1991; Keen, 2004; Slotoroff, 1994), and mental health (Frank, 2005; Frisch, 1990; Gardstrom, 2003; Haines, 1989; Hendricks & Bradley, 2005; Tervo, 2001; Zonneveldt, 1969). Mental health has remained the most frequently identified population over time. Since the year 2000, refugees and bereaved youth have appeared as specifically identified populations, and the term at-risk youth has appeared with greater frequency.

While each category has distinguishing characteristics, it is important to note that youth often meet the criteria for multiple populations. For example, Fouche and Torrence (2005) conducted a study with gang-involved youth, who had also experienced one or more concurrent issues, including bereavement, abuse, abandonment, parent in jail, aggression, withdrawal, or trauma. Similarly, McFerran-Skewes (2004) described the youth she worked with as having a mixture of issues, including difficulties with social skills, school, mental illness, substance misuse, bereavement, and chronic illness. The at-risk youth described by Buchanan (2000) included youth in corrections and hospice programs, as well as street-involved youth. Not only may youth have more than one area of need surfacing in their life, but they may also be grouped with youth who have differing needs within one program.

Assessment. Cassity and Cassity (1994) surveyed clinical training directors at major psychiatric hospitals to determine the assessment and treatment practices in adult, adolescent, and child psychiatric music therapy. They found that listening, instrumental playing and improvisation, singing, games, and movement were used in the assessment of adolescent clients. Standardized assessments were not being used by these music therapists, although they identified this as a needed tool. Wilson (2002) outlines four methods of assessment with adult psychiatric clients. These include interviewing, observing, testing, and reviewing existing information. In this study, assessment methods include means through which a music therapist gathers information about a client or group of clients in order to guide their practice.

The assessment methods identified by Wilson (2002) and Cassity and Cassity (1994) area also discussed in some of the publications reviewed. Authors of only twenty-

two of the thirty-seven studies reviewed specified the assessment methods used. The lack of reporting on specific assessment methods used in the remaining studies might be indicative of the need for music therapy assessment tools identified by Cassity and Cassity.

Music-based assessments, standardized non-music assessment tools, review of records, treatment team and professional referrals, client interview and self-assessment, and mixed methods were the techniques identified in published articles. Music-based assessment methods included formal tools such as Bruscia's Improvisation Assessment Profiles (Gardstrom, 2003), and a songwriting adaptation of the Beck Hopelessness Scale (Goldstein, 1990), as well as non-standardized means including song choice, improvisation, instrument playing, lyric analysis, songwriting, and singing (Burkhardt-Mramor, 1996; Frank, 2005; Wells, 1988). Non-musical assessments were used in thirteen studies and included the Coopersmith Self-Esteem Inventory (Haines, 1989), Beck Depression Inventory (Hendricks & Bradley, 2005), Stait-Trait Anxiety Inventory (Gladfelter, 1992), and Shere and Maddux's Self-Efficacy Scale (Nelson, 1997). Additionally, Dalton and Krout (2005) developed a Grief Process Scale for use in their work with bereaved youth.

Other assessment methods included reviewing records (Burkhardt-Mramor, 1996; Slotoroff, 1994; Tervo, 2001), treatment team and professional referrals (Fouche & Torrence, 2005; Haines, 1989; Kivland, 1986, Skaggs, 1997), and client interview or self-assessment (Boyd, 1989; Gardstrom, 2003). Two studies emphasized using a combination of music therapy and non-music therapy assessments (Burkhardt-Mramor; Gardstrom).

Treatment goals. While it was not always clear how clinicians were assessing the needs of the youth, the literature provided a wealth of information pertaining to the treatment goals addressed. Clinical training directors surveyed by Cassity and Cassity (1994) identified lack of awareness of self and others, withdrawal, lack of cooperation, inappropriate use of leisure time, failure to engage in leisure activities, inability to identify and express emotions, anger and rage, inappropriate affect, low self-esteem, difficulty problem solving, and paranoia as important areas of need. This list closely paralleled the goal areas identified by the authors in the remaining studies.

The list of treatment goals identified in these studies was extensive, with over one hundred issues articulated by these authors. For the purposes of this investigation, the researcher developed a list of ten goal areas through combining similar items and eliminating those that were identified in only one study. These ten items were grouped into three general categories: sense of self, coping, and relating to others.

Sense of self included goals related to self-expression, self-esteem/identity, and self-awareness. The area of coping included coping skills, decision-making skills, and behavior management skills. Social interaction skills, communication, interpersonal relationships, and cultural awareness, comprised the final category, termed relating to others. All of these goals areas were identified with exact or similar language by multiple authors in this literature review.

The most frequently identified goal areas, self-esteem/identity, coping skills, behavior management skills, and self-expression, were consistently cited over time, from 1969 to 2005. Decision-making skills, self-awareness, and social interaction skills were

also cited in many studies, more frequently in those published prior to 2000. A new area that emerged in the twenty-first century literature was that of cultural awareness.

Interventions. The final area examined in the review of literature was that of treatment interventions. Cassity and Cassity (1994) found that improvisation, performance, listening and discussion, and composition were all used by clinical training directors in treating adolescent psychiatric clients. The interventions most commonly identified (by ten or more authors) in this literature review were song/lyric writing, improvisation, song choice, drumming, listening, lyric analysis, instrumental instruction, and relaxation/imagery. The first five of these interventions were cited with increasing frequency in recent publications, while the latter three decreased since 2000. Other interventions identified in three or more studies included singing/rapping, integrated creative arts, movement/dance, ensembles, games, and musical role-playing.

These interventions were not found to be connected to a particular subgroup of high-risk youth. Improvisation was used with youth who were offenders, refugees, angry, gang-involved and experiencing mental illnesses. Song sharing was found to be beneficial for youth who were aggressive, gang-involved, refugees, depressed, using substances, experiencing mental illnesses, or recovering from trauma. Youth who were at-risk, aggressive, bereaved, and using substances were among those who successfully engaged in songwriting as part of their treatment.

The majority of studies used a combination of interventions in treating individuals or groups of high-risk youth. Rio and Tenney (2002) combined improvisation, listening to recorded music, singing, movement to music, drumming, and discussion in their work with juvenile offenders. Music therapy sessions consisting of instrumental improvisation,

rhythmic drumming, song sharing, songwriting, singing, and dancing were found to have an effect approaching significance on reducing the severity of maladaptive behaviors of refugee students (Baker & Jones, 2005). Depression of an adolescent male was alleviated through counseling that incorporated music listening, song choice, music collage, reframing, and verbal processing (Hendricks & Bradley, 2005).

Therapeutic effectiveness. The aspects of the therapeutic process that contributed to the effectiveness of the interventions were also discussed by these authors. Brooks (1989) asserted that, "communication between adult and adolescent is the key to treatment," (p. 37) and that music therapy helps to bridge the gap between youth and clinician. Similarly, Keen (2004), finds that music interventions provide tools for the therapist to "establish a therapeutic relationship, to facilitate interaction, self-awareness, and personal change within a relatively short period of time" (p. 373).

Twelve themes were drawn from the discussions of these authors relating to the efficacy of music therapy with high-risk youth. These themes included enhancing communication (Brooks, 1989; Currie, 2004; Fouche & Torrance, 2005), creating non-threatening environments (Buchanan, 2000; Burkhardt-Mramor, 1996; Frisch, 1990; Kivland, 1986; Slotoroff, 1994), building relationships between youth and adults (Boyd, 1989; Fouche & Torrance; Frank, 2005; Gardstrom, 1987; Keen, 2004; Ragland & Apprey, 1974), facilitating peer connection and group cohesion (Clendenon-Wallen, 1991; Edgerton, 1990; Haines, 1989; Rickson & Watkins, 2003, Zonneveldt, 1969), promoting self-expression (Dalton & Krout, 2005; Edgerton; McFerran-Skewes, 2004; Skaggs, 1987; Zonneveldt), focusing on strengths-based approaches (Currie; Jones, Baker, & Day, 2004; Rio & Tenney, 2002), engaging and motivating youth (Buchanan;

Haines; Hendricks & Bradley, 2005), allowing youth to be in control (Buchanan; Frank; James, 1988), fostering identity formation (Currie; Fouche & Torrance; Frisch), promoting self-esteem (Burkhardt-Mramor; Clendenon-Wallen; Gardstrom; James), symbolizing inner experience (Currie; Frisch; Slotoroff), and developing coping skills (Currie; Slotoroff). These ideas are summarized by Frisch, who states that the nondirective, non-confrontational nature of music therapy can be employed in promoting "a sense of self, a healthy connection with others, and joy in the responsibility of creating" (p. 33).

Summary

The recent publication of studies related to music in therapeutic practice with high-risk youth indicates that clinicians from a number of fields, including music therapy, counseling, and social work, find music to be an effective tool in their work with high-risk youth. Formal results from the published studies reviewed were overwhelmingly positive. Researchers documented increases in self-esteem (Kivland, 1986), reduction in depression (Hendricks & Bradley, 2005); increased school success (Ragland & Apprey, 1974), increases in self-awareness (Saroyen, 1990), and healthy connections with others (Frisch, 1990). These results are echoed in the meta-analysis of Gold, Voracek, and Wigram (2004) who found positive effects for music therapy interventions with children and adolescents with psychopathology. However, Gold, Voracek, and Wigram also cited the need for additional research targeting specific settings, populations, interventions, and outcomes.

When searching the literature for information related to the seeking behaviors of music therapists working with high-risk youth, no publications were found. One article

did discuss the general information needs of music therapists (Richardson & Giustini, 2004), but left the questions of where music therapists find information to support their practices with high-risk youth unanswered.

The search for the relatively small number of publications reviewed here required searching English-language music therapy, social work, and counseling journals and dissertations published worldwide in the twentieth and twenty-first centuries. These studies provide a basis for exploring the needs and goals addressed with high-risk youth, assessment methods and interventions utilized, and factors contributing to the effectiveness of treatment.

Research questions

The primary area of inquiry relates to the current practice of music therapists in the United States and Canada with high-risk youth. The review of the extant literature served as the basis for the development of specific research questions to guide the development of the survey instrument. It was determined that additional foundational information about areas of need, assessment, goals, and treatment would be beneficial to clinicians and researchers interested in developing effective programs. Knowledge of information-seeking behaviors could assist researchers in deciding where to disseminate information about music therapy practice with high-risk youth. Collecting baseline data regarding the demographics of music therapists working with high-risk youth would also contribute new information to the current body of knowledge in this field, and allow for future study of trends and changes relating to clinician attributes, work settings, and funding of positions. Qualitative inquiry into practices perceived by clinicians as

effective with high-risk youth would offer valuable information about the nature of this area of music therapy practice. The following research questions were developed from these themes and organized in the following categories: age and gender demographics; areas of need assessment methods, goals, and interventions; clinical practice compared to literature; United States and Canada; training programs; and highly effective interventions.

Age and gender demographics

Research Question 1

Will age and gender demographics of clinicians practicing with high-risk youth differ from overall age and gender statistics for music therapists practicing with all populations?

Research Question 2

Will relationships be found between age or gender demographics and treatment settings or information seeking behavior?

Areas of need, assessment methods, goals, and interventions

Research Question 3

Will the areas of need, assessment methods, goals and interventions used differ by education, clinical theoretical orientation, treatment setting, or information seeking behavior?

Research Question 4

Will the assessment methods identified by each music therapist as most effective differ from the assessment method identified as most frequently used?

Clinical practice compared to literature

Research Question 5

Will the areas of need, assessment methods, goals and interventions identified by music therapists differ from those identified in the literature?

United States and Canada

Research Question 6

Will funding sources, treatment settings, clinical theoretical orientation, training program adequacy, areas of need, assessment methods, goals, or interventions identified by clinicians differ between the United States and Canada?

Training programs

Research Question 7

Will clinician ratings of adequacy of undergraduate training, practicum experience with high-risk youth, and internship experience with high-risk youth relate to differences in identified areas of need, assessment methods, goals, and interventions?

Highly effective interventions

Research Question 8

Will the interventions described by respondents as highly effective differ based on demographics, experience, hours in practice, degrees held, primary clinical theoretical orientation, treatment settings, funding sources, or clinical training?

Research Question 9

What insight into current practice with high-risk youth can be gained from clinician descriptions of highly effective interventions?

CHAPTER 3

METHOD

Participants

The participants selected for this study were credentialed music therapists currently practicing in Canada or within the United States. Qualifying music therapy credentials were limited to Music Therapist Accredited (MTA), Music Therapist-Board Certified (MT-BC), Certified Music Therapist (CMT), and Registered Music Therapist (RMT). The music therapist must have been employed within the previous ten years as a clinician working part-time or full-time with high-risk youth.

A ten-year window was selected for several reasons. A generation of youth, ages 12 through 18, lasts only seven years. While some of the issues faced by youth may be enduring over time, the social context is not. Recent changes in funding, service provisions for youth, and other social factors underscored the importance of concentrating on current or very recent practice. However, a balance between ensuring study of current, rather than "historical" practice, and allowing a large enough window to ensure a sufficient subject pool was of importance. The lack of information regarding current practice with high-risk youth made it impossible to identify how large the potential subject pool was. The decision to limit the window of practice to ten years was deemed appropriate in order to obtain a reasonable sample while accounting for the rapidly occurring changes in the field of youth work.

The sample for this study included all members of the Canadian Association for Music Therapy (CAMT) and members of the American Music Therapy Association (AMTA) likely to work with high-risk youth. Because neither professional association

listed which music therapists were working with high-risk youth in their membership directories (Member Sourcebook, 2006; Membership Directory, 2006), it was not possible to determine the complete population size or form a representative sample. AMTA members listed in the Membership Sourcebook (2006) as working with the following populations were included in the study as they were considered most likely to work with high-risk youth: abused/sexually abused, AIDS, behavior disorder, dual diagnosed, eating disorder, emotionally disturbed, forensic, non-disabled, other, PTSD, school age, and substance abuse. All members of CAMT were contacted because the Membership Directory (2006) does not indicate populations served by individual clinicians.

Those without e-mail addresses listed were not included in the study, as the survey format online. This subset of music therapists represented less than fifteen percent of the available sample listed in the membership directories (Member Sourcebook, 2006; Membership Directory, 2006). In total, 1151 credentialed music therapists were identified as potential subjects.

Research design

Due to the limited number of investigations into the clinical practices of music therapists with high-risk youth, a survey-based, mixed-method exploratory study was designed. A survey instrument was designed to collect both demographic and clinical practice responses for quantitative analysis, and narrative responses relating to effective practice for qualitative analysis.

A self-administered online survey format was selected for this study for several reasons. First, online questionnaires are efficient for the participant to receive, complete, and return. Second, data are compiled instantaneously through the online system and readily available for analysis by the researcher. The nature of the study's examination of current practice makes it important to disseminate results expeditiously. Third, the number of invalid responses can be minimized through an online survey because the online instrument enforces compliance with question format.

Finally, this was a cost efficient method of surveying (Wigram, 2005), allowing for a large participant pool. A sizable subject pool was of great importance in this study because there was no published information found identifying music therapists who work with high-risk youth. Therefore, self-identification from the greater population of music therapists was concluded to be the most feasible method of attaining the largest possible sample for the investigation. It was recognized that this method does not allow for calculation of response rate, therefore any statistical relationships discovered would not be able to be generalized to a greater population.

A questionnaire was developed to determine demographic information as well as clinical practice information. The questions related to demographic data were designed to enable comparison with demographic data from the AMTA Member Sourcebook (2006). The questions related to clinical practice were developed through the review of studies reporting on therapeutic applications of music with high-risk youth. Areas of need, treatment goals, assessment methods, and interventions included in each study were recorded, categorized, and used to formulate the list of commonly identified items for inclusion on the questionnaire. (see Appendix A)

In this exploratory investigation it was recognized that reviewing the body of extant literature for this diverse area of practice might not yield all of the information needed to design an effective survey tool. The concern that the list of treatment needs, goals, assessment methods, and music therapy interventions generated through a review of published studies would be incomplete was addressed by providing opportunities for participants to enter free-text responses for each of the areas. An open-ended survey question asked that therapists describe one highly effective intervention used in their practice with high-risk youth. This question was designed to elicit responses that could provide greater insight into the factors relating to the effectiveness of various interventions, as well as discovering innovative approaches to treatment that could be replicated by other clinicians.

The survey tool (see Appendix A) was piloted with four music therapists experienced in practicing with high-risk youth and in conducting research, as evidenced by successful completion of one or more thesis-based graduate degrees. One music therapist from the United States and three from Canada completed the pilot survey (see Appendix B for letter of invitation to participate in the pilot study). The instrument was judged by the pilot phase participants to be thorough, clear, and concise. One of the participants stated that she "liked the last question best as it was specific and provided one good example of what really works." No changes were made to the instrument as a result of the pilot study.

Data collection

An online research company, Survey Monkey, was selected for this study based on the researcher's positive experience regarding user accessibility. The survey was posted online for two weeks in April of 2007. An e-mail requesting participation in the survey was sent to each participant with the link to the online survey (see Appendix C) contained in the e-mail. Human subjects institutional review board (HSIRB) application, supporting materials, and letter of approval are included in Appendix D.

Analysis of quantitative data

The quantitative portions of the questionnaire yielded nominal data. Descriptive statistics of mean, median, mode, and variability were calculated. Descriptive statistics were collected for age, gender, ethnicity, years in practice, degrees held, advanced trainings completed, country of practice, primary clinical theoretical orientation, hours practicing music therapy, hours practicing with high-risk youth, funding sources, treatment settings, subpopulations, areas of need, assessment methods, treatment interventions, practicum experience, internship experience, training program adequacy, and information seeking behavior. Where sample sizes were sufficient (minimum of five responses per cell), one-sample chi-square tests were conducted to determine the probability of differences between observed and expected outcomes occurring by chance.

Thematic analysis of qualitative responses

Thematic analysis, influenced by grounded theory (Amir, 2005), was selected to explore relationships of the free responses to questions regarding highly effective

interventions. Grounded theory involves generating theory from a set of data through a process of induction, deduction, and verification (Green, 1998). Coding of data involves constant comparison of categories that emerge against the original data, looking for deviant cases. These deviant cases are examined and contribute to the refining of the theory. The constant comparative analysis can extend beyond the original data set to include material from other research (Green).

While it was determined that the data collected in this study was not detailed enough in its description to warrant a formal grounded theory analysis leading to the development of a theory, elements of this process were included in the thematic analysis conducted. The respondents own words were used in the process of coding data and generating categories, versus the alternative of folding this data into the existing categories formed through the literature review for the development of the survey tool. The language used by respondents was considered a potentially valuable tool in examining differences between these descriptive responses and the information drawn from the literature review. As codes were developed and categories formed, they were compared against the original data set and revised to accommodate all of the responses. A model was developed to account for relationships identified between categories formed, again through ongoing comparison of individual data sets to the emerging model.

The first step of the thematic analysis was to examine the responses to each individual question, regarding descriptions of the population, treatment setting, intervention, and factors contributing to the effectiveness of the interventions (hereafter referred to as effectiveness factors). Categories were generated from patterns found in the narrative responses for each question and each respondent's survey was compared to the

emerging categories. Modifications to the categories were made to account for cases that did not fit, and subsequently all responses were coded with the revised categories.

Next, the four questions (Questions 26 through 29 in Appendix A) were examined in pairs for interrelationships of the coded responses. For example, coded responses for treatment settings and types of interventions described were compared in order to identify and explore relationships. Several relationships were identified in these question pairings, prompting further examination of the data to explore relationships across three of the questions. A theory of relationships between these elements was identified and compared against all available individual responses from the original data set.

The final phase of analysis was focused in identification of interventions that were innovative, effective, and had the potential to be replicated by other music therapists. These three themes, of innovation, efficacy, and replicability, were drawn from the researcher's original intent in conducting the research, in order to better inform the researcher's own practice as well as the practice of others. The intervention description (Question 28, Appendix A) and corresponding effectiveness factor description (Question 29, Appendix A) provided by each clinician were reviewed as a unit. The interventions selected as cases to be reported most strongly embodied the three themes.

Interventions were considered innovative if they described either a technique unique to those found in the literature, or a unique variation on a commonly recognized intervention. The effectiveness of interventions was determined based on the relationship of the description to the effectiveness factors found in the literature, as well as the connections made by each respondent between the descriptions of the intervention and its effectiveness. An intervention was deemed able to be replicated based on the richness of

its description. If the researcher could clearly understand the process and intent of the intervention, and no highly specialized training was required, the intervention was considered easily replicable. Ultimately, the selection of these descriptions was influenced by the researcher's knowledge of the extant literature and experience in the field.

Implications and delimitations

The limitations of this study included its dependence on anonymous and voluntary participant response. No calculation of response rate could be made due to the self-selection of respondents, thus statistical significance and generalizability beyond this sample were impossible. The lack of directory listing of high-risk music therapists practicing in either the United States or Canada necessitated the self-selected model.

In Canada, all accredited music therapists were required to maintain membership in the national association in order to be eligible for accreditation, so it is likely that all Canadian clinicians who supplied current e-mail addresses to the CAMT received the invitation to participate. However, in the United States no such requirement for AMTA membership existed, meaning that clinicians who met the criteria for inclusion may not have been listed in the association directory (Member Sourcebook, 2006), and subsequently not received an invitation to participate. The survey was only presented in English due to translation costs, so non-English speaking therapists may not have responded based on this limitation.

The survey was intended to establish what interventions and assessment tools were used, but did not serve to measure their effectiveness in meeting youth needs, nor

did it serve to explore information related to program development. It was hoped that this study would provide information useful in guiding future research, educational programs, and clinicians who currently practice, or who may someday decide to practice with high-risk youth. Subsequent publication and presentation of this information could serve to inform youth, parents, advocates, health professionals in other disciplines, administrators, and policy-makers of the benefits of music therapy for high-risk youth populations. Knowledge of information-seeking behavior on the part of music therapists working with high-risk youth will assist in determining the most effective means by which to make information available. Ultimately it is high-risk youth who could benefit from the sharing of information related to practice effective in meeting their needs.

CHAPTER 4

QUANTITATIVE RESULTS

Response

Sixty credentialed music therapists responded to the survey. One respondent completed only demographic data and one did not provide an age; the data from these surveys were included when appropriate. The remaining 58 participants completed the questionnaire through the clinical practice section (Question 25, Appendix A). The free-response questions relating to highly effective interventions (Questions 26 through 29, Appendix A) were completed by 44 of the 60 participants.

Response rate could not be calculated for this study, as the subject pool of credentialed music therapists practicing with high-risk youth in the United States and Canada remains unidentified. E-mails were sent to 1151 credentialed music therapists who were members of CAMT or members of AMTA who were listed as practicing with one or more populations likely to include high-risk youth (Member Sourcebook, 2006). Participants in the pilot study were not included in the final sample. Several individuals responded directly to the e-mail stating that they were not working with high-risk youth.

Demographic information

The mean age of the respondents was 37.2 years (*Mdn* 34, mode 27, range 24 to 59 years, *SD* 10). The gender of the respondents was 90% (n=54) female and 10% (n=6) male. 88% (n=53) were practicing in the United States and 12% (n=7) in Canada.

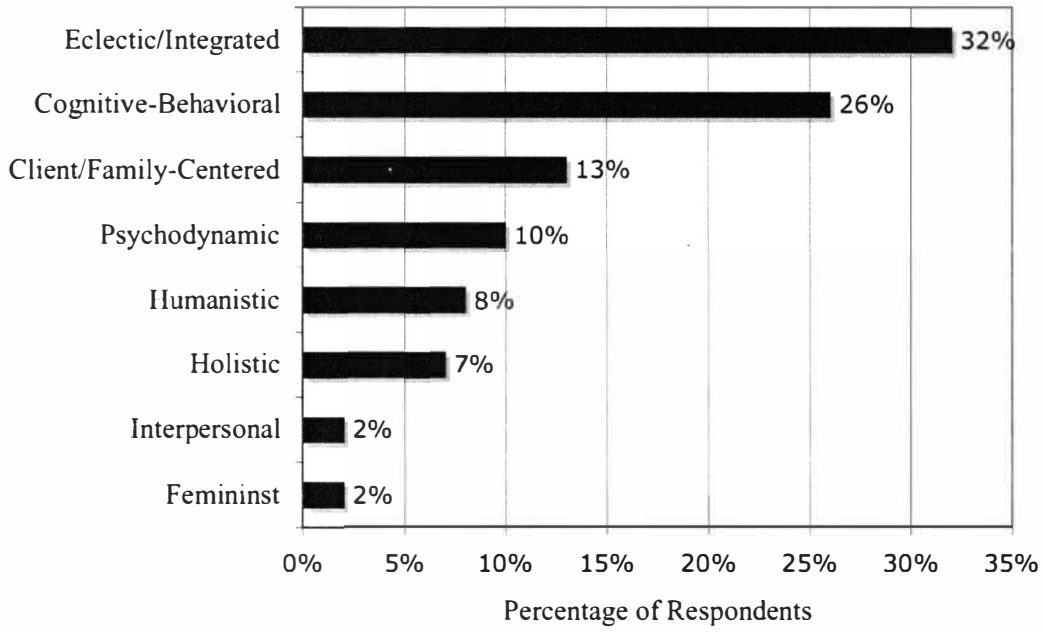
The level of education completed ranged from undergraduate to doctoral level; 53% held a Bachelors degree, Equivalency degree, or Diploma, 42% held a Master's

degree, and 5% held a doctorate. Areas of study for the master's level of education included music therapy, music education, special education, education, and mental health counseling. Doctoral areas of study included arts in human development, curriculum and instruction, and music education/music therapy.

A criterion for inclusion in the study was a professional certification, registration, or accreditation. The credentials of the participants included Music Therapist-Board Certified (n=51), Music Therapist Accredited (n=6), Registered Music Therapists (n=3), and Certified Music Therapists (n=2). Eleven clinicians identified additional credentials and designations, including Neurologic Music Therapist (n=6), Neurologic Music Therapy Fellow (n=1), Neonatal Intensive Care Unit Music Therapist (n=1), Teacher (n=2), Licensed Creative Arts Therapist (n=1), Registered Massage Therapist (n=1), and Certified Infant Massage Instructor (n=1). Two of these clinicians identified multiple, additional credentials.

Participants were asked to indicate one primary clinical theoretical orientation. A list was provided and space left for a free response. The Eclectic/Integrated category had the greatest response (32%), followed by Cognitive-Behavioral (26%), and Client-Centered/Family-Centered (13%). All clinical theoretical orientations that received responses are included in Figure 1.

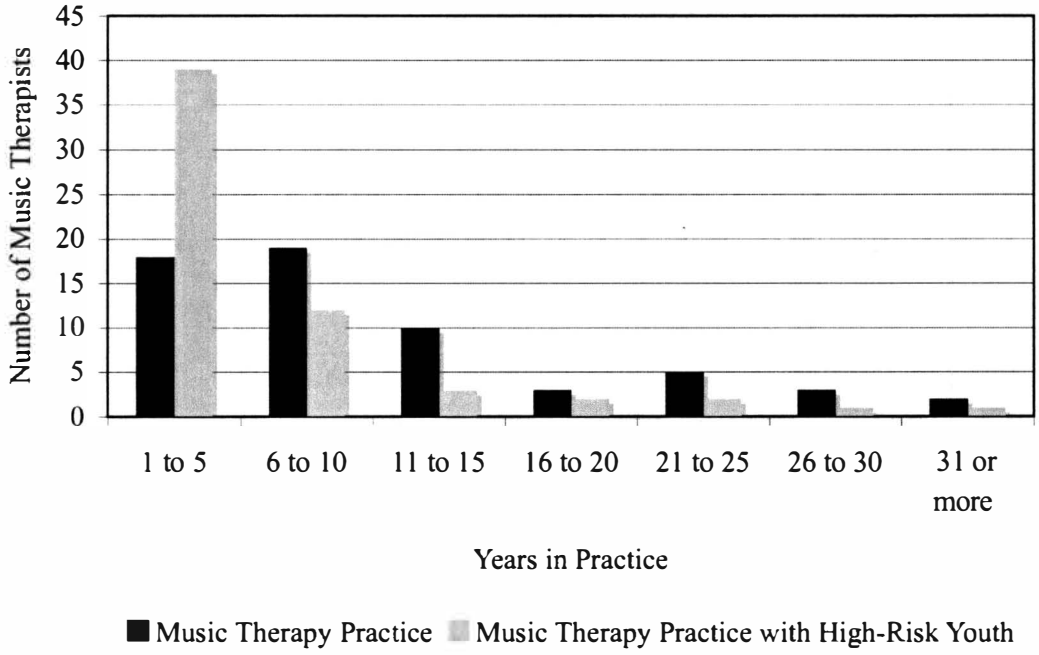
Figure 1. Primary clinical theoretical orientation



Years in practice

The mean length of time the participants had practiced music therapy was 11.1 years (*Mdn 9, mode 4, range* 1 to 32 years, *SD* 8). The mean length of time clinicians had practiced with high-risk youth was 6.7 years (*Mdn* 4.5, mode 1, range 1 to 32 years, *SD* 6.6) (see Figure 2). The mean for the most recent year of practice with high-risk youth was 2005 (*Mdn* 2007, mode 2007). The majority of music therapists surveyed, 63% (n=38), were currently practicing with high-risk youth. The range of responses was from the year 1998 to 2007 (*SD* 2.6).

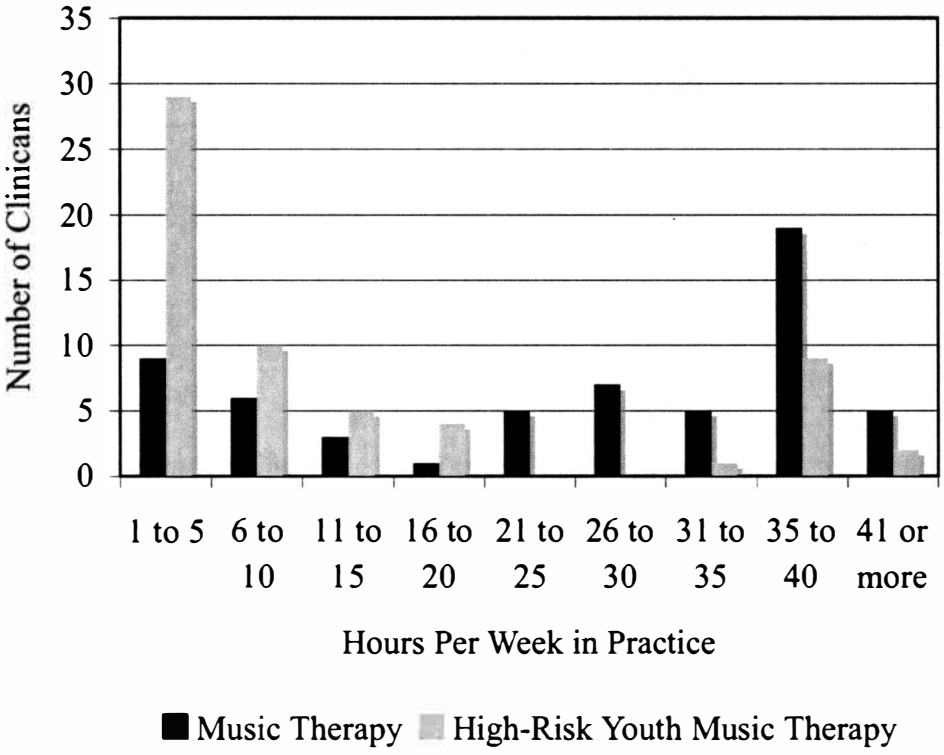
Figure 2. Number of years in practice



Hours per week in practice

Clinicians were asked how many hours per week they currently practiced music therapy, and how many of those hours were spent with high-risk youth. The greatest response for hours per week worked in music therapy practice was 35-40 hours per week (32%). In contrast, 48% of participants worked with high-risk youth only 1-5 hours per week (see Figure 3).

Figure 3. Hours per week in practice



Funding sources

Participants indicated that their clinical work with high-risk youth was funded through a variety of sources. A majority of clinicians (68%) were funded completely or in part by facility budget. Forty percent of clinicians reported receiving funding from a combination of sources, while 50% of the positions were funded through a sole source, including facility budget, grant, endowment, or third party payment. Ten percent of respondents did not know where their funding originated (see Table 1).

Table 1

Funding sources

Source	Receiving Funding	Funded Exclusively
Facility Budget	41	21
Private Pay	14	3
Grant	11	2
Government Health Plan	10	0
Other Government Funding	10	0
Endowment	8	1
Don't Know	6	6
3rd Party Pay	5	1
Combination	24	

Treatment settings

Respondents indicated that they worked in a variety of settings, with the largest number working in multiple settings (32%). Twenty percent worked exclusively in hospitals, 20% in schools, and 12% in residential treatment. Exclusive work in community-based programs (10%), corrections/forensic settings (3%), or private practice (3%) was reported less often. 40% of participants worked at least some of the time in schools, 35% in private practice, 30% in hospitals, 25% in residential treatment, and 25% in community-based programs. Only 5% spend any time working in corrections/forensic settings (see Table 2).

Table 2

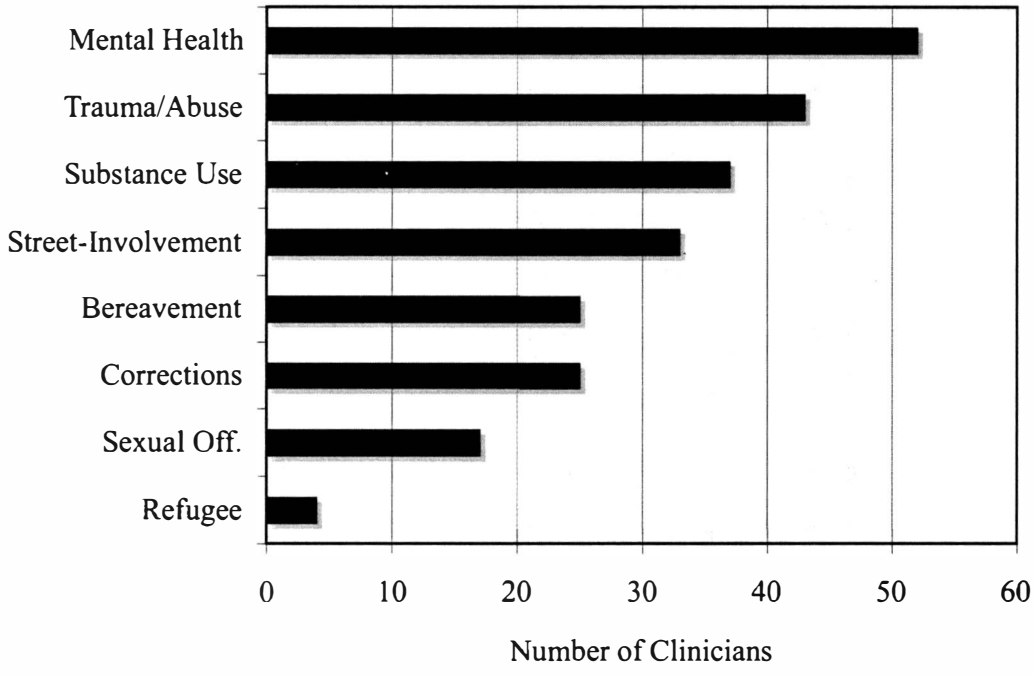
Treatment settings

Setting	Work Exclusively in Setting	Work in Setting
School	20%	40%
Hospital	20%	30%
Residential Treatment	12%	25%
Community-based	10%	25%
Private Practice	3%	35%
Corrections/Forensic	3%	5%
Multiple Settings	N/A	32%

Areas of need

The areas of need for youth selected by participants included all the categories identified through the literature for this survey (see Figure 4). More than half of respondents reported working with youth whose needs related to mental health (87%), trauma and abuse (72%), substance use (62%), and street-involvement (55%). Other areas of need addressed included bereavement (42%), involvement with corrections or forensics (42%), sexual offending (17%), and refugee status (7%).

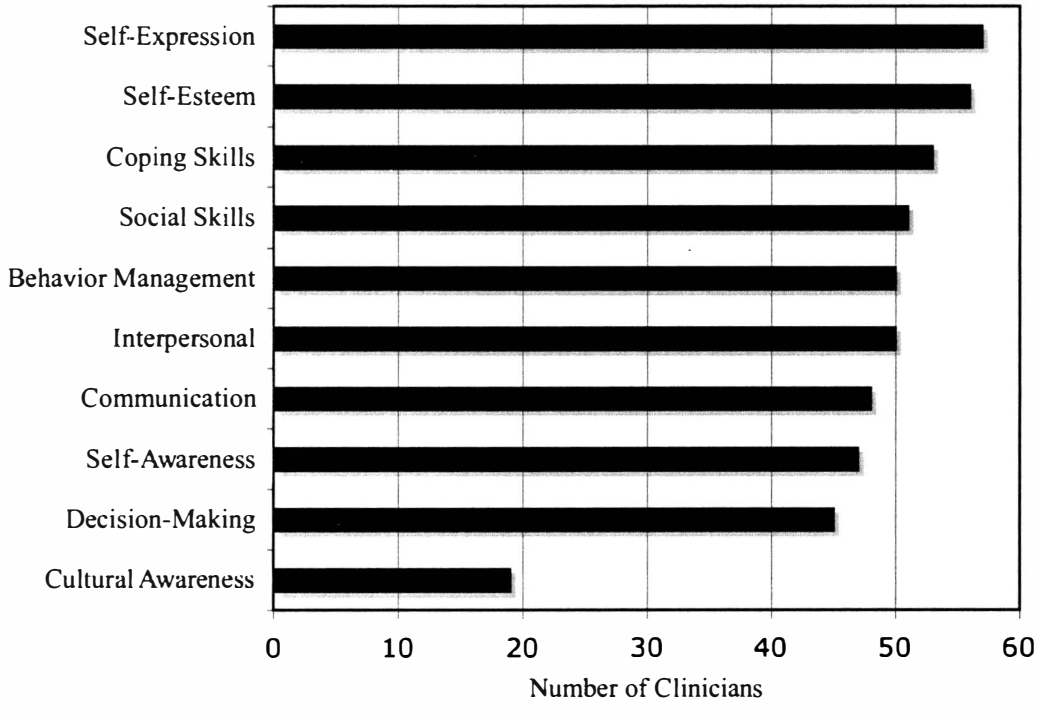
Figure 4. Areas of need



Treatment goals

Each of the ten goal areas supplied in the questionnaire was selected by multiple clinicians as a goal addressed in their work (see Figure 5). Cultural awareness was identified least often, by only 31% of clinicians. Self-expression (95%), self-esteem (93%), and coping skills (89%) were the top three areas of need selected. Those were closely followed by social skills (85%), behavior management skills (83%), interpersonal relationships (83%), communication skills (80%), self-awareness (78%), and decision-making skills (75%). Ten respondents shared additional goals, including self regulation, forgiveness, use of imagination/creativity, leisure skills, respect for authority, respect for self, plan of action, relapse prevention, teamwork, leadership, anger management, music education, and music technology proficiency. Each of these areas was identified by a single respondent.

Figure 5. Treatment goals



Each clinician was asked to identify the two goals most frequently addressed in their work. Self-expression (n=23) and coping skills (n=22) were identified most often. Self-esteem (n=16), social skills (n=16), decision-making skills (n=14), and behavior management skills (n=12) were identified by ten or more clinicians. Fewer than ten clinicians rated communication skills (n=6), interpersonal relationships (n=5), self-awareness (n=4), and cultural awareness (n=0) as one of the two goal areas most frequently addressed.

Assessment methods

Participants were asked to identify all of the assessment methods used in their practice with high-risk youth. The methods identified by the most clinicians were observation in the music therapy setting (78%) and treatment team or professional referral (78%). Review of records (69%), interview/self-assessment (58%), observation in non-music therapy setting (34%), and formal music therapy assessment (25%), were the other methods selected. 12% of respondents indicated using assessments other than those provided in the questionnaire, while 3% reported conducting no formal assessments.

The second question related to assessment methods asked the participants to identify the method that was most effective in their work with high-risk youth. The follow-up question asked what assessment method the clinicians used most frequently. The second question was answered by 24 of the 58 respondents. The responses provided are included in Table 3.

Table 3

Assessment methods

Method	Most effective clinicians (n=58)	Most frequently used clinicians (n=24)
Observation	17	14
Interview/self-assessment	13	1
Team/professional referral	10	1
Review of records	7	2
Formal music therapy assessment	7	2
No formal assessment	2	0
Combination of methods	0	4
Other assessment	1	0
Don't know	1	0

Interventions

The list of interventions generated from the literature was presented on the survey along with an opportunity to supply additional responses. There was no limit on the number of interventions participants could select. Eleven of the twelve interventions were each selected by more than 50% of clinicians, while 24% included role-playing in their intervention repertoire (see Table 4). Free response answers included recording (music recording, and music video), family systems with instruments, and songs with books and other visual aids. The clinicians were also asked what two interventions were used most

frequently in their practice. The four interventions selected most often by clinicians for use in practice matched the four used most frequently: song/lyric writing, drumming, improvisation, and lyric analysis (see Table 4).

Table 4

Interventions

Intervention	Used in practice	Most frequently used
	% of clinicians	% of responses
Song/lyric writing	90%	15%
Drumming	86%	17%
Improvisation	80%	11%
Lyric analysis	75%	15%
Listening	73%	2%
Singing/rapping	71%	4%
Song choice	69%	4%
Inst. playing	58%	7%
Musical games	56%	7%
Relaxation/imagery	54%	7%
Integrated creative arts	54%	9%
Role playing	24%	0%
Free response: Recording	2%	2%
Free response: Other	3%	0%

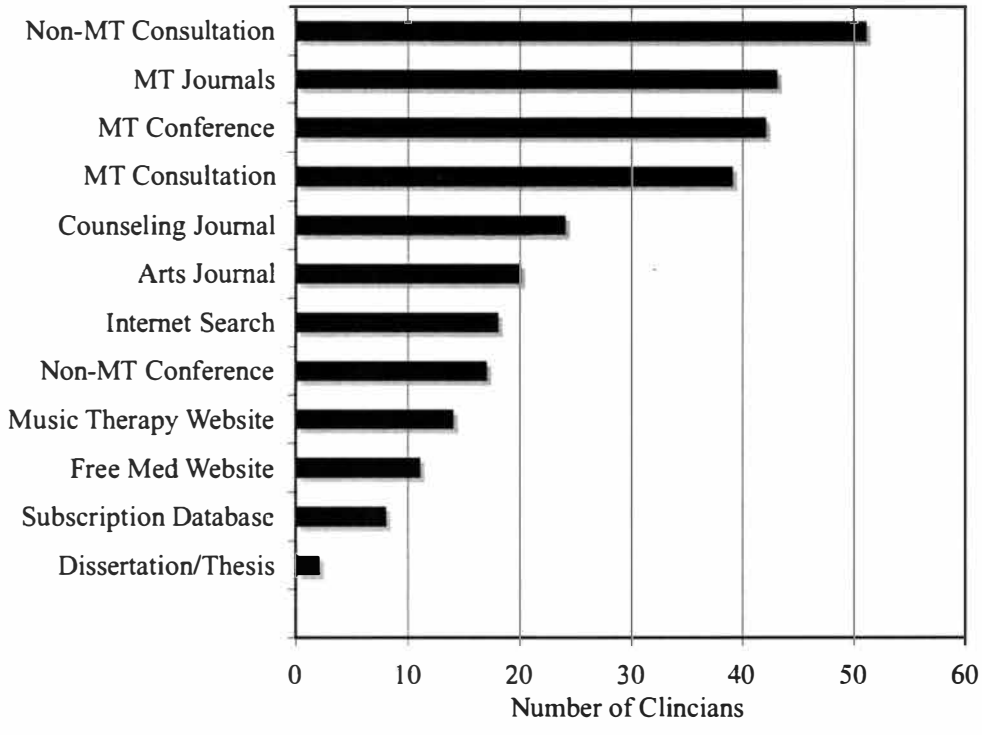
Clinical training

The participants reported if practicum or internship experiences with high-risk youth were part of their undergraduate training in music therapy. Practicum placements were reported by 46%, and internship experiences by 57% of participants. In total, 69% of respondents had completed one or more practicum or internship experiences with this population. When asked to rate the adequacy of the undergraduate training experience in preparing clinicians to work with high-risk youth, 24% rated inadequate, 56% adequate, and 20% superior.

Information seeking behavior

Clinicians identified sources of information that guide their practice with high-risk youth. A majority of the respondents reported utilizing consultation with non-music therapy professionals (85%), music therapy journals (72%), attending music therapy conferences (70%), and consultation with other music therapists (65%). Other sources of information used are included in Table 8. In addition to the list of sources provided, texts, youth interview, and youth literature were reported in the free response section (see Figure 6).

Figure 6. Information seeking behavior



Research questions

Research questions one, two, three, six, and seven were analyzed using one-sample chi square tests, when sample sizes were sufficient.

Research question 1

Will age and gender demographics differ from age and gender statistics for music therapists practicing with all populations?

Age statistics were reported by AMTA (2006) in 10-year age cohorts. Due to the small Canadian sample size (n=7) and the absence of significant differences in the age and gender responses from Canadian and U.S. participants, the entire sample was compared with the AMTA statistics. When the number of high-risk youth clinicians in

each 10-year age cohort was compared with the AMTA member age cohorts, the observed age was significantly lower than expected (X^2 (3, 59) = 10.31, p = .016). Seventy percent of subjects in the current study were under the age of 40, while only 42% of AMTA members were under the age of 40. Gender statistics from AMTA (2006) (87% female) did not differ significantly from the survey sample (90% female).

Research question 2

Will relationships be found between age or gender demographics and treatment settings or information seeking behavior?

Sample sizes did not meet the minimum requirements to perform chi-square tests.

Research question 3

Will the areas of need, assessment methods, goals and interventions used by music therapists differ based on experience, hours per week in clinical practice, education, clinical theoretical orientation, treatment setting, or information seeking behavior?

The areas of need with sufficient sample sizes to perform chi-square tests are indicated in parentheses. No relationships were found between areas of need (mental health, substance use, trauma and abuse, bereavement, and street-involvement) and years of music therapy experience (using the following age cohorts: 1-5 years, 6-10 years, over 10 years). However, those with only 1-5 years of experience working with high-risk youth were less likely to work in the areas of trauma and abuse than those with over 10 years of experience (approaching significance, X^2 (2,33) = 5.28, p = .071). Similarly, two

relationships were identified between areas of need (mental health, substance use, and street-involved) and hours per week worked in music therapy (using cohorts of 1-5 hours, 6-30 hours, and over 30 hours per week worked). Those clinicians working over 30 hours per week with high-risk youth were more likely to work in the area of trauma and abuse (approaching significance, X^2 (2,38) = 5.08, p = .079) and bereavement (X^2 (2, 25) = 5.97, p = .050). No significant results related to years of experience or hours per week of work and assessment methods, goals, or interventions used were discovered.

No relationships were identified between areas of need, assessment methods, goals and interventions used by music therapists and either degrees earned or primary clinical theoretical orientation. The areas of need, assessment methods, goals, and interventions used by music therapists were not found to be related to treatment settings. No relationship was found between the areas of need, assessment methods, goals and interventions used by music therapists and their information seeking behavior.

Research question 4

Will the assessment methods identified by each music therapist as most effective differ from the assessment methods identified as most frequently used?

Of the 58 participants who responded to the question of the most effective assessment practice, 34 did not answer the question of which assessment method was employed most frequently. Of the 24 participants (40%) who answered both questions, 21 (88%) reported using a different tool most frequently for assessment than the tool each identified as most effective. The remaining three (12%) indicated that they used a combination of tools most frequently, but had identified a single tool as most effective in

the first question. The most effective assessment methods cited by these clinicians were client interview, record review, and treatment team consultation. In contrast, the method identified by the greatest number of clinicians as used most frequently was observation, in or outside of the music therapy setting. Thirty-five percent of clinicians reported that the assessment method used most frequently was not the method they perceived to be most effective.

Research question 5

Will the areas of need, assessment methods, goals and interventions identified by music therapists differ from those identified in the literature?

All areas of need found in the literature were addressed by four or more of the participants in the survey, with the largest number (n=31) addressing mental health needs. Open-ended responses to needs addressed with high-risk youth yielded the following responses: palliative care, social skills in school setting, educational needs, developmental disabilities, and gender identity.

In this survey, 15 or more participants identified each of the assessment methods found in the literature as methods used in their practice with high-risk youth, and seven clinicians indicated using methods other than those found in the literature. Two clinicians stated that they did not conduct formal assessments of high-risk youth.

The goal areas addressed in treatment by the participants included goals in all categories drawn from the literature. Those cited most frequently in the literature were self-esteem/identity, coping skills, behavior management skills, and self-expression.

Similarly the participants selected self-expression, self-esteem/identity, and coping skills most frequently in this survey.

The interventions identified in the literature were consistent with the responses given in the present survey. More than 10 authors in the literature review and more than 30 clinicians in this study identified each of these interventions: song/lyric writing, improvisation, song choice, drumming, listening, lyric analysis, instrumental instruction, and relaxation/imagery.

Research question 6

Will funding sources, treatment settings, clinical theoretical orientation, training program adequacy, areas of need, assessment methods, goals, or interventions identified by clinicians differ between the United States and Canada?

Due to the limited sample of Canadian clinicians (n=7), it was not possible to determine relationships using chi-square tests for any of these areas.

Research question 7

Will clinician ratings of adequacy of undergraduate training, practicum experience with high-risk youth, and internship experience with high-risk youth relate to differences in identified areas of need, assessment methods, goals, and interventions?

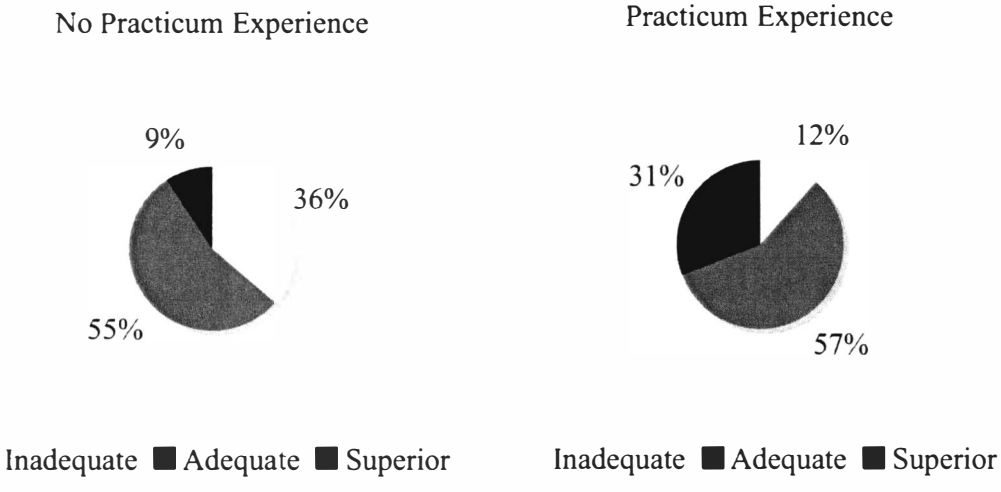
Practicum experiences and clinician ratings of adequacy of undergraduate training were not significantly related to any of these factors. However, internship experience with high-risk youth was related to increased use of integrated creative arts interventions in practice (X^2 (1, 32) = 4.32, continuity correction, p = .037). It was also noted that

internship experience with this population was connected to clinical practice with youth sexual offenders (approaching significance, X^2 (1, 17) = 3.28, continuity correction, p = .071)

Additional trend

One additional set of data was compared after the results were reviewed. A connection between positive training program adequacy ratings and completion of undergraduate practicum experiences with high-risk youth was identified (see Figure 7). Sample sizes did not permit chi-square test, however the strikingly low response in the superior category (n=3, for participants without practicum experiences) and in the inadequate category (n=3, for participants with practicum experience) is noteworthy.

Figure 7. Adequacy of training program and practicum experience



CHAPTER 5

QUALITATIVE RESULTS

Thematic analysis of highly effective interventions

To address the research questions related to the descriptions of highly effective interventions provided by the participants (Questions 26 through 29, Appendix A), a thematic analysis was undertaken. Forty-four of the 60 total respondents offered descriptions of interventions (see Appendix E). Of these clinicians, 4 were male and 40 were female.

The responses to each individual question were reviewed and patterns identified. From these patterns categories were formed for each of the descriptive areas: population (see Table 5), treatment settings (see Table 6), interventions (see Table 7), and effectiveness factors (see Table 8). The survey responses were then coded to reflect these categories. Table 5 through 8 include both the categories that emerged and the individual responses that formed each category.

While gender of subjects and group versus individual treatment were themes that arose in the population descriptions, there were relatively few responses that specified the gender of clients, or that described work with individuals. While these factors were not explored in depth, two trends were noted pertaining to individual sessions: instrumental instruction was more often used with individual clients than groups or families, and this category of intervention was frequently focused on building rapport between youth and therapist.

Table 5

Thematic analysis: Population categories

Population categories	Includes
Emotional/behavioral	Conduct disorder, ODD, ADD, ADHD, aggression poor coping skills, inappropriate peer interaction
Psychiatric/mental health	Mental illness, acute mental health, depression, bipolar, schizophrenia, anorexia, psychosis, adjustment disorder
Self harm/suicide	Suicidal, suicide ideation, suicide attempts, self-abuse, danger to self/others, self-mutilation
Trauma/abuse	Sexual abuse
Social/environmental/legal	Substance abuse, dual diagnosis, inner city, broken homes, social issues, placement issues, ESL issues, low income African American, trouble at school, street-involved

Table 6

Thematic analysis: Treatment setting categories

Treatment setting categories	Includes
School	After school, summer program, public school, private school, special school
Residential treatment	Correctional centre
Inpatient psychiatric	
Day treatment/outpatient	Community-based
Private practice	

Table 7

Thematic analysis: Interventions categories

Intervention categories	
Song/rap writing	Drumming/improvisation
Lyric analysis/song choice	Relaxation/imagery
Recording	Dance
Instrumental instruction	Choice/planning
Mandalas/art	Musical role playing/storytelling
Musical interview	Singing
Games	

Table 8

Thematic analysis: Effectiveness factor categories

Effectiveness factor categories	Includes
Engaging	Motivating, fun, cool, unique, pride, success, believing in music therapy, valuing music therapy
Safety/respect	non-threatening, engage within comfort zone, honor confidentiality, being respected
Facilitating discussion	Intervention led to discussion of treatment issues
Choice	Control
Peer connection	Co-create with peers, peer feedback, sharing expertise with peers
Adult rapport	Therapist personality, reconnection with family members
Music/technology	Live music, music selection, integration of other arts or modalities, use of technology, memories associated with songs
Emotional expression	Emotional release

These categories identified for populations, treatment settings, interventions, and effectiveness factors were similar, but not identical to, those derived from the literature for development of the survey. In tables 9 through 12, the categories from the literature

review are contrasted with the categories drawn from the thematic analysis of qualitative responses.

The terminology used by clinicians in the free response descriptions differed somewhat from the language in the literature review. Mental health disorders were referred to as either psychiatric/mental health issues or emotional/behavioral issues. Trauma and abuse remained the same, but bereavement and refugee/new immigrant issues did not surface as themes in the free responses. Self-harm/suicide emerged as a distinct category in the free responses, while correctional system involvement and street-involvement were not presented in the same manner in the free responses. Instead these two issues were included in a broader category of social/legal/environmental issues (see Table 9).

Table 9

Comparison of population categories

Literature review	Free response
Mental health disorders	Psychiatric/mental health
Substance use	Emotional/behavioral
Trauma/abuse	Trauma/abuse
Bereavement	Self-harm/suicide
Refugee/new immigrant	Social/legal/environmental
Correctional system involvement	
Street-involvement	

Schools, private practice, and residential treatment were consistently cited as treatment settings in both sources of information. Hospitals were more specifically referred to inpatient psychiatric settings. Community-based programs were part of a larger grouping including day treatment and outpatient programs. While corrections/forensic programs were discussed in the literature, the free responses did not include these settings (see Table 10).

Table 10

Comparison of treatment setting categories

Literature review	Free response
Hospital	Inpatient psychiatric
Residential treatment	Residential treatment
Correctional/forensic program	
Community-based program	Day treatment/outpatient
School-based program	School
Private practice	Private practice

Many of the interventions described in the free responses mirror those found in the literature review. The language used and descriptions offered by respondents did lead to some differences in categorization. Drumming and improvisation were combined, as the improvisation interventions were generally drumming centered. Lyric analysis and song choice were amalgamated, and listening eliminated, based on the finding that youth typically selected the songs for lyrics analysis and that listening was used in combination

with these or other interventions. The addition of choice/planning reflected the free responses that included the act of planning and making choices as an intervention unto itself. Integrated creative arts emerged as two distinct categories, dance and manadalas/art. The new area identified through the free responses in both the quantitative data collection and the descriptions of highly effective interventions was recording of original music generated by youth (see Table 11).

Table 11

Comparison of intervention categories

Literature review	Free response
Song/lyric writing	Song/rap writing
Improvisation	Drumming/improvisation
Lyric analysis	Lyric analysis/song choice
Song choice	Choice/planning
Instrument instruction	Instrumental instruction
Relaxation/imagery	Relaxation/imagery
Singing/rapping	Singing
Musical games	Games
Musical role-playing	Musical role-playing/storytelling
Integrated creative arts	Mandalas/art
Drumming	Dance
Listening	Musical interview
	Recording

The final area, effectiveness factors, evidenced many conceptual similarities, but frequent semantic differences. Enhancing communication was best reflected in the free responses as facilitating discussion. Creating a non-threatening environment related to safety/respect. The factors that represented similar concepts in the literature review and the free responses are paired in Table 12. Five of the factors drawn from the literature did not emerge in the respondent descriptions: focusing on strengths-based approaches, fostering identity formation, promoting self-esteem, symbolizing inner experience, and developing coping skills. Music/technology was identified as an effectiveness factor in the free responses, but not in the literature (see Table 12).

Table 12

Comparison of effectiveness factor categories

Literature review	Free response
Enhancing communication	Facilitating discussion
Creating non-threatening environment	Safety/respect
Building relationships between youth and adults	Adult rapport
Facilitating peer connection and group cohesion	Peer connection
Promoting self-expression	Emotional expression
Engaging and motivating youth	Engaging
Allowing youth to be in control	Choice
Focusing on strengths-based approaches	Music/technology
Fostering identity formation	
Promoting self-esteem	
Symbolizing inner experience	
Developing coping skills	

Research question 8

Will the interventions described by respondents as highly effective differ based on demographics, experience, hours in practice, degrees held, primary clinical theoretical orientation, treatment settings, funding sources, or clinical training?

Sample sizes were too small to conduct chi-square tests for the categories identified and the demographic information gathered in the quantitative portion of the

survey. However, one observed finding was that the four male participants responded to this set of questions accounted for two of the four intervention descriptions incorporating recording technology.

Research question 9

What insight into current practice with high-risk youth can be gained through clinician descriptions of highly effective interventions?

Following the formation of categories for populations, treatment settings, interventions, and effectiveness factors, interrelationships of these categories were examined. Several relationships between the identified categories emerged through constant comparison of responses. For example, all cases identifying a common treatment setting were compared in order to identify and explore relationships with interventions used in that setting. The identification of relationships prompted further comparison of the data to explore relationships across three of the questions. A model for relationships between these categories was formed, and all available cases from the original data set were compared against it. The findings that emerged through this process are outlined, followed by a table representing the model for connections across the categories of population, interventions, and effectiveness factors.

The terminology used to describe populations was found to relate to treatment settings. Clinicians working in schools tended to use the terms emotional and behavioral disorders, while those in inpatient psychiatric settings referred to the clients as having psychiatric or mental health disorders. The category of social, environmental, and legal issues was identified across all treatment settings, with the exception of private practice.

Therapists in schools and residential treatment centers described interventions in the rap/songwriting and musical role-playing categories, while those in inpatient psychiatric settings did not. In contrast, those in inpatient psychiatric settings utilized musical interview, while clinicians in schools and residential treatment settings did not identify this in their descriptions of highly effective interventions. Drumming and improvisation interventions were described by clinicians practicing in all of these settings.

The treatment setting categories were also linked to effectiveness factors. Respondents working in school and residential settings focused their descriptions of effectiveness on engagement and peer connection, while those in inpatient psychiatric settings were more apt to discuss choice and expression. The discussion of safe environment was frequently addressed across all treatment settings.

The effectiveness factors were also related to the interventions used in several cases. Both peer connection and engagement were factors found primarily in the descriptions of rap/songwriting, lyric analysis, and drumming/improvisation. Choice and expression were most often related to lyric analysis, drumming/improvisation, and planning. Adult rapport was important in connection with rap/songwriting, drumming/improvisation, and instrumental instruction (predominantly an individual intervention). Finally, discussion was consistently a factor in the effectiveness of interventions involving mandalas or other visual arts integrated with music.

Models for each of the population categories (emotional/behavioral, psychiatric/mental health, and social/environmental/legal) were created from the interrelationships identified through this process. In order to organize the connections

between population groups, intervention categories, and effectiveness factors, the relationships identified were amalgamated into a single table (see Table 13). Three major linear relationships were established, connecting the population groups with specific interventions and linking them to effectiveness factors.

Table 13

Relationships between populations, interventions, effectiveness factors

Population	Interventions	Effectiveness factors
Emotional/behavioral	Drumming/improvisation	Peer connection
	Lyric analysis	Music
Psychiatric/mental health	Drumming/improvisation	Discussion
	Musical role-playing	Safety
	Mandalas/art	Expression
		Choice
		Peer connection
Social/environmental/legal	Drumming/improvisation	Engagement
	Rap/songwriting	Adult rapport
	Lyric analysis	Peer connection
	Recording	
	Instrumental instruction	

All available cases that identified one of these populations exclusively (n=28) were compared against the models generated from the population as a whole. There were no cases within the exclusive populations that did not fit for one or both of the categories of interventions and effectiveness factors. Twenty of the 28 cases fit for both categories. For each population, there was at least one, but not more than three responses that were outside of the parameters presented. Based on these responses, three minor changes were made to the categories, which are reflected in Table 14.

Drumming/improvisation appears as an intervention applied with all populations and peer connection is consistently cited as a factor in effectiveness. However, unique to psychiatric/mental health populations were interventions that involved musical role-playing and mandalas or other visual art; the ideas of safety, expression, and choice were identified most frequently for these clients. The populations with social, environmental and legal issues were likely to utilize rap/songwriting, recording, and instrumental instruction. Effectiveness measures were centered on engagement and adult rapport/relationships in these cases.

Descriptions of innovative and effective interventions

The final portion of the analysis centers on the themes of innovation, effectiveness, and accessible replication by other music therapists. In order to meet the criterion of innovative, the intervention described was either a significant variation on a commonly recognized intervention, or a technique unique to any intervention found in the literature. The criterion of effectiveness was met when the respondent made clear connections between the intervention and the effectiveness factor, and when these factors

reflected those identified in the literature review. The final criterion, ease of replication, was met when the process and intent of the intervention were described clearly, and no highly specialized training would be required to implement the intervention.

Sixteen interventions were selected as examples that meet all three criteria, and shared here to provide information regarding the applied work of music therapists with high-risk youth. These interventions are organized into three groups: improvisation, collaboration, and self-expression (see Table 14).

Many of the clinicians surveyed described improvisation techniques. One such example involved a drum circle with the theme of forgiveness for juvenile male sexual offenders. The group improvised on a 4/4 pattern while a talking stick was placed in the center of the circle. Over the course of the intervention, a youth would voluntarily pick up the talking stick and speak. While a youth was speaking, the group would support him by maintaining a heartbeat pattern, and then resume a 4/4 improvisation between speakers.

Some of the improvisation-based interventions were designed to promote leadership, through encouraging youth to nonverbally direct the music created by their peers. After a youth had a turn directing, some clinicians encouraged peer feedback about their communication. Another intervention utilized peer feedback through drumming improvisation in musical conversation. For this activity, two youth selected percussion instruments and sat facing one another. The task was to have a nonverbal, musical conversation, while other group members observe body language and facial expressions. At the conclusion of the conversation, peers shared their observations and engaged in discussion about nonverbal communication. Another variation on this idea was to provide

a youth with an emotion and ask that the youth pantomime this for a group. The group members then mirrored the pantomimed emotion through musical improvisation and verbally guessed what emotion the youth was attempting to communicate.

Finally, in the area of improvisation, clinicians discussed interventions that involved teaching specific drumming techniques. For one therapist, the goals of this intervention focused on assisting youth in developing the social, behavioral, and musical skills necessary to integrate into the school band. In another case, self-esteem, self-confidence, and self-image were developed through the self-expression, risk-taking, and leadership opportunities involved in learning djembe techniques.

Collaborative endeavors were undertaken in many ways, including games, instrumental instruction, and songwriting. One clinician described a unique program that involved individual music instruction with both the therapist and peers. In this program, youth with developed skills taught novice youth to play guitar. The peer-teaching model for both guitar skill teaching and songwriting was found to be beneficial in the areas of self-esteem and positive relationship building. Another clinician described team composition as an effective method for providing motivation and developing social skills and self-esteem. In this intervention, youth collaborated as a group to write songs, select instruments, and make decisions about accompaniment.

Lyric analysis is another intervention used with groups of youth. Two clinicians described selection of songs for lyric analysis relevant to youth treatment issues. After the analysis of the song, the youth collaborated in choreographing dances to the music. Another approach to lyric analysis was to provide copies of lyrics to youth with space for written reflection. After each line of the song was played, the recording was paused,

allowing time for youth to write responses. A group discussion of responses was held after the song was finished.

The last group of interventions focused on self-expression. One example is a relaxation method utilizing songwriting and drawing. Youth are asked to engage in songwriting or drawing about their present emotional state prior to experiencing relaxation and imagery with music. Following the relaxation youth are again asked to write a song or draw about their new emotional state, and then discuss the differences in these creative expressions with the therapist.

A music interview technique used in psychiatric settings was designed to create a fun and non-threatening means for youth to communicate about treatment issues with family and care providers. Youth wrote questions to create a script for an interview about themselves. They were provided with a large selection of recorded music and found musical excerpts to answer each of the questions. These questions and answers were recorded and shared with families and care providers.

One clinician described an intervention for youth with depression, aggressive behaviors, and poor coping skills. Social stories were created by the youth and then reflected in musical improvisations. Building on the original stories, youth were able to write lyrics, improvise vocally, and rap. Ultimately, the social stories evolved into music videos and journals incorporating poetry, pictures, and audio recordings.

The final type of intervention described was recording original songs and raps, created individually and by groups. One clinician worked with a group, starting with lyric analysis and lyrics adapting. The youth were able to progress to group songwriting to

promote expression and insight into treatment issues. Art and expressive writing were also developed and the group eventually recorded an original song in a recording studio.

Two therapists described projects focused on original rap writing and recording. In the first, youth were encouraged to write a rap about a current situation in their life. The youth then created rap soundtracks using professional audio software and assisted in editing, mixing, and mastering their original raps. Another clinician described a similar method, through which youth wrote raps about current treatment issues and recorded them using professional studio equipment. This process was repeated throughout the course of treatment and the raps were analyzed by the therapist in order to assess progress.

The interventions reported here were considered innovative because they were unique to those found in the literature review or represented a unique variation on an intervention commonly recognized. The descriptions of effectiveness reflected the same concepts pertaining to effective therapeutic relationships found in the youth literature. The richness of these descriptions provided sufficient information for replication by other music therapists.

In conclusion, much can be learned from asking clinicians to describe highly effective interventions from their practice with high-risk youth. Variations on interventions found in the extant literature, such as drumming, improvisation, and lyric analysis, provide ideas for new approaches using familiar tools. Other interventions highlighted, such as music interview and social stories, may provide ideas for new approaches to integrate into the clinical repertoire.

Table 14

Innovative, effective, and accessible interventions

Intervention area	Specific description
Improvisation	Heartbeat improvisation with talking stick
	Nonverbal musical leadership
	Musical conversation
	Emotion pantomime and musical improvisation
	Instruction for social and musical skill development
Collaboration	Peer teaching of guitar skills
	Team composition
	Group discussion of lyrics and dance choreography
	Lyric analysis with written response and group discussion
Self-expression	Songwriting or drawing before and after relaxation
	Music interview recorded with client-selected musical clips
	Youth generated social stories, lyrics, music, videos, journals
	Group songwriting incorporating art and pro recording
	Original rap writing and pro quality mixing and mastering
	Original rap writing analyzed to assess therapeutic progress

CHAPTER 6

DISCUSSION

Findings

The intent of this study was to provide a clearer picture of the current practices of music therapists working with high-risk youth. This was attempted through an online survey, to which 60 credentialed music therapists from the United States and Canada responded. The responses received assisted in forming a profile of a typical music therapist practicing with high-risk youth, relating trends in youth practice identified in the literature with current music therapy practice, identifying educational needs, and increasing insight into the development of therapeutic relationships through music.

Clinician profile

Based on the information collected, a profile of a typical music therapist practicing with high-risk youth may be formed. This therapist is 37 years old, female, and holds the MT-BC credential. She has completed undergraduate level training in music therapy, including either a practicum or internship experience with high-risk youth. She rates her training as adequate in preparing her to work with this population. She has been in practice in the United States for 11 years, working with high-risk youth for 7 years.

This therapist works in music therapy 35-40 hours per week and spends 1-5 of these hours practicing with high-risk youth. Her approach to treatment is eclectic or integrated in her work with youth who have interrelated psychosocial needs. She works in more than one setting and her funding comes primarily from facility budgets. Her assessments of clients are frequently completed through observation, and she uses drumming, improvisation, songwriting, and lyric analysis most often in her practice. To

inform her practice with high-risk youth, the therapist consults with non-music therapy professionals, attends music therapy conferences, and reads music therapy journals.

This music therapist profile differs from that of the average music therapist who is a member of the American Music Therapy Association, in that she is younger and has been in practice for fewer years. The reason for this is unknown, but may include one or more of the following explanatory factors. First is a theory of attrition from this area of practice by older and more experienced clinicians, possibly influenced by the limited number of hours offered in many positions. Younger therapists may be more likely to feel able to connect with youth than older clinicians, and the challenging nature of this work cannot be overlooked as a potential factor in clinician burn-out. Another possible explanation is that the number of clinicians working with high-risk youth may be growing, and that as new positions are created it is recent graduates who naturally fill these openings. The increased number of articles related to music in practice with high-risk youth published in the last 10-20 years supports this proposed idea of an expanding area of practice.

Trends in clinical practice

Many ideas developed through the analysis of data in this investigation can be related to trends found in the review of literature. The findings both reflect and add to the literature published to date, and also highlight areas for future research involving music therapy practice with high-risk youth.

While issues of bereaved youth and youth sexual offenders were addressed by many clinicians in this study, 42% and 17% respectively, these topics have received relatively little attention in the extant literature. Likewise there were issues raised in the

survey responses and the non-music therapy youth literature that have not appeared in the youth music therapy literature to date. These include sexual health, sexual orientation, and gender identity. Cultural awareness has been identified as an area of need in the literature since 2000, but received low response by clinicians in this study, as did practice with refugee youth. The inconsistent presence of the issues of bereavement, sexual offending, refugee status, sexual health, sexual orientation, gender identity, and cultural awareness across the music therapy literature, youth literature, and survey results indicate that these areas hold potential as topics of inquiry.

The review of literature evidenced a decline in the proportion of studies involving music therapy for youth with psychosocial needs in hospitals since the year 2000, with increases in school, private practice, community-based, and correctional setting studies. The present investigation confirms that music therapists are working in all of these settings, with the greatest number in schools and the least number in correctional programs. The impact of funding availability, deinstitutionalization, managed health care, and other health care reforms on service provision are important areas to monitor, as they are likely to have continued impact on models of service delivery to high-risk youth.

A surprising finding in this study was that only three respondents reported working in correctional settings. With 90,000 youth in detention on a given day in the United States in 2003 (National Center for Juvenile Justice, 2006), it raises the issue of custodial verses therapeutic care for today's juvenile offender populations. It is possible that comparatively little treatment is offered to youth in custody versus youth in mental health or school settings, or it may be that music therapy is not yet a generally accepted form of treatment within the juvenile corrections culture. There may also be an

unidentified factor that resulted in a low response rate from music therapists working in correctional programs. Future study of this area could be conducted directly through youth corrections programs in order to explore the scope of music therapy practice in this area.

The results from this study pertaining to assessment methods warrant some discussion. Modes of assessment were not included in many of the studies reviewed in the literature, and responses to this survey were inconsistent around the issues of assessment methods. Thirty-four of the 58 clinicians who responded to the question of which assessment method was most effective in their work did not respond to the question of what method they used most frequently. One plausible explanation for this rate of response is that some or all of these clinicians use the same method that they perceive as most effective in their work most often.

Regardless of the reason for this lack of response, it was clearly stated by 21 of the participants that the assessment method they perceived as most effective was not what they used most frequently. It is possible that these clinicians did not have sufficient time to conduct the type of assessments that they view as most beneficial. Those who work a limited number of hours per week may be especially likely to dedicate all of those hours to direct service. However, these results may reflect the need identified by Cassity and Cassity (1994) for assessment tools, specifically tools that are time-efficient and cost-effective.

When the therapeutic interventions reported in the literature are compared to those found in this study, many similarities are found. The interventions found most predominately in this study are mirrored in the literature: songwriting, drumming,

improvisation, and lyric rewrite. Integrated creative arts interventions were used by only 54% of the clinicians surveyed. In contrast, clinicians frequently described interventions that integrated multiple creative arts as highly effective. Likewise, relaxation (54%), musical role-playing (24%), and use of recording technology (free response by 3%) were integral to many highly effective interventions described, but used by relatively few clinicians in this survey, and not represented strongly in the literature.

Conversely, evidence that drumming improvisation was used in virtually all settings, with all populations, for all areas of need was found in the descriptions of highly effective interventions. This could be a function of the accessibility of this type of intervention to therapist and clients, or the availability of trainings to prepare therapists in undergraduate programs and continuing education settings.

Information and education

Therapist ratings of undergraduate experiences as inadequate in preparing them for work with high-risk youth leads to contemplation of how training could be made more efficacious. The low numbers of therapists using interventions that many others find to be highly effective may be the result of limited exposure to the interventions and lack of preparation for facilitating them. While therapists may be aware of the potential benefits of integrated creative arts and recording technology in practice with high-risk youth, these interventions may be out of the scope of their professional training and therefore out of their comfort zone. It was found in this study that practicum experiences may be a predictor of perceived adequacy of undergraduate training. This supports the idea that more in-depth, direct client work with a broad range of interventions may be an underdeveloped element of some training programs. It stands to reason that increased

practicum opportunities at the undergraduate level would be one way to address the issue of inadequate undergraduate training program ratings.

Assisting music therapists and students in learning where to find relevant resources to inform their practice could be another avenue for improving training. Music therapists reported seeking information from non-music therapy colleagues, music therapy conferences, and music therapy journals. In the last few years, the dissemination of information about therapeutic use of music with high-risk youth has expanded from North American music therapy journals to worldwide music therapy and youth literature, with sources now appearing online and in freely accessible (open access) formats.

The journals in which articles related to therapeutic applications of music with high-risk youth populations were found in the review of literature for this study are presented in Appendix E. This list includes more non-music therapy sources (10) than music therapy sources (7), and may provide assistance to therapists seeking information or possible publication venues. Two of these sources, the Canadian Journal of Music Therapy and Voices: A World Forum for Music Therapy, were completely open access online, while the Nordic Journal of Music Therapy and five of the non-music therapy sources offered selected issues or articles in an open access format. The only journals that did not provide free or paid access to articles online (outside of subscription databases) were the British Journal of Music Therapy, Journal of Music Therapy, Music Therapy, and Music Therapy Perspectives. Students, educators, and practicing therapists can benefit from increased awareness of where these and other relevant information can be accessed.

It is logical to focus attention on the internet when exploring ways to make relevant information accessible to clinicians, as there is a wealth of information available from online health and music therapy sources, much of it freely accessible to those without subscription database access. Only 53% of respondents to this survey report seeking any information related to their practice with high-risk youth online. Since this was a web-based survey, it can be assumed that all of the respondents have access to the internet. Sixty-five percent of music therapists surveyed reported consulting with music therapy colleagues in their work. This may indicate that the remaining 35% of therapists are isolated in some way and could potentially benefit from an online youth music therapist community. Continuing education related to a range of online resources could benefit a large number of music therapists.

This study established that the majority of clinicians are working just a few of their professional hours with high-risk youth. Music therapy resources developed for these clinicians should be easily accessible and contain practical information to assist therapists in their clinical work. The collection of material for a monograph or book detailing current issues of high-risk youth, trends in care, and how music therapists can be effective as agents of change may be a useful resource to develop in order to efficiently deliver a broad range of pertinent information to clinicians, educators, and students.

Therapeutic relationships with youth

The youth literature contained several studies confirming the idea that building therapeutic relationships is essential for positive treatment outcomes. In this survey, respondents described relationship development between therapist and client as well as

among peers as important factors in effective interventions. Other factors, such as engagement and safe environments, are also reflective of this emphasis placed on the development of relationships.

Safe environments require trust and respect. This must be present before emotional expression, risk-taking, leadership development, and meaningful discussion of treatment issues can take place. Identity formation, or reformation, increases in self-esteem, and coping skill development can be realized in non-threatening environments, once therapeutic relationships are established. All of these themes generated from the descriptions of effectiveness factors can be related to, and described as dependent on, the presence of effective therapeutic relationships. Establishing such relationships must be an integral part of discussions about music therapy practice with high-risk youth.

Conclusions and recommendations for future research

This exploratory study identifies several directions for future research. Implementation of the ideas set forth here would serve to further inform clinicians, educators, students, researchers, and policy-makers, as well as youth and their care providers. The conclusions outlined encompass recommendations for future research, education, networking, and advocacy related to music therapy practice with high-risk youth.

Research

The demographic data gathered in this study lays a foundation for future study of trends in this area of practice. Replication of this study in seven years, when the next generation of youth is being served, could assist in identifying changes related to areas of

need, treatment settings, goals, and interventions. The relationship of these elements of practice to the music therapy literature could be examined, as well as how the music therapy profession mirrors or differs from the directions seen in general psychosocial practices with high-risk youth. Innovations in youth music therapy practice could once again be identified and shared. Additional areas relevant for examination, provided this area of practice expands in the future, include identifying differences in practice of urban and rural clinicians, differences between Canada and the United States, new social issues germane to youth practice, reasons training programs are rated inadequate or superior, and applications of technology in practice.

Many issues relevant to current youth practice were identified through this study. Most of these were addressed through both the music therapy literature and the survey responses. However, some issues raised through the youth literature or survey responses were underrepresented in or completely absent from the music therapy literature. It is therefore recommended that research be conducted to explore effective practice with youth who are experiencing difficulties due to substance use, correctional system involvement, sexual offending, bereavement, sexual health, sexual orientation, and gender identity. Research on the role cultural awareness plays in high-risk music therapy practice could be highly beneficial.

Research is warranted to explore the potential of interventions such as integrated creative arts, musical role-playing, and recording. These interventions were included in multiple descriptions of highly effective interventions by the clinicians surveyed, but were not discussed as frequently in the literature as drumming, improvisation, songwriting, and lyric analysis. It will be an important step to identify, research, and

disseminate information about expanding ideas for interventions with this population as issues related to youth practice continue to change.

The topic of integrating technology into practice includes three major aspects: using technology in practical work, using technology to access resources, and using technology to reach youth who could benefit from services. All of these areas warrant attention through research with the goal of providing the most appropriate and effective services to those who are in need. The literature indicated that the youth of the "net generation" are online, and that is one place they seek out health information. The first step for engaging certain youth in music therapy services may be reaching out to them in their online community, rather than their physical community.

The information-seeking behavior of music therapists is a new area of inquiry, one which may best be approached through a study of the information needs and behavior of music therapists working across all areas of clinical practice and all treatment settings. Determining what online tools and resources music therapists engage with in and outside of work could assist in developing resources that will reach music therapists through platforms with which they are already familiar.

The youth literature contains a great deal of information about building therapeutic relationships with youth and the impact this has on treatment outcomes. Also explored is the idea that child and adult treatment models may not fit for youth, and that unique models are needed to meet youth needs. Examination of these theories, as well as the tenants on strengths-based practice, within the context of music therapy could provide a wealth of information for therapists to draw upon.

Education and resource development

The results of this survey indicate that increased educational opportunities through undergraduate training and continuing education programs could assist in better preparing music therapists to work with high-risk youth. The link between practicum experiences with high-risk youth and positive training program adequacy ratings indicates an opportunity to strengthen this area of practice through providing additional high-risk youth practicum experiences. Additional methods for expanding learning opportunities could include education on locating resources (including web-based information), as well as direct contact with high-risk youth through interviews or panel presentations.

Resource development is another key area for consideration. In addition to publication of individual research studies, a resource presenting a compilation of information relevant to music therapy practice with high-risk youth could be a valuable asset for student, educators, and clinicians. Such a resource could include: contemporary issues in high-risk youth practice, the role of music therapy in the continuum of youth care, how models of service for youth differ from those for children and adults, effective therapeutic relationships, assessment tools, descriptions of interventions, and information on locating relevant resources.

Networking is an issue that emerged from clinician responses related to information-seeking behavior. Only 65% of clinicians indicated consulting with other music therapists when looking for information about practice with high-risk youth. The possibility that this reflects isolation of some music therapists leads to the question of how to provide networking opportunities for music therapists who serve high-risk youth.

An online forum could provide a virtual resource through which resources, questions, research articles, and opportunities for jobs, funding, and research could be shared. Another arena in which to share many of the same ideas and resources could be roundtable discussions at music therapy conferences, with the idea of facilitating a crossover between these two forums, thus encouraging more clinicians to access the online network.

Promotion

The last area to be discussed in that of promoting music therapy services for high-risk youth. It is important to balance the publication of materials in the music therapy literature with publication in venues likely to be accessed by other helping professionals. Publishing resources in open access forums is likely to increase readership among students and professionals, especially those who are not associated with an institution that has access to subscription databases. Articles in peer-reviewed journals and in association newsletters for professions outside of music therapy could contribute to increased awareness and eventually a more established presence in practice with high-risk youth in areas such as juvenile corrections.

Information relating to music therapy practice with high-risk youth can be shared through workshops, community presentations, local media, and online forums serving to increase public awareness, including that of policy-makers, service providers, caregivers, and youth. Financial support provided by music therapy and other organizations could promote research to inform best practice in this area.

Reflections

Cycles of progress and regression in service provision for youth and other individual with psychosocial needs have been documented over the last 400 years (Goldman, 1990; Pratt, 1947; Rypins, 1948; Shorter 1997; Thompson, 1994). These cycles have been impacted by many factors, including changing philosophies for treatment, and availability of funding for facilities, education, research, and direct service. Clinicians, researchers, advocates, and clients who have fought for the rights of individuals in care have faced these challenges in different ways, but members of all of these groups have ultimately been successful in reducing barriers and improving the quality of services.

This study confirms that music therapists in the United States and Canada are using a broad range of therapeutic approaches in work with high-risk youth. Whether through drum circles or music video production, music therapists encourage youth to utilize their natural strengths and talents in order to share their stories. The therapeutic relationships developed through music foster experiences of self-awareness, self-expression, and identity formation, ultimately assisting youth in building capacities necessary to cope with future challenges. The growing body of youth music therapy literature provides evidence as to the efficacy of this modality. Continued research efforts, publication of resources, and increased educational opportunities for students, music therapists, other professionals, policy-makers, caregivers, and youth are important elements in advocating for continued and increased music therapy services for high-risk youth.

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Appendix A

Questionnaire

Music Therapy with High-Risk Youth

Exit this Music Therapy Survey >>

1. Welcome

Thank you for participating in this study on current music therapy practice with High-Risk Youth. This survey contains 29 questions and will take approximately 20 minutes to complete. Your browser back arrow will not work to move you to a previous page during this survey.

For the purposes of this study, High-Risk Youth are defined as:

Youth ages 12 through 18 who are likely to experience a decline in global level of functioning due to one or more issues related to:
- Mental Health
- Substance Use
- Other Social, Economic, or Cultural Factors such as correctional system involvement, street-involvement, unstable home environment, etc.

Excluded from this study are youth whose primary needs are related to a:
- Developmental Disorder
- Learning Disability
- Brain Injury
- Physical Disability or Disease

If you are a credentialed music therapist who has practiced with High-Risk Youth in the last 10 years in the United States or Canada, please respond to the survey questions based on your personal clinical music therapy practice.

If you have not practiced music therapy with High-Risk Youth in the last 10 years, please stop here. Thank you for your time.

Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

2. Demographic Information

1. Your age

2. Your gender

3. Country of practice (check all that apply)

- United States
- Canada
- Other(s) (please specify)

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

3. Experience

4. Years in clinical music therapy practice

5. Years in clinical music therapy practice with High-Risk Youth

6. When did you most recently practice with High-Risk Youth? (check only one)

- I currently practice with High-Risk Youth
- 2006
- 2005
- 2004
- 2003
- 2002
- 2001
- 2000
- 1999
- 1998

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

4. Education and Credentials

7. Degrees held (indicate field of study for all that apply; e.g. music therapy, music education)

Diploma in
Bachelor's in
Equivalency in
Master's in
PhD / Doctorate in

8. Professional Certifications, Accreditations, and Registrations (check all that apply)

- [ ] MTA
- [ ] MT-BC
- [ ] CMT
- [ ] RMT
- [ ] Other(s) (please specify)

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

5. Clinical Theoretical Orientation

9. Primary Clinical Theoretical Orientation (check only one)

- Cognitive-Behavioral
- Psychodynamic
- Holistic
- Humanistic
- Interpersonal
- Client-centered/Family-centered
- Strengths-based/Solution-focused
- Systems/Family Systems
- Feminist
- Multicultural
- Anthroposophic
- Eclectic/Integrated
- Other (please specify)

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

6. Hours in Clinical Practice

10. Hours per week currently practicing music therapy (check only one)

- 1-5
- 6-10
- 11-15
- 16-20
- 21-25
- 26-30
- 31-35
- 36-40
- 41 or more

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

7. Clinical Practice with High-Risk Youth

For the remaining questions in the survey, please base your responses on your current work with High-Risk Youth.

If you do not currently practice with High-Risk Youth, base your responses on your most recent professional experience with this population.

11. Hours per week practicing music therapy with High-Risk Youth (check only one)

- 1-5
- 6-10
- 11-15
- 16-20
- 21-25
- 26-30
- 31-35
- 36-40
- 41 or more

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

8. Funding and Treatment Settings

12. Treatment setting(s) where you practice music therapy with High-Risk Youth (check all that apply)

- Hospital
- Residential Treatment
- Correctional/Forensic Program
- Community-Based Program
- School-Based Program
- Private Practice
- Other(s) (please specify)

13. What sources provide funding for your position(s) working with High-Risk Youth? (check all that apply)

- Facility Budget
- Government Health Plan (e.g. Medicaid, TRICARE, Provincial Health Funding)
- Other Government Funding (e.g. Grants)
- Grants from Non-Government Source(s)
- Endowments
- 3rd Party Reimbursement
- Private Pay
- Don't Know
- Other(s) (please specify)

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

9. Areas of Need

14. What areas of need of High-Risk Youth do you address through music therapy treatment? (check all that apply)

- Mental Health Disorders
- Substance Use
- Trauma / Abuse
- Bereavement
- Refugee / New Immigrant
- Correctional System Involvement
- Sexual Offending
- Street-Involvement
- Other(s) (please specify)

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

10. Assessment

15. Which of these assessment methods do you use in your practice with High-Risk Youth? (check all that apply)

- Youth Interview / Self Assessment
- Review of Existing Records
- Treatment Team / Other Professional Consultation
- Observation outside of Music Therapy setting
- Observation within Music Therapy setting (e.g. improvisation, song choice)
- Music Therapy Assessment Tool
- Other Standardized Assessment Tool (e.g. Beck Depression Inventory)
- Other(s) (please specify)

16. What assessment method do you find most effective with High-Risk Youth?

17. What assessment method do you use most frequently with High-Risk Youth?

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

11. Goals

18. Which of these goal areas do you address in your work with High-Risk Youth? (check all that apply)

- Self-Expression
- Self-Esteem / Identity
- Self-Awareness
- Coping Skills
- Decision Making
- Behavior Management
- Social Interaction
- Communication
- Interpersonal Relationships
- Cultural Awareness
- Other(s) (please specify)

19. What two goal areas do you address most frequently with High-Risk Youth?

1
2

<< Prev | Next >>

20. Which of these interventions do you use with High-Risk Youth? (check all that apply)

- Song / Lyric Writing
- Improvisation
- Song Choice
- Drumming
- Listening
- Lyric Analysis
- Instrument Instruction
- Relaxation / Imagery
- Singing / Rapping
- Integrated Creative Arts (e.g. music with dance, visual art, or drama)
- Musical Games
- Musical Role Playing
- Other(s) (please specify)

21. What two interventions do you use most frequently with high-risk youth?

1
2

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

13. Clinical Training

22. Did you work with High-Risk Youth in any music therapy practicum experience?

- Yes
- No

23. Did you work with High-Risk Youth in any music therapy internship experience

- Yes
- No

24. How do you rate your undergraduate music therapy training program in preparing you to work with High-Risk Youth? (check only one)

- Superior
- Adequate
- Inadequate

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

14. Information Seeking

25. Where do you seek out information to assist you in your practice with High-Risk Youth? (check all that apply)

- Music Therapy Journals (e.g. Journal of Music Therapy, Canadian Journal of Music Therapy)
- Other Therapeutic Arts Journals (e.g. The Arts in Psychotherapy)
- Counseling / Social Work / Psych. Journals
- Dissertations / Theses
- Consultation with other Music Therapists
- Consultation with other Professionals
- Music Therapy Conferences / Workshops
- Other Conferences / Workshops
- Music Therapy Web Resources (e.g. Music Therapy World)
- Free Medical Web Resources (e.g WebMD, PubMed)
- Subscription Databases (e.g. Medline, PsycInfo, RILM)
- Internet Search Engines (e.g. Google)
- Other(s) (please specify)

<< Prev | Next >>

15. Highly Effective Intervention

Please describe a highly effective intervention you have used with High-Risk Youth.
Briefly describe the population, setting, and intervention, and tell why it was highly effective.

26. Description of Population

27. Description of Treatment Setting

28. Description of Intervention

29. What contributed to the effectiveness of this intervention?

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

16. Pilot Phase Feedback

Please provide feedback for the researcher on the length of time it has taken you to complete the survey and the clarity of the survey tool. All responses are greatly appreciated and will be used in in the survey tool revision process.

30. How long did it take you to complete the survey?

31. Please provide feedack relating to the survey tool.

<< Prev | Next >>

Music Therapy with High-Risk Youth Exit this Music Therapy Survey >>

17. Thank You!

Thank you for taking the time to complete this survey

Your responses are completely anonymous

<< Prev | Done >>

Appendix B

Letter of invitation to participate in pilot study

[E-mail Subject line: Music Therapy with High-Risk Youth]

[Name of pilot subject],

You are invited to participate in the pilot study for a research project designed to collect information related to music therapy practice with high-risk youth. This research is being conducted as part of thesis requirements for Beth Clark, for the degree Master of Music in Music Therapy, at Western Michigan University.

If you are a credentialed music therapist (MTA, MT-BC, RMT, CMT) who has practiced with high-risk youth within the last ten years in the United Stated or Canada, you are invited to participate by completing an online survey within the next week.

You will also be asked to answer questions relating to demographics, goal areas, assessment tools, treatment methods, and information seeking behavior. The survey is comprised of 29 multiple choice and free-response questions.

As a participant in the pilot phase of the project, you will be asked to answer an additional free response question to provide feedback to the researcher about the survey instrument. Please note the length of time it takes you to complete the survey to include in the feedback for the researcher.

Confidentiality will be maintained through the anonymous online survey format. Completing the online survey form indicates your consent for use of the answers you supply. Your responses will benefit clinicians and researchers through expanding the body of information available related to current music therapy practice with high-risk youth. The voluntary nature of the anonymous survey results in a minimal risk to participants. You may choose to not participate in this survey.

If you have any questions, you may contact Edward Roth, at 269.387.4679, or Beth Clark at 778.995.5735. To participate in this survey, please click on the link below. Thank you.

http://www.surveymonkey.com/s.asp?u=38503132662

Western Michigan University, Department of Music
Principal Investigator: Edward Roth, Student Investigator: Beth Clark
Study Title: Music therapy with high-risk youth: An investigation of current practice in the United States and Canada

Appendix C

E-mail invitation to participate and give consent

[E-mail Subject line: Music Therapy Current Practice Survey]

You are invited to participate in a research project designed to collect information related to music therapy practice with high-risk youth. This research is being conducted as part of thesis requirements for Beth Clark, for the degree Master of Music in Music Therapy.

If you are a credentialed music therapist (MTA, MT-BC, RMT, CMT) who has practiced with high-risk youth within the last ten years in the United Stated or Canada, you are invited to participate by completing an online survey within the next two weeks.

You will be asked to answer questions relating to demographics, goal areas, assessment tools, treatment methods, and information seeking behavior. The survey is comprised of multiple choice and free-response questions and will take approximately 15 minutes to complete.

Confidentiality will be maintained through the anonymous online survey format. Completing the online survey form indicates your consent for use of the answers you supply. Your responses will benefit clinicians and researchers through expanding the body of information available related to current music therapy practice with high-risk youth. The voluntary nature of the anonymous survey results in a minimal risk to participants. You may choose to not participate in this survey.

If you have any questions, you may contact Edward Roth, at 269.387.4679, or Beth Clark at 778.995.5735. You may also contact the Chair, Human Subjects Institutional Review Board (269-387-8293) or the Vice President for Research (269-387-8298) if questions or problems arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner of the consent document attached to this e-mail. Do not participate in the study if the stamped date is older than one year. (Approval date: March 22, 2007)

To participate in this survey, please click on the link below. Thank you.
http://www.surveymonkey.com/s.asp?u=38503132662

Western Michigan University, Department of Music
Principal Investigator: Edward Roth, Student Investigator: Beth Clark
Study Title: Music therapy with high-risk youth: An investigation of current practice in the United States and Canada

Appendix D

HSIRB application and approval letter

WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board

APPLICATION FOR PROJECT REVIEW

I. REQUIRED HUMAN SUBJECTS WEB-BASED TRAINING AT www.citiprogram.org must be completed before HSIRB can approve this protocol.

II. PROJECT TITLE: Music therapy with high-risk youth: An investigation of current practice in the United States and Canada

III. INVESTIGATOR INFORMATION

WMU INVESTIGATORS

PRINCIPAL INVESTIGATOR OR ADVISOR

Name: Edward Roth Department: MUSIC Title: Assistant Professor
Degree Attained: MM
Email Address: edward.roth@wmich.edu
Street or Campus Address: School of Music, Western Michigan University
City: Kalamazoo State: MI ZIP: 49008
Office Phone: 269.387.4679 Home Phone: 269.373.0426
Human Subjects web training at www.citiprogram.org completed: Yes

CO-PRINCIPAL OR STUDENT INVESTIGATOR

Name: Beth Clark Department: MUSIC Title: Select one
Degree Attained: MM
Email Address: musictherapy.bc@gmail.com
Street or Campus Address: 1809 McSpadden Ave
City: Vancouver State: BC ZIP: V5N1L3 Canada
Office Phone: 778.995.5735 Home Phone: 604.225.5735
Human Subjects web training at www.citiprogram.org completed: Yes
Status and level of involvement of student investigator:

☐ Undergraduate ☒ Master level ☐ Doctoral level
☐ Assisting ☒ Thesis ☐ Dissertation ☐ Other (please specify):

CO-PRINCIPAL OR STUDENT INVESTIGATOR

Name: Department: Title: Select one
Degree Attained:
Email Address:
Street or Campus Address:
City: State: ZIP:
Office Phone: Home Phone:
Human Subjects web training at www.citiprogram.org completed: Select one
Status and level of involvement of student investigator:

☐ Undergraduate ☐ Master level ☐ Doctoral level
☐ Assisting ☐ Thesis ☐ Dissertation ☐ Other (please specify):

If there are more WMU investigators, please complete the "Additional WMU Investigators" form

COLLABORATING INVESTIGATORS AND AFFILIATIONS

Name: Affiliation:
Name: Affiliation:
Name: Affiliation:

IV. PROPOSED PROJECT DURATION:

From (mm/dd/yy): 04/01/07 (date following anticipated approval) To (mm/dd/yy): 12/30/07 (maximum one year later)

V. TARGETED PARTICIPANT POOL

Total number of subjects: 1300 Number of subjects in the control group: 0
Age range (lower limit – upper limit, e.g., 18-99): 18-99
Gender: Both
Targeted Race/Ethnicity: None/Not applicable
Inclusionary criteria: Music Therapists, registered or certified, and practicing in the United States or music therapists accredited and practicing in Canada currently, or within the five years prior to the survey
Exclusionary criteria: Music therapists who have not practiced within the last five years, or music therapists who are not credentialed (registered, certified, or accredited)
Source of participants: Membership directories of the American Music Therapy Association and the Canadian Association for Music Therapy
Length of participation (x min/session, y sessions, over z months): 20 minute one-time participation to complete online questionnaire

Targeted Participants in Special Consideration Categories: (Check all that apply.)

☒None ☐Military personnel
☐Children (age range:) ☐Wards
☐Cognitively impaired persons ☐Institutionalized individuals
☐Prisoners ☐Non-English speaking individuals
☐Pregnant or lactating women ☐Students
☐Blind individuals
☐Other subjects whose life circumstances may interfere with their ability to make free choice in consenting to take part in research (please specify):

VI. FUNDING

Funding source: None No funding source
WMU proposal number for funded project: 0
Date of submission to funding agency: N/A

VII. RESEARCH SITE(S)

Site(s) and organizations involved in data collection and/or research activity: WMU
Letters of approval from project site officials: are not needed (research on-campus).

VIII. Protocol Outline

Prepare and attach a proposal that follows the outline below. NUMBER YOUR PAGES. Do not submit your thesis or dissertation proposal, grant application, etc. Please review your proposal and mark each box below with a ☒ following review of that section.

☒**ABSTRACT:** One page maximum.

☒**PURPOSE/BACKGROUND INFORMATION:**

☒**SUBJECT RECRUITMENT:** Describe in detail how you intend to contact and recruit participants. Attach all written advertisements, posters and oral recruitment scripts.

☒**INFORMED CONSENT PROCESS:** Describe the process by which informed consent will be obtained. If the participant is a child or mentally challenged, explain how the parent(s)/guardian(s) will be contacted for consent and how the researcher will insure that the participant understands and assents to the research.

☒**RESEARCH PROCEDURE:** (including what exactly subjects will do as part of the study), Method of data collection, Instrumentation, Location of data collection, and Duration of the study.

☒**METHODOLOGY:** Design, Analysis, and Dissemination (e.g., thesis, dissertation, peer-reviewed journal, presentation).

☒**RISKS AND COSTS TO AND PROTECTIONS FOR SUBJECTS:** Describe the nature and likelihood of possible risks (e.g., physical, psychological, social, economic) so far as they are known. Risks include mild discomforts, inconveniences, and potential for disclosure of sensitive information. Describe measures to be taken to protect subjects from possible risks or discomforts.

☒**BENEFITS OF RESEARCH:** Briefly describe the expected or known benefits of the research. Indicate benefits specific to the research participant, longer term or more general benefits, and benefits to the knowledge base.

☒**CONFIDENTIALITY OF DATA:** Describe precautions to ensure the privacy of subjects and confidentiality of information. Be explicit if data are sensitive. Describe coding procedures for subject identification. Include the method, location and duration of data retention. (Federal regulations require data to be maintained for at least 3 years. Your professional society may require you to keep it longer.)

☒**APPENDICES:** Attach questionnaires, interview scripts, and data collection instruments, etc. Attach coding sheets for video- or audio-tapes and other data collection procedures. Attach a copy of all consent/assent documents, including non-English and Braille translations, if applicable.

IX. CONSENT DOCUMENT DEVELOPMENT CHECKLIST

The following information must be included in the consent documents. Mark (☒) each of the requirements you have included. Omitted information must be justified on a separate sheet of paper. Sample consent documents are posted on the HSIRB WebPage under Consent/Assent Document Development.

GUIDELINES

☒Leave a minimum top margin of 2 inches on all pages. Submit the final version of the consent document without headers such as "Draft" or "Appendix___."

☒Language in the form of an invitation to participate AND at a reading level appropriate for the participants (Note that the mean reading level in the United States is 6th grade.)

☒Do not include phrases like "I am aware" or "I understand" anywhere in the document.

☒Do not include language that would absolve the researcher of responsibility for negligence

REQUIRED COMPONENTS

☒A header that includes "Western Michigan University, Department of _____" (if departmental letterhead is not used), Principal Investigator: (name), Student Investigator: (name(s)), and title of the study.

☒The nature, purpose, and duration of the study

☒Procedures to be employed in the research; exactly what the subject is expected to do

☒Risks (hazards, inconveniences, discomforts) the subject may undergo, so far as they are known, and how any risks will be minimized

☒Benefits to the subject (and to the general subject population)

☒Conditions of participation

☒How confidentiality will be maintained and any limits to confidentiality

☒Statement that the participant can refuse to participate; stop participating at any time; or refuse to answer any question without prejudice, penalty, or risk of any loss of service he/she would otherwise have

☒The researchers' names and telephone numbers (including the faculty advisor) as well as the following statement: *"You may also contact the Chair, Human Subjects Institutional Review Board (387-8293) or the Vice President for Research (387-8298) if questions or problems arise during the course of the study."*

☐A place for date and signature of participant and a witness line, if required (e.g., with subjects who are not legally competent); a place for date and signature of translator, if applicable; a place for date and signature (or initials) of individual obtaining the consent, if applicable

☒The following statement must be included in all consents: *"This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year."*

The following are only to be included if appropriate:

☐If there is physical activity or a possibility of physical injury, include the statement: *"As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to you except as otherwise stated in this consent form."* Any available compensation or additional treatment should then be specified, if appropriate.

☐If the research is therapeutically related, disclose alternate procedures the subject might choose.

☐Any significant new findings affecting risks will be promptly reported to the participant.

☐Circumstances under which the researcher may terminate the subject's participation

☐Any additional costs the participant may have to bear

☐Consequences of the participant's withdrawal from the study

☐The approximate number of participants in the study

☐Debriefing procedures

X. LEVEL OF REVIEW

☒ **Administrative or Expedited:** This project does not require a full board review because it meets at least one of the following criteria: data collection is anonymous

Forward the **original** application to the office of the research compliance coordinator, 251W Walwood Hall.

☐ **Full:** Forward **original** application plus 15 copies to the office of the research compliance coordinator, 251W Walwood Hall.

If blood products are involved, you must complete and attach the HSIRB collection of blood and blood products form.

Your application must be in the research office by 5:00 pm on the first Wednesday of the month in order to be reviewed at the board meeting on the third Wednesday of that month.

XI. CERTIFICATION/SIGNATURE

I certify that the information contained in this HSIRB application and all attachments is true and correct. I certify that I have received approval to conduct this research from all persons named as collaborators and from officials of the project sites. If the Human Subjects Institutional Review Board approves this proposal, I agree to conduct the research according to the approved protocol. I agree not to implement any changes in the protocol until such changes have been approved by HSIRB. If, during the course of the research, unanticipated risks or harm to subjects are discovered, I will report them to HSIRB immediately.

_____ _____

Principal Investigator/Faculty Advisor Signature Date

_____ _____

Co-Principal or Student Investigator Signature Date

_____ _____

Co-Principal or Student Investigator Signature Date

_____ _____

Co-Principal or Student Investigator Signature Date

Abstract

This study explores the practices of music therapists in the United States and Canada who have worked with high-risk youth within the past ten years. High-risk youth as a population are defined for this study as youth likely to experience a decline in global level of functioning due to one or more issues related to mental health, substance misuse, or other social, economic, or cultural disadvantages, including correctional system involvement, street-involvement, or unstable home environment.

An online survey has been designed to obtain demographic and clinical practice information as well as information related to information-seeking behavior of credentialed music therapists practicing in the United States and Canada. Music therapists working with high-risk youth will be asked to identify the most common areas of need, goal areas, assessment methods, and interventions used with this population. Finally, these music therapists were invited to describe an intervention that was highly successful in meeting the needs of high-risk youth.

A pilot of the survey tool with three music therapists having experience working with the population and in conducting graduate level music therapy research indicated that the survey tool was clear and comprehensive. Synthesis of the results and examples will be presented with discussion related to the need for further research in the area of music therapy with high-risk youth.

Purpose/Background Information

The distinct needs of youth have been recognized by health practitioners and policy makers for over a century. The mental health movements in the United States and Canada have followed similar courses over this period of time, and the music therapy literature reflects that clinicians in both countries are working presently with high-risk youth.

The music therapy and general health literature both reflect recognition of the effectiveness of the therapeutic music interventions with youth populations. Studies published in peer-reviewed journals indicate that music therapists, social workers, and other health professionals understand the potential of music therapy as an effective agent for assisting youth with a diversity of needs (Baker & Jones, 2005; Currie, 2004; Dalton & Krout, 2005; Frank, 2005; Keen, 2004; Tervo, 2001). Music therapy is used in mental health, oncology, substance misuse, and bereavement programs for adolescents (McFerran-Skewes, 2004). Music therapy research published in the United States and Canada indicates that youth who are at-risk, aggressive, or juvenile offenders are also benefiting from music therapy programs (Buchanan, 2000; Rickson & Watkins, 2003; Rio & Tenney, 2002; Wyatt, 2002). The global music therapy literature reveals programs targeted at meeting the needs of youth refugees and youth involved in gangs, as well as those experiencing schizophrenia, trauma, and body image issues (Fouche & Torrence, 2005; Baker & Jones, 2005; Frank, 2005; Ruutel, 2004).

Studies indicate that clinicians are using music in their work with youth who are considered "at-risk" or "high-risk" (Buchanan, 2000; Nelson, 1997). While these terms are used without standard definition, they generally refer to youth who are served by mental health, substance use, street-involved, and correctional programs (Springer, Sale, Herman, Soledad, Kasim, & Nistler, 2004; Keating, Tomishina, Foster, & Alessandri, 2002; Ungar, 2000). Youth often align with more than one of these general categories, making it both impractical and illogical to separate them. Instead the term "high-risk youth" may be used as a general term to describe a cohort of youth that is distinct from the general population, and distinguishable from those whose primary areas of need relate to developmental disabilities, learning disabilities, or physical disabilities or diseases.

No studies were found in the extant literature that sought to explore the state of current practice of music therapists specifically with high-risk youth. Studies related to this clinical population in the music therapy literature provide strong support for the application of music therapy with high-risk youth around the globe (Baker & Jones, 2005; Buchanan, 2000; Frank, 2005; Gardstrom, 2003; Rio & Tenney, 2002; Wyatt, 2002). However, the limited number and the scope of these studies do not provide a comprehensive picture of the treatment settings and needs of youth currently being served, or of the demographics and needs of clinicians engaged in this type of practice. An exploratory study surveying music therapists is warranted in order to provide information to clinicians, educators, students, researchers, and policy-makers, as well as youth and their care providers.

A survey of music therapists will assist in identifying demographic information, common treatment issues, assessment and treatment practices, successful interventions, and information seeking behavior. This will benefit the music therapy profession through assisting students who are preparing to enter the field, educators in training programs, clinicians developing their practices, and researchers working toward identifying best practice standards. Ultimately it is the youth of the United States and Canada who will benefit from clinicians who have a broader understanding of how others in the profession are finding success in their work.

References

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Buchanan, J. (2000). The effects of music therapy interventions in short-term therapy with teens at risk: An opportunity for self-expression in a group setting. *Canadian Journal of Music Therapy, 7(1),* 39-50.

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Subject Recruitment

The participants selected for this study are credentialed music therapists currently practicing in Canada or within the fifty United States. Qualifying music therapy credentials include Music Therapist Accredited (MTA), Music Therapist-Board Certified (MT-BC), Certified Music Therapist (CMT), and Registered Music Therapist (RMT). The music therapist must have been employed as a clinician working part-time or full-time with high-risk youth within ten years of the date of completing survey.

The sample for this study includes all members of the Canadian Association for Music Therapy (CAMT) and members of the American Music Therapy Association (AMTA) likely to work with high-risk youth. Because neither professional association lists which music therapists were working with high-risk youth in their membership directories (Member Sourcebook, 2006; Membership Directory, 2006), it is not possible to form a representative sample. AMTA members listed in the Membership Sourcebook (2006) as working with the following populations were included in the study as they were considered by the to be likely to work with high-risk youth: abused/sexually abused, AIDS, behavior disorder, dual diagnosed, eating disorder, emotionally disturbed, forensic, non-disabled, other, PTSD, school age, and substance abuse. All members of CAMT were contacted because the Membership Directory (2006) does not indicate populations served by each clinician.

Those without e-mail addresses listed are not included in the study, as the survey format is an online survey, and this subset of music therapists represents less than fifteen percent of the available sample listed in the membership directories (Member Sourcebook, 2006; Membership Directory, 2006).

Subjects will be contacted via e-mail and invited to complete the anonymous, online survey. The e-mail (Appendix A) will have the HSIRB letter of approval attached.

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Informed Consent Process

In the e-mail letter of invitation to participate in the survey, the following excerpt appears:

> You will be asked to answer questions relating to demographics, goal areas, assessment tools, treatment methods, and information seeking behavior. The survey is comprised of multiple choice and free-response questions and will take approximately 15 minutes to complete.
>
> Confidentiality will be maintained through the anonymous online survey format. Completing the online survey form indicates your consent for use of the answers you supply. Your responses will benefit clinicians and researchers through expanding the body of information available related to current music therapy practice with high-risk youth. The voluntary nature of the anonymous survey results in a minimal risk to participants. You may choose to not participate in this survey.
>
> If you have any questions, you may contact Edward Roth, at 269.387.4679, or Beth Clark at 778.995.5735. You may also contact the Chair, Human Subjects

Institutional Review Board (269-387-8293) or the Vice President for Research (269-387-8298) if questions or problems arise during the course of the study.

Research Procedure

Subjects will follow the link from the e-mail message to the online survey. They will answer 29 multiple choice and free response questions. No identifying data is collected through the survey.

The survey will be open for response for no longer than one month. The data will stored on SurveyMonkey.com until one month after the survey has been closed. Data will be downloaded to the researcher's computer for analysis.

Methodology

Due to the limited number of recent investigations into the clinical practices of music therapists with high-risk youth, a survey-based, mixed-method exploratory study was designed. The survey instrument was designed to collect both demographic and clinical practice data for quantitative analysis, and narrative responses relating to effective practice for qualitative analysis.

A self-administered online survey format was selected for this study for several reasons. First, online questionnaires are efficient for the participant to receive, complete, and return. Second, data is compiled instantaneously through the online system and readily available for analysis by the researcher. The nature of the study's examination of current practice makes it important to disseminate results efficiently in order to provide relevant information to the music therapy community. Third, the number of invalid responses can be minimized through an online survey because the online instrument enforces compliance with question format.

Finally, this is a cost efficient method of surveying (Wigram, 2005), allowing for a large participant pool. This is of great importance in this study because there was no published information found identifying music therapists who work with high-risk youth. Therefore, self-identification from the greater population of music therapists was concluded to be the most feasible method of attaining the largest possible sample for the investigation, although it is recognized that this method will not allow for calculation of response rate.

A questionnaire was developed through the review of literature related to music therapy with youth. Through the literature review process areas of need, goals, assessment methods, and interventions included in each study were recorded, categorized, and used to formulate the list of commonly identified items for music therapists to select from when completing the questionnaire. (Appendix B, or http://www.surveymonkey.com/s.asp?u=38503132662)

In this exploratory investigation it is recognized that reviewing the body of extant literature for this diverse area of practice might not yield all of the information needed to design an effective survey tool. The concern that the list of treatment needs, goals, assessment methods, and music therapy interventions generated through a review of published studies would be incomplete was through providing options for the participant to indicate unique responses. Second, an open-ended survey question asked the high-risk youth practitioners to identify a highly effective intervention used in practice. This qualitative inquiry was intended to provide greater insight into the settings and specific populations various interventions are being used with, and with what results.

The survey instrument was piloted with three music therapists who were experienced in working with high-risk youth and in conducting graduate level research. The instrument was judged to be thorough, clear, and concise. One subject stated that she "liked the last question best as it was specific and provided one good example of what really works." No changes were made to the instrument as a result of the pilot study.

The quantitative portions of the questionnaire will yield nominal data. Descriptive statistics of mean, median, mode, variability, and if ample size warrants, correlation will be calculated. This will allow for identification of trends related to demographic information, treatment settings, specific populations, assessment and treatment procedures, and information-seeking behavior. Descriptive statistics will be reported for age, gender, ethnicity, years in practice, degreed held, advanced trainings completed, country of practice, primary clinical theoretical orientation, hours practicing music therapy, hours practicing with high-risk youth, funding sources, treatment settings, subpopulations, areas of need, assessment methods, treatment interventions, practicum experience, internship experience, training program adequacy, and information seeking behavior. Correlations will be calculated if the sample size is large enough.

Direct reporting of responses as well as constant comparative method of analysis are selected to interpret the results of the free response questions regarding highly effective interventions. The process of ongoing coding, sampling, and comparing, ultimately allowed for synthesis of data into theories intended to give direction to future research in the area of music therapy with high-risk youth populations.

The results of this study will be published in the form of a Master's thesis, submitted for publication peer-reviewed journals, and for presentation at conferences for music therapy and related professions.

Risks and Costs to and Protections for Subjects

No risks or costs to the subjects are foreseen, as it is the choice of the subject to complete the anonymous online survey.

Benefits of Research

This study will assist clinicians, including those who participate as subjects in the study, in developing their clinical practice with high-risk youth by providing information about the treatment methods of others in the field. It will also provide information useful in guiding future research and in informing the development of educational programs.

Publication and presentation of this information will serve to inform youth, parents, advocates, health professionals in other disciplines, administrators, and policy-makers of the benefits of music therapy for high-risk youth populations. Knowledge of information-seeking behavior on the part of music therapists working with high-risk youth will assist in determining the most effective formats to make information available. Ultimately it is high-risk youth who benefit from the sharing of information related to interventions effective in meeting their needs.

Confidentiality of Data

No identifying information is collected in this study. The e-mail address used to contact each subject is in no way linked to the results, making the process anonymous. Data will be stored on the researcher's password protected computer.

Appendices

E-MAIL INVITATION TO PARTICIPATE AND GIVE CONSENT
[E-mail Subject line: Music Therapy Current Practice Survey]

Western Michigan University, Department of Music
Principal Investigator: Edward Roth, Student Investigator: Beth Clark
Study Title: Music therapy with high-risk youth: An investigation of current practice in the United States and Canada

You are invited to participate in a research project designed to collect information related to music therapy practice with high-risk youth. This research is being conducted as part of thesis requirements for Beth Clark, for the degree Master of Music in Music Therapy.

If you are a credentialed music therapist (MTA, MT-BC, RMT, CMT) who has practiced with high-risk youth within the last ten years in the United Stated or Canada, you are invited to participate by completing an online survey within the next two weeks.

You will be asked to answer questions relating to demographics, goal areas, assessment tools, treatment methods, and information seeking behavior. The survey is comprised of multiple choice and free-response questions and will take approximately 15 minutes to complete.

Confidentiality will be maintained through the anonymous online survey format.

Completing the online survey form indicates your consent for use of the answers you supply. Your responses will benefit clinicians and researchers through expanding the body of information available related to current music therapy practice with high-risk youth. The voluntary nature of the anonymous survey results in a minimal risk to participants. You may choose to not participate in this survey.

If you have any questions, you may contact Edward Roth, at 269.387.4679, or Beth Clark at 778.995.5735. You may also contact the Chair, Human Subjects Institutional Review Board (269-387-8293) or the Vice President for Research (269-387-8298) if questions or problems arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner of the consent document attached to this e-mail. Do not participate in the study if the stamped date is older than one year. (Approval date:)

To participate in this survey, please click on the link below. Thank you.
http://www.surveymonkey.com/s.asp?u=38503132662

(See Appendix A for complete Questionnaire)

WESTERN MICHIGAN UNIVERSITY
Human Subjects Institutional Review Board

Date: March 22, 2007

To: Edward Roth, Principal Investigator
Beth Clark, Student Investigator for thesis

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 07-03-26

This letter will serve as confirmation that your research project entitled "Music Therapy with High-risk Youth: An Investigation of Current Practice in the United States and Canada" 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: March 22, 2008

Walwood Hall, Kalamazoo, MI 49008-5456
PHONE: (269) 387-8293 FAX: (269) 387-8276

Appendix E

Descriptions of highly effective interventions

1	**Description of Population** I only work with adolescents on a one-to-one basis. One of the best of these was with an older teenage male who already possessed very fine guitar skills. **Description of Treatment Setting** This is a state psychiatric hospital which includes one building that houses children and adolescents and one building which is their school. **Description of Intervention** In this case, self expression was very important to the patient. Most of each session was spent allowing him to improvise on guitar. Some instruction on basic piano skills was also done at his request. Just getting to play the guitar for about an hour was something he considered highly therapeutic. This led to discussions about coping skills and decision making. **What contributed to the effectiveness of this intervention?** We stress to our patients the importance of not allowing their past to determine their entire future. This young man was discharged with what seemed to be a much more hopeful sense of a positive future.
2	**Description of Population** middle school aged students [identified] with severe emotional disturbances and other health impairments **Description of Treatment Setting** K-8 SED special education school focused on therapy and academics. students seen in the music room in groups of 6-10 **Description of Intervention** various interventions used - primary focus on behavior management, self-worth, responsible for self, social skills.....different music techniques are used to meet this needs **What contributed to the effectiveness of this intervention?** student pride and ability to work with others proves effectiveness of each intervention
3	**Description of Population** High-Risk Youth within a pediatric acute mental health setting. Age range from 5-17, various mental health diagnoses: i.e. conduct disorder, suicide ideation, depression, bipolar, schizophrenia, adjustment disorder. Average stay 5 days to 3 weeks. Frequent social and placement issues, [English] as a second language issues. **Description of Treatment Setting** Two acute mental health units; I provide a weekly, open group on each unit, [approximately] 30 minutes in duration. They receive daily recreation activity, OT (consult basis), Psychology (consult basis), daily school provided by a teacher and regular meetings with the unit psychiatrist, regular contact with unit nurses. **Description of Intervention** Because I run a short, open group, I have to be responsible and ethical in the activities I choose. My group is usually an activity-oriented group with some insight-oriented [activities] integrated. I use musical games to help establish rapport

	and to increase level of participation. I do get some feedback from the participants as to whether they would like to use instruments or to choose and listen to songs of their choice (includes lyric analysis) in order to provide them some choices and to get them involved. **What contributed to the effectiveness of this intervention?** The games help establish a rapport with the participants and very quickly gets them involved. In addition, those who appear to be withdrawn even participate on some level. The song choice and lyric analysis are highly effective because it gives them the opportunity to share what is important and meaningful to them and I listen with open ears...always asking questions to help understand their ideas and feelings. In this way, I glean what is important to them, the role music has in their life, what are their support systems, how the music reminds them or connects them with people in their life, the influence of pop/music culture etc…
4	**Description of Population** Teens in addictions recovery. Drug users, drug dealers and gang bangers. But really sweet kids when you get them 1:1 away from all the junk. **Description of Treatment Setting** a Residential treatment [facility] /boarding school for teens with addictions and other serious behaviour problems. Family and wilderness therapy form the core of the program. **Description of Intervention** 1) Encourage youth to write original raps expressing something relevant to current situation. 2)With the guidance and approval of the youth the therapist constructs high quality beats (rap soundtracks not just drums) using professional audio production software such as REASON 3.0, CUBASE SX 3, a variety of VSTi plug ins, and outboard hardware [synthesizers]. 3) Set up mics, preamps, headphones, and get the youth to rap over the beats that have been co-produced. 4) Use Cubase to edit together a perfect take as needed.. 5) Mix and master the recording with input from the youth as much as possible **What contributed to the effectiveness of this intervention?** Professional CD quality creative product On a number of occasions the pride that the youth had in the CD created in MTX was instrumental in [catalyzing] a reconnection with parents on departure from treatment facility
5	**Description of Population** Elementary age - Emotional/Behavior Disorder, Large % of the kids are low income, African American children. **Description of Treatment Setting** Special Education school setting **Description of Intervention** Lyric Analysis - Listen to a song, lyrics are typed up with blank lines after lines. Students listen to the song in silence while reading the lyrics, song is played again and paused during the song for the students to [reflect] their thoughts about the line that was just sung. Class discussion is held afterwards. **What contributed to the effectiveness of this intervention?** Self reflection, self realization, communication with peers, greater understanding of

	peers and students, increased self-esteem, increased knowledge/appreciation of different genres of music. and more.
6	**Description of Population** ages 5-13; crisis situation, ODD, ADD, ADHD, Bipolar, Depression **Description of Treatment Setting** Pediatric In-patient psychiatric unit **Description of Intervention** turn taking structure allowing each participant who is willing to "conduct" the other "players" with a limited set of hand signs **What contributed to the effectiveness of this intervention?** opportunity for control of other patients and staff who participate, expression
7	**Description of Population** high-risk youth glorifying street [violence] a.k.a. Thug Life (ala Tupac Shakur) **Description of Treatment Setting** residential treatment center **Description of Intervention** residents write raps about treatment issues...record [using] adbaced recording studio technology...[analyzed results] periodically and compare as treatment continues...use to see where "the resident is at" during [treatment] **What contributed to the effectiveness of this intervention?** "rapping" and "being in the lab (recording studio)" is VERY exciting and [motivating] for my patients
8	**Description of Population** Law offenders...Behavior problems, inappropriate interaction with other. **Description of Treatment Setting** For Behavioral Problem YOuth **Description of Intervention** Improv with Orff instruments for ensemble work and interaction with others, taking turns etc. Lyric Analysis is effective with limts sets on songs. Drumming for self expression and venting emotions. **What contributed to the effectiveness of this intervention?** Music involvement...personality of therapist. selections of the right kind of music. Some preference is okey.
9	**Description of Population** Currently: Private psych. hospital. Mainly dial diagnosis (addictions + mental illness)12-17 y/o, some with charges pending. **Description of Treatment Setting** Home-like atmoshpere. Residential (3 weeks +, but not usually longer than 8 months). Milieu therapy, school setting 8-10:30 & 1-3:30, Rehabilitation groups (gym, outside, swimming, relaxation group, self-awareness group, walking, craft room), group therapy, individual therapy, DBT training, CBT training, Chemical Dependency track, Agenda meeting (pts. talk about their issues w/one another at end of day-mimics good skills for talking w/family at home) Non-acute setting, but structured. **Description of Intervention**

	Team building activities: Musical conversations-have a variety of rhythm instruments available and ask for 2 volunteers to choose one instrument. Ask them to sit directly across from one another. Their task is to hold a conversation using only their instrument. They will have to determine how & when they will start and finish without using their voices or gesturing. Onlookers are asked to observe body language, facial expressions, share their observations w/others. This session allows everyone to observe how people communicate naturally and learn to read facial expressions & body language. **What contributed to the effectiveness of this intervention?** It allows everyone a chance to participate both actively and passively. Individuals learn that sharing their observations aren't "good" or "bad", it's their interpretation of things. We always check with the 2 who played, if our observations are correct. We also try to connect what we observe to what we observe on a daily basis with our patients.
10	**Description of Population** Students age 8-14 w/behavioral & emotional disorders **Description of Treatment Setting** non-public school **Description of Intervention** I often use Drum Circles (based on a mixture of the Arthur Hull and HealthRhythms trainings) Students take turns being the leader - I give them a small goal (i.e. each student gets in the middle, invites students in 1 by 1, cuts out all but 3, then does a countdown) and each student HAS to do this (non-verbal directions.) After each students turn, his/her peers give them feedback (one positive, one constructive criticism) and the leader can not comment back. **What contributed to the effectiveness of this intervention?** At first, the students have a difficult time with not using their words and with receiving criticism/compliments without being able to remark back. After a little while they are able to do this and learn to incorporate the feedback. Student also have a hard time giving compliments without making it about themselves (i.e. "you did a great job of leaving the best person playing at the end", etc.)
11	**Description of Population** In patient adolescent psychiatry **Description of Treatment Setting** 15 bed unit within large metropolitan general medical hospital **Description of Intervention** Mandalas - patients given blank paper with a circle drawn on it. Live music was played while patient encouraged to connect to colors that express her/his feelings. Music used to support, and connect to time and place while encouraging pt to reflect on self **What contributed to the effectiveness of this intervention?** Live music and permission to explore colors, not draw specifics if they don't emerge. Non-verbal until mandala completed, then kid can share. Usually kids like to discuss something about their mandala, and almost always, kid comments on relaxed feeling w/live music provided

12	**Description of Population** Girls in a residential setting, sex offenders unit **Description of Treatment Setting** Residential setting. treated in MT office **Description of Intervention** music assisted relaxation **What contributed to the effectiveness of this intervention?** client's belief in the effectiveness and valuing of the intervention
13	**Description of Population** 5th/6th graders on a special campus. Mostly male. **Description of Treatment Setting** Educational campus. **Description of Intervention** Team composition. Not only do students write the music/song, but they collaborate on which instruments to include, and how to include or accompany. **What contributed to the effectiveness of this intervention?** Students work together on a music project, which is motivating in itself. They learn to compromise/collaborate on an end product that they had a part in, and can claim ownership of: self-esteem. Facilitates comraderie in working toward a common goal. Thus, they improve social skills.
14	**Description of Population** adolescent poly-substance abusers **Description of Treatment Setting** day treatment center- last attempt to stay out of adult psychiatric placement **Description of Intervention** group work- had a each client bring in a musical contribution to share and discuss **What contributed to the effectiveness of this intervention?** content/ topic of sessions decided by individual group participants- client centered
15	**Description of Population** I teach them songs, [keyboard], recorder and choreographed dances **Description of Treatment Setting** school **Description of Intervention** above **What contributed to the effectiveness of this intervention?** my personality
16	**Description of Population** At-Risk Females-ages 12-18 **Description of Treatment Setting** In-patient psychiatric facility **Description of Intervention** Singing with them--usually popular or seasonal songs. **What contributed to the effectiveness of this intervention?** The familiarity and memories attributed to the songs themselves. Allowing the pts to choose their own music is crucial with this population.

17	**Description of Population** High Risk Youth (ages 12-17) **Description of Treatment Setting** (individual or small group) Inpatient psych or Intensive outpatient programs. **Description of Intervention** Music Interview.. Give client(s) a good variety of music CD's and cassette tapes (approx. 80) and ask them write an interview of [themselves]. The client writes a question and then finds the answer in a clip from a song. Each question is then recorded with the clip to follow. The interview is then used to help the clients describe his/her feelings to parents/peers/therapists/doctors/teachers, etc. **What contributed to the effectiveness of this intervention?** The process creates a very fun and non-threatening way of allowing the client to discuss some difficult feelings or situations. The process is very engaging and the outcome is quite often very powerful and helpful to the family and treatment team.
18	**Description of Population** Elementary school students in a self contained classroom due to emotional disturbances/behavior disturbances that kept them from being successful in regular classroom. **Description of Treatment Setting** Self contained classroom in an elementary school **Description of Intervention** The intervention was a music passing game that involved getting an object around the circle a predetermined about of times before the song ended (I sang the song). This strategy facilitated goal setting in that they set a goal for the number of times they wanted to get the object around the circle. If they met the goal we talked about how it felt and then set a higher goal. If they did not meet the goal we talked about why they didn't and how they could make it better. **What contributed to the effectiveness of this intervention?** The live music was a huge [contributor] and I could manipulate (ever so slightly) the amount of time they had to meet their goal. Sometimes I felt that it was important for them to meet their goal as the frustration levels were rising or it was time for our session to be over and I wanted to end on a positive note, etc.
19	**Description of Population** self mutilation, suicide attempts, sexual abuse, aggression, depression are the most prevalent reasons for admission **Description of Treatment Setting** acute behavioral care setting, locked, close observation, intense behavioral program. two MT groups weekly. **Description of Intervention** group setting. group member will pantomime emotion given by therapist. Other group members will mirror act by musical improvisation then guess what emotion was given. **What contributed to the effectiveness of this intervention?** Elicit awareness for communication of emotions on various levels. Acting, observation, improvisation, intellectual integration and feedback through peers. It is

	an onsite learning by doing cycle to double-check own nonverbal messages sent. If reviewed by peers it is especially high in impact.
20	**Description of Population** 15-16 yr olds in a locked down school setting **Description of Treatment Setting** Restorative circle and drum circle as part of their home room start of the day. **Description of Intervention** Musical role playing, decision making, leading, following, song writing and discussion **What contributed to the effectiveness of this intervention?** Enjoyment of the instruments and being a leader whose voice was respected and heard.
21	**Description of Population** 5th and 6th grade students; one group was classified "teachable MR" or learning disabilities; second group was more behavioral with [parole] officers checking in on them. **Description of Treatment Setting** school setting; choral room; variety of instruments to play; **Description of Intervention** focused mainly on group cohesiveness -- working together, talking with each other, planning the session -- who is playing what instrument, plan songs to play during session; all music color coded as well as letter coded since some of the students were not reading or identifying letters, but they knew their colors **What contributed to the effectiveness of this intervention?** coaching -- assisting in giving possible phrases to use when they were angry at someone versus throwing chairs or other objects at their peers, modeling -- gradually allowing them to lead the session after the model had been given
22	**Description of Population** emotionally disturbed; sexually abused; sexual [predators]; oppositional defiant disorder; self [abusive]; anorexia; psychosis; **Description of Treatment Setting** day partial hospitalization treatment [center] **Description of Intervention** song writing/[drawing] about present state, relaxation/imagery, song writing/drawing about new state. **What contributed to the effectiveness of this intervention?** Client was able to discuss the differences in the before and after.
23	**Description of Population** Adolescent sex [offenders] **Description of Treatment Setting** Outpatient group therapy **Description of Intervention** Lyric analysis **What contributed to the effectiveness of this intervention?** This helped the concept of feelings lead to thoughts which lead to plans and

	actions.
24	**Description of Population** Juvenile Male Sexual Offenders (aged 11-18) **Description of Treatment Setting** Residential Psychiatric Hospital (Behavioral Health) Setting **Description of Intervention** A drum circle was set up where everyone was in a circle with a "talking stick" placed in the center of the circle. Group started by reading inspirational phrases, poems, etc. based on the idea of forgiveness and what that means. Group began playing a 4/4 beat pattern and continued until someone became ready to speak. The speaker walked to the center and held the "talking stick" and spoke their peace. While they spoke, the rest of the group played a supportive heart beat pattern (1,2,rest,rest). When the speaker sat down everyone once again improvised on the 4/4 pattern until another peer spoke. **What contributed to the effectiveness of this intervention?** Everyone participated and understood that what was said during the circle had the "what happens in Vegas stays in Vegas" idea behind it and no one shared anyone else's personal testimony outside of the group.
25	**Description of Population** I created a weekly drum circle with High-Risk Youth on an inpatient psychiatric unit. The group included as many as 22 adolescents, a music therapy intern, and myself. The adolescents were all diagnosed with an Axis I psychiatric diagnoses, and some of the adolescents also had an Axis II diagnosis. Many of the adolescents had been victims of abuse. **Description of Treatment Setting** We conducted the group in the dayroom on the unit. Having the group on the unit enticed additional staff to participate - i.e. unit secretaries, mental health techs, nurses. **Description of Intervention** We began the drum circle by allowing each participant to improvise on their name. We then conducted several call and response activities, and concluded with an opportunity for each participant to create a rhythm for improvisation. **What contributed to the effectiveness of this intervention?** The drumming provided the patients with an opportunity to release anger and tension. Having the group on the unit in the dayroom enticed other unit staff - i.e. nurses, mental health tech, unit secretaries - to participate!
26	**Description of Population** I used drumming with a group of students who were actively engaged in substance abuse and drug dealing. **Description of Treatment Setting** The treatment setting was the band room in an urban high school. The school is considered one of the best in the system. However, the administration referred to my students as [descriptor removed by researcher] that is, students who do not benefit from the exceptional offerings of the school.

	Description of Intervention We worked on drumming techniques and performing structured pieces. The goal was to help them develop a skill that they could use to get into the regular band where they could engage in appropriate behavior and appropriate peer interactions with other students in the school. **What contributed to the effectiveness of this intervention?** Having the students isolated from their peers was a definite contribution, which is in contrast to the idea of integration.
27	**Description of Population** A classroom group of 10-13 adolescent males and females with history of abuse, trauma, mental illness and/or correctional involvement. **Description of Treatment Setting** Music Therapy group within the classroom. **Description of Intervention** Creating a list of the group's favorite musical artists. Using a white board, the students took turns sharing their favorite artists and naming the genre (most often the genre was rap/hip-hop). Following sessions students shared music with the group (if content was appropriate). Therapist then also shared different genres of music with the group (i.e., jazz, blues, rock). **What contributed to the effectiveness of this intervention?** Iso-principle was used to meet them where they are. It created unity within the group when members liked the same artists. Because of the nature of the group, some group members felt safe to share that they enjoyed other styles of music such as rock or country. This in turn, increased their sense of self and self-esteem. Therapist also was given then opportunity to share her favorite style and provide education to group about different genres of music.
28	**Description of Population** Danger to self or others **Description of Treatment Setting** Acute care setting **Description of Intervention** Self Worth group titled; "Respect". **What contributed to the effectiveness of this intervention?** True based insight.
29	**Description of Population** At risk youth - songwriting and analysis - give clients positive control over environment - work together toward a common goal **Description of Treatment Setting** School and private clinic **Description of Intervention** clinical songwriting **What contributed to the effectiveness of this intervention?** I set up the environment to be a safe place for them to offer input
30	**Description of Population** at-risk adolescent males, various cultural differences, four year span of ages,

	numerous personal issues **Description of Treatment Setting** at a adolescent treatment facility, in a private room at the music therapy building. **Description of Intervention** drum circle - used various drum circle techniques to work on self-esteem, communication, following authoritative directions, self-expression, improvisation, singing, creating music **What contributed to the effectiveness of this intervention?** the teens were receptive to learn new things and worked together to create a drum circle group. The enjoyed making music
31	**Description of Population** EI youth **Description of Treatment Setting** residential treatment **Description of Intervention** weekly one-on-one for 30 minutes, structuring the activities so I pick one, then they pick one, giving them choices **What contributed to the effectiveness of this intervention?** structure, giving them control for a portion as well as following directions
32	**Description of Population** At-risk teenage girls, aged 12-15. Inner city, broken homes, been in trouble in school and sometimes with legal system. **Description of Treatment Setting** Community-based youth center; after-school programs including recreation and therapeutic opportunities. Funded through various sources, including local school system, the county of residence, government and non-government grants, private donations. **Description of Intervention** Program titled "SELF-Songs Express Life & Feelings"; primarily using lyric analysis, lyric adapting, and songwriting to help group members express themselves and gain insight to their situations. Incorporated various art media and expressive writing. Culminated in recording original group song in professional recording studio and applying for copyright for the song. **What contributed to the effectiveness of this intervention?** Giving the girls responsibility and accountability for the group. They signed a contract that they would attend or call if they could not, their parent/guardian signed a contract. They helped choose songs, they adhered to rules of confidentiality. They also felt what they were doing was unique and something not just anyone was doing.
33	**Description of Population** Mental Health Out-Patient Day Program - ages 12-18 male and female weekly 2x **Description of Treatment Setting** Psychiatric hospital in small city in a state mostly with rural populations **Description of Intervention** drumming using HealthRhythms adult drums and extra [instruments] included

	smaller percussion. **What contributed to the effectiveness of this intervention?** Individual control of contribution to group process
34	**Description of Population** girls age 13-17 **Description of Treatment Setting** residential treatment center **Description of Intervention** Analysis of song "Video," including discussion of body image and self-esteem. Group composed dance to go with this song. **What contributed to the effectiveness of this intervention?** Co-creation of dance underscored positive body image message and built group cohesion
35	**Description of Population** children ages 12-21 who are emotionally disturbed **Description of Treatment Setting** a Summer program to reinforce and maintain skills learned throughout the year **Description of Intervention** [choreographing] movements to popular songs heard on the radio and discussing the meaning of the lyrics. **What contributed to the effectiveness of this intervention?** The students had the opportunity to express their feelings and thoughts through movement discussion, and singing.
36	**Description of Population** Dual Diagnosis **Description of Treatment Setting** private practice **Description of Intervention** use of mandalas and music - **What contributed to the effectiveness of this intervention?** This is especially helpful as an initial [therapeutic] tool to help my clients to open up and begin dialog with themselves and with me as their therapist. It gives them the container of the music and the art to help establish safety and trust.
37	**Description of Population** I conducted a qualitative study (not yet published) with 9 high-risk youth in an alternative high school for 12 weeks. The intervention was a weekly drumming circle co-led by myself and a professional percussionist. Data analysis was triangulated and suggested definite therapeutic benefits from this drumming intervention. **Description of Treatment Setting** Small private alternative high school for individuals unable to stay in regular school. Extremely difficult home environments were the norm. One individual was a convicted felon living in jail on the weekends. Drug use among parents was common, as well as violence in the home. **Description of Intervention**

	A drum circle model was adapted for therapeutic work with these individuals. Group members were taught basic djembe drumming techniques, with a very strong emphasis upon individual expression, development of creativity and self-expression as well as risk-taking and leadership skills. Goals were focused on improving self-esteem, self-confidence, self-image. **What contributed to the effectiveness of this intervention?** The school itself, which the kids loved,(this resulted in excellent attendance each week) the support of the staff, the 'coolness' and charisma of my co-leader; the very strong support we gave the kids as co-leaders; the 'coolness' of drumming as an intervention.
38	**Description of Population** High school students, both sexes. **Description of Treatment Setting** After-school program. **Description of Intervention** Musical storytelling, in which participants play instruments as sound effects for the characters and environment described in the story. **What contributed to the effectiveness of this intervention?** Being multi-modal and multi-sensory engages more members of the group in attentiveness and immersion in the story, which then helps them relate to the plot, the characters and the metaphors/symbolism used in the story.
39	**Description of Population** On a 1:1 am working with a suicidal 13 yr. old young man, [trauma]. I am teaching him piano and we also do singing and free time activities and he loves it all. He has perfect pitch so he is very motivated with music. He has some behavior issues. **Description of Treatment Setting** In my home music therapy studio. **Description of Intervention** Described above. **What contributed to the effectiveness of this intervention?** He feels successful and feed into his music addiction, that perfect pitchers have.
40	**Description of Population** adolescents **Description of Treatment Setting** hospital **Description of Intervention** CD about me **What contributed to the effectiveness of this intervention?** allowed participants to engage at their own level of comfort, included music and art
41	**Description of Population** At risk youth, hospitalized for depression, suicide attempts, substance abuse or behavioral disorders. **Description of Treatment Setting** In-patient psychiatric. **Description of Intervention**

	Drumming/Improvisation - having clients select instruments, getting them to work together when ready, giving them opportunities to be heard. **What contributed to the effectiveness of this intervention?** Gives them opportunities for emotional release, they are safely heard as well as at times get the chance to work out of their comfort zone safely, try something new, which is what we are often asking them to do in therapy. Simple having an opportunity to be together in the music. By shaping the intervention as they need it they get a sense of control over their environment, reconnect with their creativeness.
42	**Description of Population** street wise adolescents who demonstrate aggressive behaviors, depression, and poor coping [skills] **Description of Treatment Setting** high school **Description of Intervention** musical improvisation based on social story created by teens. Leads to writing lyrics, vocal improvising/rap, creating music videos, making poetic, picture & audio journals. **What contributed to the effectiveness of this intervention?** using technology
43	**Description of Population** Male young offenders **Description of Treatment Setting** Youth correctional facility. Sessions took place in the chapel of the facility. **Description of Intervention** Program consisted of: One-on-one music lessons in piano or guitar; Pairs of youth working together in song writing or the learning of instruments; Small group sessions which consisted of lyrical analysis, song choice, some drumming / instrument playing **What contributed to the effectiveness of this intervention?** The [chaplain] provided a great deal of support, and helped establish the program. She also had a good rapport with the youth that initially participated in the program, which helped with their acceptance of it. The one-on-one sessions provided a time to build a rapport with youth. There was an improvement in the self-esteem of these youth. They found it very rewarding to learn to play an instrument. Having youth working with a partner for song writing or teaching one another to play an instrument was excellent in building positive relationships between the youth. It was also very effective to have a youth with better guitar skills to teach a youth who was beginning to play. Both youth benefited from this arrangement.
44	**Description of Population** 16 year old male [trauma] **Description of Treatment Setting** residential placement, 1-1 [music therapy] **Description of Intervention** song writing

	What contributed to the effectiveness of this intervention? symbolism used in song writing allowed him to articulate exactly what had happened to him

Appendix F

Journal sources

Music therapy sources	Online access
British Journal of Music Therapy	No online access
Canadian Journal of Music Therapy	Open access
Journal of Music Therapy	No online access
Music Therapy	No online access
Music Therapy Perspectives	No online access
Nordic Journal of Music Therapy	Selected articles freely accessible
Voices: A World Forum for Music Therapy	Open access
Non-Music Therapy Sources	
The Arts in Psychotherapy	Selected articles freely accessible
Clinical Child Psychology and Psychiatry	Paid online access
Family Journal: Counseling and Therapy for Couples and Families	Selected articles freely accessible
International Journal of Group Psychotherapy	Selected articles freely accessible
Journal of Child Psychology and Psychiatry	Paid online access
Journal of Group Psychotherapy	Paid online access
Journal of Humanistic Counseling	Paid online access
Journal of Physical Education, Recreation, and Dance	Paid online access
Social Work in Health Care	Selected articles freely accessible
Social Work in Groups	Selected articles freely accessible