THESIS

THE EXPERIENCES OF AT-RISK ADOLESCENT GIRLS IN GROUP THERAPY, COFACILITATED BY A PSYCHOTHERAPIST AND MUSIC THERAPIST: A PILOT STUDY

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WE HEREBY RECOMMEND THAT THE THESIS PREPARED UNDER OUR SUPERVISION BY DAVID L. BRAHAM ENTITLED THE EXPERIENCES OF AT-RISK ADOLESCENT GIRLS IN GROUP THERAPY, COFACILITATED BY A PSYCHOTHERAPIST AND MUSIC THERAPIST: A PILOT STUDY BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE.

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ABSTRACT OF THESIS

THE EXPERIENCES OF AT-RISK ADOLESCENT GIRLS IN GROUP THERAPY, COFACILITATED BY A PSYCHOTHERAPIST AND MUSIC THERAPIST: A PILOT STUDY

This study bridges the gap between psychotherapy and music therapy. Based on the experiential essence of musical interventions, it is hypothesized that the inclusion of music therapy in the context of adolescent group psychotherapy may enhance the therapeutic process. At-risk adolescent girls age 14-18 participated in the study. Both quantitative and qualitative data was collected. Pre-and post-tests were administered to each participant using the Therapeutic Factors Inventory (TFI; Lese & MacNair-Semands, 2000), and descriptive information was collected through informal interviews following the 6-week intervention. While the TFI showed little promise in identifying the therapeutic factors contributing the outcomes due to a small sample size (n=3), qualitative data supports the use of music as an influential and significant contribution to group psychotherapy with at-risk adolescents.

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CHAPTER 1

Introduction

The use of experiential therapy is important in helping clients understand and experience their situation through a different lens than traditionally offered in clinical psychotherapy. The basic premise underlying experiential approaches is that human beings are aware, experiencing organisms who function holistically to organize their experiences in coherent forms (Watson, Greenberg, & Lietaer, 1998). Bruscia (1998) defined experiential therapies as specifically designed activities or experiences that help clients relive and work through their problems. In other words, experiential therapies focus on creating experiences in the room that are presumably transformative. The field of psychotherapy uses many experiential models that work with the clients' awareness both by focusing on subjective experiences and by promoting reflexivity and a sense of agency (Watson et al., 1998).

One form of experiential therapy that has been modestly researched in the field of psychotherapy is the use of music as a means for expression, connection, and communication. Although the psychotherapeutic literature presents few connections for using music as an intervention, the field of music therapy presents a great deal of research and implications with populations similar to those who are commonly seen in the office of a psychotherapist.

In the field of psychotherapy, outside of the specific field of music therapy, the use of music has been given little attention. Unkefer and Thaut (2002) stated that music therapy services were ranked the highest by professionals such as nurses and rehabilitation therapists who had the most direct contact with music therapy by observing

treatment sessions, but music therapy services were ranked lowest by psychiatrists and psychological professionals who had only limited contact with a professional music therapist. Even though the latter group ranked the contribution of music therapy to the patient's development of social skills and enjoyment very positively, they had less positive attitudes towards music therapy's ability to address clinical goals. For psychotherapists to fully understand the benefits music can bring to achieving clinical goals, they must recognize what each therapist's role is in the therapeutic process and more importantly how music can lead to further self-reflection and evaluation.

I was interested in how the involvement of a music therapist can aid in the psychotherapeutic process. It was my hope to create a therapeutic approach where psychotherapists can use the experiential medium of music alongside a board certified music therapist. When psychotherapy and music therapy work together in a co-facilitated therapeutic process, unique outcomes may be achieved.

As a psychotherapist, I believe that this study is vital to our field. The implications of using the experiential modality of music in psychotherapy have not been explored, leaving a gap in the psychotherapeutic literature. It is my hope to create a co-facilitated therapeutic model that may assist psychotherapists who wish to include the use of music in their practice. This study presents a unique contribution to two holistic and therapeutic fields as it attempts to bridge the gap between psychotherapy and music therapy.

In the following pages, I will highlight research in the field of adolescent development, group psychotherapy, music therapy, and music psychotherapy. Links will be made supporting musical interventions as an experiential tool used to aid adolescents

in gaining nonverbal experiences leading to a greater level of overall enjoyment, participation, and self-disclosure. It is my hope that the inclusion of these nonverbal experiences in addition to verbal talk therapy will lead adolescent participants to report on the usefulness of this combined approach.

It is important to understand that the goal of this study is not to cure at-risk adolescent girls from drug abuse, anorexia, or other debilitating health problems in only six weeks and nine hours of therapy. Rather, the hope is to instill a sense of empowerment among the group participants. This new sense of hope and empowerment will give them the skills and opportunity to find themselves closer to achieving their long-term goals.

Research Questions

The study will assess the experiences and therapeutic outcomes associated with group therapy among at-risk adolescent girls age 14-18. The group was structured through the co-facilitation of guided interventions of a psychotherapist and music therapist. Sessions were structured using musical interventions. The musical experiences facilitated by the music therapist were explored through discussions led by the psychotherapist. The central questions asked in this study are:

1. What therapeutic factors contribute to the outcomes associated with the group?
2. What were the experiences of the youth who participated in the group?

It is assumed that the inclusion of music therapy interventions in group psychotherapy with at-risk adolescent girls contributes to the therapeutic process. Music will play a key role in facilitating a fun and creative atmosphere, leading group members and therapists to develop a strong level of cohesion. Once these creative musical

experiences are employed, the group will process reactions and thoughts related to the intervention that will increase the participant's level of self-disclosure.

Literature Review

Adolescent Development

Adolescents represent a group that present challenges to many therapists and caretakers as they journey through life searching for identity, relationship development, and peer approval. Communicating these challenges to adults can be difficult, especially when it seems likely that an adult may take a rigid stance on issues such as sexuality, substance use, and peer and dating relationships (Joan, McKenzie, Wales-North, & Gonzalez, 1995). The time of adolescence is crucial to healthy development. These developmental issues include the cognitive, social, and physical changes that occur throughout the young adolescent's life both for the self as well as relationships with others. Adolescence is a vital time, as youngsters may feel divided between the worlds of child and adult, constantly searching for a place in which they belong.

Essential to any form of therapy provided for the adolescent population is to understand how they think and feel (Sugar, 1975). Knowledge of adolescent development helps to guide the therapeutic process. Sugar suggested that the developmental tasks of adolescence include: (a) emancipation from parental attachments' (b) development of satisfying and self-realizing peer attachments while appreciating the ability to love and appreciate the worth of others as well as oneself; (c) endurable and sustaining sense of identity in the familial, social, sexual, and work creative areas; and (d) a flexible set of hopes and life goals for the future. Understanding these concepts aids the therapist in age-appropriate expectations of the adolescent's behavior.

For the purpose of examining the role of experiential therapies with adolescents, I will discuss Jean Piaget's theory of adolescent development. Piaget focused his attention on the conflict-free, rational side of development and emphasized the thought process, the structure of intelligence, and the development of logical thinking (Muuss, 1996).

According to Piaget, some adolescents are in the final stage of cognitive development, known as formal operational thinking. Although Piaget describes formal operational thinking as the final stage of cognitive development, it is not universal for all adults to achieve. Through formal operational thinking, adolescents are able to cognitively surpass children as they use the ability to think into the future concerning present or future work in society. To aid the adolescent in implementing this form of thinking, he or she will commit to all possibilities in life (Piaget & Inhelder, 1958). In other words, "the adolescent goes through a phase in which he attributes an unlimited power to his own thoughts so that the dream of a glorious future or of transforming the world through ideas (even if this idealism takes a materialistic form) seems to be not only fantasy but also an effective action which in itself modifies the empirical world" (pp. 345-346).

Regarding formal operational thinking, Muuss (1996) stated that adolescents not only think beyond the present moment but analytically reflect about their own thinking, which he referred to as second degree thinking or thinking about thinking (i.e., metacognition). Likewise, Elkind (1974) asserted that adolescents can see themselves as an object and evaluate themselves from the perspective of other people with respect to personality, intelligence, and appearance. This new perspective creates self-consciousness that is a simple manifestation of this new capacity for introspection. In

formal operational thinking, adolescents have the ability to understand and even form theories while participating in society and the ideologies of adults. This participation often entails a desire to change or alter society by way of the adolescent's imagination (Muuss).

Muuss (1996) suggested that adolescence is a time when the imagination of possibilities and consequences of behaviors are present without actually trying them out in real life. For example, adolescents are able to imagine their parents' reactions to their behavior, what might happen if they brought home a bad report card, how they might perform on a test if they did not study enough or at all, among many other situations. In other words, adolescents are able to think about their thoughts, to construct ideals, and to reason realistically about their future (Elkind, 1974). Adolescents have the ability to imagine possible outcomes, which may be very powerful for them as they think of the consequences of such behaviors as unprotected and/or promiscuous sex, alcohol and drug abuse, and other risk-taking behaviors (Muuss). Although adolescents are able to predict realistic or imagined outcomes, this does not imply that they are going to make the wisest choices.

Elkind (1974) identified adolescent egocentrism as a key issue. Piaget indicated that egocentrism is a characteristic of the developmental process. He noted that egocentrism changes according to the child's particular stage of development. In the formal operational thinking of a young adolescent, the primary concerns are with the self. As adolescents fail to differentiate between what others are thinking about and their own mental preoccupations, they assume that other people are obsessed with their own behavior and appearance as they themselves are. The belief that others are preoccupied

with the adolescent's appearance and behavior constitutes the egocentric attitudes of this population (Elkind, 1974). Adolescent egocentrism also presents implications for self-disclosure in group therapy because the participant may hesitate to share personal information as protection from feelings of embarrassment.

Elkind stated that adolescents are continually constructing or reacting to an imaginary audience such as how the peer group might perceive them. It is an audience because the adolescent truly believes he or she will be the focus of attention. Therefore, the imaginary audience may play an important role in the self-consciousness of the adolescent. Because of the powerful forces of egocentrism, gatherings of young adolescents are unique in the sense that each young person is simultaneously an actor to him or herself and an audience to others.

Educating Adolescents

There are many issues to keep in mind when working with the adolescent population. For the purpose of this study, I will consider myself a therapist, teacher, guide, coach, or friend. While interacting with adolescents throughout the therapeutic process, it will be helpful to approach them with an understanding of their developmental growth to aid the group facilitators in gaining greater communication and connections with the group.

Muuss (1996) stated that a key point in interacting with adolescents is to encourage them to become active participants in decision making and problem solving. He identified three steps to achieving this goal. The first step is to encourage children to make their own decisions and to enforce their own rules. Second, children may work harder when the problems and questions are relevant to them and arouse their curiosity,

thereby fostering intrinsic motivation. Third, the facilitator should not merely identify correct and incorrect responses, because this inhibits thinking. Rather, the facilitator must guide the child in her or his self-construction of knowledge and values by encouraging them to exchange viewpoints.

In terms of the therapeutic process, it is important to keep in mind that the facilitator must act with dedication. The idea of dedication is important because learning, the essential element of growth, is living; no matter what children are doing, they will usually be learning something. To do so successfully, Elkind (1974) contends that a teacher dedicated to growth must also be dedicated to his or her own personal growth. I believe this is true for all people in authority positions. This includes teachers, therapists, coaches, bosses, and parents. To be effective leaders we must dedicate ourselves to achieve the best possible results in our own lives. To achieve this, all leaders should work to maintain their personal health and happiness. This is an important idea for several reasons. First, when intervening with the adolescent population, it is important to act as positive and healthy role models. Second, if we are acting out of dedication we will send messages that what we are doing is believed to be meaningful, which would ideally lead to a greater sense of trust.

Piaget observed that children often show resistance to learning from traditional instruction. Just as Piaget was able to challenge his subjects to the limits of their understanding (Muuss, 1996), it is my hope that music will serve as the experiential tool for the adolescents in this study to be challenged as well. To do so effectively, according to Elkind (1974), would mean that facilitators need to be trained in understanding not only the teens' verbal communication, but also strive to understand and leave room for

nonverbal experiences and communication. In this study, these nonverbal experiences will surface in the form of musical interventions.

The structure of group therapy for adolescents may give them the chance to experience a fuller appreciation of honest, tempered relationships with others. However, not all psychotherapy groups are structured the same, allowing for a variety of outcomes between participants depending on the type and style of the group (Sugar, 1975). When working in a group setting, adolescent egocentrism is an important concept to keep in mind. Given that groups are designed to help each other through support and understanding, while providing validation through examples of similar life experiences, it could be easy for adolescents to remember that there are other members in the group. Yet, they may feel as if the focus of the group is always on them. Using music as an experiential component in adolescent group therapy may aid these group dynamics in a number of ways. According to Gaston (1968), the very nature of music will draw the group together for the purpose of increasing intimacy and order with a minimum of verbal communication. However, before I explore the use of music in adolescent group psychotherapy, let us gain a better understanding of music therapy and all it has to offer.

Music Therapy

Music. Music has the power to relax, stimulate, or open up channels of self-expression at deep personal levels. Gaston (1968) identified three core principles that form much of the foundation of music therapy. The first principle is the use of music to create a social environment. As humans are social beings, music may serve as a tool to connect people, and in this case, the therapist and client. The second basic function of music is its power to elicit positive changes in self-esteem. The third principle of music

therapy is the utilization of the unique potential of rhythm as it energizes and creates order.

Music therapy is aimed at achieving transference and self-expression, regardless of the musical skills or ability of the participants (Turvo, 2001). Turvo defined music therapy as the prescribed use of musical interventions by a qualified person to effect positive changes in the psychological, physical, cognitive, or social functioning of individuals with health or educational problems.

Music is a tool that the therapist uses as a means of attaining predefined goals and assisting clients in lengthening the amount of time they engage in constructive and desirable behaviors (Parente, 1989b). Music has qualities that are associated with recreational and leisure activities; thus, it can be mistakenly viewed as a nice break from the stress of "real" therapy leading to significant therapeutic change (Parente).

Music is a form of expression that is not necessary for survival, yet it is a prevalent part of everyday life and can be found in every culture known to humankind (Davis, Gfeller, & Thaut, 1999). Music brings beauty and enjoyment to life. It can be used to elicit social involvement and physical activities while encouraging the expression of emotions. Merriam (1964) identified 10 major functions of music seen in most cultures. These function include: (a) physical response, (b) communication, (c) emotional expression, (d) symbolic representation, (e) enforcement of conformity to social norms, (f) validation of social institutions and religious rituals, (g) contribution to the continuity and stability of culture, (h) contribution to the integration of society, (i) aesthetic enjoyment, and (j) entertainment.

An additional function of music is its influence on learning. Wolfe (1983) contends that songs can enhance academic, social, and motor skills of children. From an early age, music may be used to teach the alphabet with the *ABC's*, learning about our body parts from the song *Head and Shoulders, Knees and Toes*, to the widely viewed television program Sesame Street that extensively employs music to promote the learning of a variety of academic and social behaviors (Wolfe & Hom, 1983). In the context of music and learning, when students are given the opportunity to listen to and/or sing melodies, they are provided with opportunities to hear and repeat instructions. Over time, it is assumed that students will begin to remember the programmed information (Wolfe & Hom). Thus, music plays a substantial role in our ability to learn.

Music as expression. What does it really mean to use music to elicit nonverbal responses? According to Camilleri (2001), when we play music alone, in groups, in a performance, in a jam session, or in a music therapy session, we are making a statement about how we are in the moment. Playing music comes through our instrument as a natural and organic extension and reflection of who we are, revealing information about us in the form of artistic expression. This expression is then usable in the form of observation, response, and self-reflection. In the context of music therapy, sessions remain free of expectation or judgment as to the artistic product of the music, but focuses on the unfolding process of musical expression and creation. This sense of nonjudgment leaves room for the individual or group who is engaged in the music to experience a strong sense of closeness while alleviating any painful or distraught feelings (Gaston, 1968).

The creative potential music stimulates extends as a form of communication eliciting responses of expression and is often referred to as the language of emotions (Winner, 1982). As the language of emotion, music serves as a societal tool and vehicle for expression of ideas and emotions that are not easily expressed through ordinary discourse (Radocy & Boyle, 1979). Not only is music used to express emotions, but music also aids in recalling emotions. Gfeller (1999) uses the term *referential*, which reflects the belief that meaning in music arises from connections the listener makes between the music itself and some nonmusical object or event. Similarly, Berlyne (1971) proposed that structural qualities of music, such as how complicated, simple, or familiar the composition is, contribute to emotional response. This means that music that is too complex or unfamiliar can leave the listener with a sense of confusion, discomfort, or chaos. In contrast, music that is too simple or has been heard again and again may lack freshness and leave the listener feeling bored and unsatisfied (Davis et al., 1999). Although the effects of music will vary from person to person, it is thought to be a means of expressing deep emotions when words no longer suffice (Masserman & Moreno, 1958).

In conclusion, Gaston (1968) argued that music "is a powerful expression of the interdependence of mankind, and, from the lullaby to the funeral dirge, an expression of the tender emotions. Because of this and the guidance of the therapist, music persuades with honesty, feeling, and power toward better individual and group behavior" (p. 25).

Music as communication. Music serves as a tool for expression, and so it provides a basis for communication. Gaston (1968) explains that,

> there is so much nonverbal communication in our everyday life that we are often unaware of it or its importance. We are unaware that some of our most valued and

> functional communications are, and will continue to be, carried on without words, because they cannot be verbalized. Therefore, it is the wordless meaning of music that provides its potency and value. (p. 23)

Similar to the beliefs of Gaston, Unkefer and Thaut (2002) argued that, unlike speech, music does not refer to specific thoughts, ideas, or events; rather it communicates an embodied meaning. Depending on its particular meaning, music can alter or intensify the psychological and behavioral response to verbal and visual forms of communication. As a form of communication, music is capable of transmitting emotional messages while influencing or reflecting the mood of an individual. Music also provides a usable medium for intensification, amplification, or alteration of meaning and embedded textual or visual information. Because music aids in reflecting, influencing, and altering emotional responses, it has particular merit as a therapeutic tool in those treatment processes that include identification, awareness, reflection, and the expression of feelings.

Music and physiological responses. Although no clear picture of specific types or direction of responses to music have been documented, the bulk of studies on physical response to music supports the notion that music influences physiological responses (Davis et al., 1999). Unkefer and Thaut (2002) suggested that music stimuli have the ability to elicit physiological responses within highly idiosyncratic response patterns, determined not only by the musical characteristics of the stimuli, but also by many variables within the individual.

For example, Davis et al. (1999) hypothesized that maintaining a steady beat can help individuals to experience internal structure and security. When individuals identify their internal rhythm through the organizing and energizing force of music, synchronicity of physiological functions such as heart rate, blood pressure, and breathing may occur

(Montello & Coons, 1998). In fact, achieving the desired physiological changes using music is dependent on the individual or client's criteria of musical preferences and selection (Davis & Thaut, 1989). Therefore, it is important for clinicians to carefully assess their clients' musical preferences when determining individual strategies to alleviate physiological symptoms such as stress, anxiety, or dissatisfying mood states.

Other studies have also found that music is a powerful tool in reducing an individual's level of stress. Aldridge (1993) found that exposure to relaxing music reduced patients' subjective anxiety levels and physiological stress reactivity in a number of clinical settings. As clients experience increased anxiety, the clinician may work on the proper relaxation techniques to bring them down. In a study conducted by Thaut and Davis (1993), music significantly reduced the anxiety level of each participant. Additionally, when patients have been exposed to music, immune responses were enhanced when compared to patients not exposed to music (Goff, Pratt, & Madrigal, 1997). Overall, music may play a crucial role in reducing harmful physiological effects while moving clients toward a more stable and relaxed sense of self.

Music therapy in psychotherapeutic settings. Listening to music with heightened consciousness has great therapeutic value and is employed by a wide range of mental health professionals, yet there is no reason why extraordinary listening experiences cannot happen everywhere and be enjoyed by everyone who loves music (Bonny & Savary, 1990). Using music as an experiential therapy can assist in achieving the primary goal of eliciting verbal responses and communication from clients. I hope to bridge the gap between the field of music therapy and psychotherapy by examining how the two therapies are used together and, perhaps, complement each other.

Bruscia (1998) defined music psychotherapy as a process encompassing both music experiences and verbal discourse. Bruscia further identified four distinct levels of engagement that may occur between therapist and the client:

> (1) Music as psychotherapy, where the therapeutic issue is accessed, worked through, and resolved through creating or listening to music, with no need for or use of verbal discourse.
>
> (2) Music-centered psychotherapy, where the therapeutic issue is accessed, worked through, and resolved through creating or listening to music while engaging in verbal discourse to guide, interpret, or enhance the music experience.
>
> (3) Music in psychotherapy, where the therapeutic issue is accessed, worked through, and resolved through both musical and verbal experiences. Here, music is used for its specific and unique qualities and is relevant to the therapeutic issues and its treatment. Words are then used to identify and consolidate insights gained during the process.
>
> (4) Verbal psychotherapy with music, where the therapeutic issue is accessed, worked through, and resolved primarily through verbal discourse. On this level, musical experiences can be used alongside verbal discourse, to facilitate or enrich the discussion, but are not considered relevant to the therapeutic issue or treatment of it (Bruscia, 1998).

As Bruscia identified, musical experiences can be used as an adjunct to verbal discourse, to facilitate or enrich the discussion, but are not considered relevant to the therapeutic issue or treatment of it.

Wells and Stevens (1984) concluded that the use of music to stimulate creative fantasies that are shared with others represents an effective approach to bridging the gap between nonverbal and talk therapy. When used in the psychotherapeutic setting music may also aid in the reduction of anxiety, to sustain attention, and to facilitate self-expression (Cooke, 1969). These goals may be especially useful in cases where group members are typically known to exhibit inappropriate behaviors. Therefore, the primary task is to use music to modulate feelings, provide alternatives to acting out, and encourage positive interactions (Wells & Stevens).

Wheeler (1983) identified the innate aspect of the music therapy experience in conjunction with psychotherapy as a gateway to achieving greater goals through the implementation of planned activities rather than through insight alone. Wheeler contends that the medium of music, when used correctly, assists clients in becoming more aware of their feelings, and emphasizes the verbal processing of this experience as the essential aspect of the therapeutic process. Diephouse (1968) further stated that not only does music have the ability to enhance the client or groups physiology and communication but may be a highly motivational therapeutic factor. Music elicits nonverbal participation in a way that is nonthreatening and even enjoyable. Although clients connect to the externally influenced medium of music, they may feel more able and free to expand their sense of self in the process of discovering greater potential within themselves as well as the group (Parente, 1989b). Many of the clients commonly seen by a psychotherapist may be experiencing psychological, personal, or familial concerns. Therefore, it is important when working with clients to fully understand how music may be best used as an effective treatment modality.

To describe the psychological experiences clients may suffer from and the effect music may have on them, Unkefer and Thaut (2002) identified six models commonly used throughout the therapeutic process. These models include the psychodynamic, cognitive, humanistic/existential, biomedical, behavioral, and holistic models. For the purpose of working with adolescent groups, I will highlight those models that fit within the context of working with this special population. Specifically, I will address all of the models presented by Unkefer and Thaut with the exception of the biomedical and behavioral models.

The psychodynamic model, which comes from contributors such as Carl Jung, Erik Erikson, and Sigmund Freud, states that disorders are driven by conflicts within the personality. It is therefore the therapist's role to foster transference and make interpretations. The therapist must also demonstrate qualities such as self-confidence and controlled emotional warmth (Unkefer & Thaut). According to Jung, performing music requires all four functions of the psyche: *Thinking*, to turn the notes into music: *feeling*, to give the music expression: *sensing*, in the person's positional awareness feedback from his or her body when playing an instrument and singing: and *intuiting*, to get into the very essence of the composer's inspiration (Priestley, 1975). To engage the client by use of the psychodynamic model using music, improvisation is a key tool to accessing the four functions of the psyche (Bruscia, 1998). Through the use of improvisation, clients create music spontaneously with instruments and/or their voice as an outlet for expression of various emotional states. Through this form of improvisation, the client is free to express any and all aspects of himself or herself.

In the cognitive model, disorders surface from irrational thinking about self and others (Unkefer & Thaut, 2002). This model parallels Piaget's concept of formal operational thinking experienced throughout adolescence. The therapist's role in the cognitive model is to act as a guide and challenge the client's notions that are self-defeating. Cognitive music therapists might structure experiences that allow for verbal processing of individual and/or group reactions to musical material. This often entails interventions such as music listening with discussion based on the lyrical content, as well as identifying the mood of the music such as slow and sad, or fast paced and energetic. Interventions should also encourage associations with past experiences of personal relevance to the individual's conscious conflicts. Songwriting can also be employed to dispute irrational thinking and encourage rational thinking (Unkefer & Thaut).

The humanistic/existential model is concerned with defining the needs that are central to human functioning. With roots set in experiential therapies such as the Gestalt approach and from theorists such as Carl Rogers, this model stresses the importance and implications of self-actualization; that is, the tendency of every human being to strive towards wholeness and fulfillment. The role of the therapist in this model is to be immediately accessible to the client and focus on the here-and-now experiences created in the therapeutic relationship. In this context, a respectful, caring, and understanding attitude will assist the client in breaking down barriers and achieving more satisfying levels of personal functioning. Experience through following music instruction and achieving a musical goal such as completion of song-writing activities or performance may contribute to a client's sense of mastery and power, thereby increasing confidence and self-esteem (Unkefer & Thaut, 2002).

In the holistic model, healing comes from within. The fundamental principle of the holistic health philosophy is the unity of mind, body, and spirit where individuals are seen as physical, emotional, mental, and spiritual beings. In the holistic model, the therapist's primary role is to encourage the client to reach and explore altered states of consciousness for the purpose of allowing imagery, symbols, and hidden feelings to surface from the inner self. The goal of the holistic model is to assist the client in developing self-awareness, clarify personal values, release blocked intuitive energy sources, bring about deep relaxation, and foster spirituality and self-empowerment. To accomplish these goals using music, clients will often select the activity according to their musical preference and ability. The use of guided imagery and music aids in such a journey, which may encourage clients in becoming more aware of their feelings, thoughts, and experiences that previously have been denied or repressed (Unkefer & Thaut, 2002).

Another very important model that illustrates the connection between the use of music therapy and psychotherapy is the Transformational Design Model (TDM). Thaut (2003) explained that the TDM acts as a practical guide for the music therapist and other helping professionals to compose goal-oriented therapeutic music experiences. These experiences are then based on a functional reasoning process that links assessments, goals, and learning and training experiences. The five steps that outline the TDM will be highlighted in the Method section because it explains its relevance to the present study.

Music therapists and psychotherapists alike may use a variety of the models mentioned above. Adolescents will often find that it is difficult to adapt to strictly structured settings. To maintain interest, attention, and spontaneity, a fusion of

interventions may lead to greater cooperation among group participants. Therefore, it is important in any therapeutic context, when music and psychotherapy are intertwined, that therapists apply each model as needed. Rather than relying on just one, an integration of each model is crucial to the support and guidance of adolescents as they journey through the therapeutic process of self-discovery, growth, and increased personal health.

In conclusion, music therapy is especially useful when it is implemented in conjunction with psychotherapy (Tervo, 2001). The interaction achieved through music therapy helps clients to express feelings verbally and in this way integrate the ability to express feelings into their personality as a whole. With the aid of the psychotherapist, many problems can be solved through creativity, communication, and close cooperation alongside a music therapist (Tervo).

Music Therapy Interventions with Adolescents

There are many reasons why music may serve as a valuable tool for adolescents who suffer from complicated psychological issues. The transitional stage of adolescence involves profound physical, sexual, psychological, and cognitive changes (Emunah, 1990). These changes may lead adolescents to feel reluctant to participate in any form of therapy. Therefore, music presents a nonthreatening mode of communication that serves as a *sneak therapy* (Brooks, 1989). Although musical interventions may happen many times throughout the therapeutic process, adolescents will be less resistant because they are joined to the influence of the music and not the therapeutic authorities. Similarly, the use of music in a psychotherapeutic context serves as a "magical bridge," permitting the mind and body, which can be barren, expressionless, or uncommunicative, to begin to

identify and express through communication the feelings and thoughts that may previously have been difficult to access (Clendenon-Wallen, 1991).

A music therapy program might help to increase adolescents' awareness of the existence and feelings of others while assisting in the development of positive relationships with peers (Rickson & Watkins, 2003). Adolescent groups who used music therapy techniques have been found to be highly successful by aiding in the approximation of natural maturation process for hospitalized adolescent patients (Sommer, 1968).

Music therapy can play a powerful role in aiding adolescents to get even more in touch with the youth culture (Tervo, 2001). This awareness helps them to create their own area where they can share the fantasies and actions of their developmental phase, outside the world of adults. Music therapy for emotionally disturbed adolescents tends to be superior to verbal group therapy in enhancing self-esteem due to its nonthreatening qualities (Haines, 1989). Music is viewed positively by teenagers because it is an important focus of adolescent subculture (Kivland, 1986). Therefore, the nature of music as therapy is nonthreatening compared to other forms of treatment (Kivland). Music is therapeutically beneficial for adolescents due to the unique potential of rhythm to energize and create order (Gaston, 1968). It is this order that allows the adolescent participant to relax and enjoy the group rather than feel rigid and uncomfortable.

Through the adult perspective, music is often seen negatively as a gateway into adolescent culture. However, we need to embrace these connections because music will often serve as a positive tool that will help enhance communication with the adolescent population (Brooks, 1989). Through the medium of music, adolescents are greatly

influenced by the dress, hair style, attitude, and cues from musicians and messages embedded in the music itself. As the facilitator allows the musical intervention to serve as the catalyst, and the therapist as the safe adult, enhanced recovery may ensue. Therefore, the combination of music therapy and psychotherapy may serve as an effective modality when working with problems experienced in adolescence (Brooks, 1989).

Structure of Music Therapy Interventions with Adolescents

Emunah (1990) identified four concepts that are important for the therapist to understand when working with adolescents. These concepts -- explosion, expression, containment, and expansion -- are central to understanding creative art therapies with adolescents. Explosion refers to the intense and complex changes experienced throughout adolescence. Although adolescents may experience an increased sense of independence, search for self, and personal decision making, these new experiences are often not ready and stable enough to be carried out. Therefore, the role of the creative arts is to provide a means of expressing the inner explosiveness of adolescents in an appropriate manner. Emunah's second concept, expression, is greatly enhanced with the use of music. Music is an artistic form that many adolescents naturally gravitate towards. With the use of music, adolescents can express conflicting psychological tensions and unsteady emotional states. Containment refers to the idea that adolescents who are given artistic structure may discover and utilize mechanism that arise from within the self, rather than being enforced from the outside. This means that participants will be given the chance to create their own means of expression and communication from within themselves through the use of music. With the guidance of a music therapist and psychotherapist, adolescents will exercise control and experience mastery through the structured

experience of these musical activities. Lastly, expansion is adolescents' newfound ability to think beyond the present and envision possibilities for the future. Under the guidance of a skilled creative arts therapist, adolescents expand their views, perceptions, actions, and daydreams through structured experiential musical activities presented by the music therapist.

Skinner and Wellborn (1994) introduced the motivational theory of coping, which offers a theoretical framework for examining how unique characteristics of children and their environment interact during times of stress. Interventionists must be aware that children seek, either successfully or unsuccessfully, to develop a sense of mastery over their environment, assert their independence, and develop secure attachments with familiar adults. This model stresses the importance of the fundamental psychological need for children and adolescents to successfully attain a sense of competency, autonomy, and relatedness to others.

Although the motivational theory of coping refers to children, it can be applied to adolescents as well. According to the motivational theory of coping, the therapist must first provide a structured environment that communicates clear expectations and consequences, provide optimal challenges, and provide positive feedback regarding the client's skills and competence. The second element focuses on autonomy and encourages freedom of expression by permitting clients to make choices and decisions about activities. The third contextual element is involvement. This element of support encourages involvement on the part of the adolescent concerning their expression of interest and enjoyment. When using the contextual support model, the therapist will

buffer the effects of stress, thus reducing the psychological distress experienced by the child, as well as influence the ways in which a child copes (Robb, 2003).

Robb (2003) further identified three aspects of music intervention that create safe, predictable environments where children can master their fears and experience success. These three interventions include the natural structure of music, the ordering of session activities, and the client-therapist relationship. Music and autonomy, the second contextual element, support the flexibility of musical structure encouraging autonomy and the freedom of expression allowing creative independence through improvisation and song writing. The third element, music and involvement, encourages turn taking and cooperative interactions while emotionally supporting the children, acknowledging their feelings, and supporting them during times of distress. Tervo (2001) also stressed that music therapy will aid adolescents in communicating and expressing themselves in a safe, fun, and nonthreatening median different than what they are accustomed to. If the therapist and adolescent work well together, the therapist will guide the adolescent to experience a new sense of self-expression and creativity.

Music Therapy and Adolescent Groups

Now that I have discussed adolescent development, music therapy, and psychotherapeutic interventions, I will examine the use of music therapy with adolescent groups. There are many ways to conduct music therapy both with individuals and groups. Rio and Tenney (2002) identified six goals of music therapy treatment in the adolescent group setting. These goals include: developing empathy, controlling impulses, improving relationships, increasing attention, improving communication and self-expression, and promoting self-esteem.

Based on existing research and established clinical practice with juvenile offenders, Wyatt (2002) constructed clinical guidelines devised to offer more meaningful music therapy experiences to this challenging population. The guidelines presented by Wyatt (2002) include: (a) keeping the attention and motivation of juvenile offenders by using a variety of interventions, (b) incorporating music listening into the sessions, (c) using caution when selecting recorded music for the session, (d) setting consistent limits on behavior for the protection of the group participants, (e) utilizing proportional interventions to redirect behavior, (f) adolescents generally enjoy percussive instruments such as the djembe, conga, and metallophone, (g) reframe negative exchanges to engage the adolescents in the therapeutic process, (h) avoid power struggles, (i) provide structure as needed, and (j) be honest. Following these guidelines will aid the therapist in gaining a credible relationship with group participants. Once trust is established, the therapist will be on his or her way to implementing successful interventions.

Group music therapy experiences present rich opportunities for juvenile offenders to learn interpersonal problem solving and conflict resolution skills that broaden their inventory of nonaggressive solutions to difficult problems (Wyatt, 2002). This process in the music therapy intervention allows the imprisoned individuals to express and release their feelings, thoughts, and opinions in a productive, structured and nonthreatening manner (Thaut, 1987). A music therapy program may help to increase adolescents' awareness of the existence and feelings of others while assisting in the development of positive relationships with peers (Rickson & Watkins, 2003).

Rio and Tenney (2002) described five stages related to music therapy interventions. The first stage, gaining the participants' focus, was achieved by

encouraging physical movement through drumming, moving to music, and singing. Movement to music can be an effective activity for adolescents who exhibit sexual acting out behaviors to learn boundaries and gain comfort with their bodies. The second stage, gaining the trust of the adolescent, can be achieved by letting the adolescents choose music that is meaningful to them, which allows them to share part of themselves with the group. The third stage, encouraging leadership, encourages participant involvement through improvisation, solo singing, and playing drum patterns that are different from other players. Leadership encourages participants to develop a sense of independence within the larger structure of the group. The fourth stage, group cohesion, gives group participants opportunities to actively sing together, drum in synchrony, act out group performances, and write songs. These activities assist in the development of interdependence within the group. The final stage is closure. Closure occurs through discussions and reflections concerning the participant's experiences in group. It may also assist the facilitators towards ending sessions and terminating therapy. In this final stage, the presence of a psychotherapist will be extremely important in eliciting verbal dialogue among group participants.

Music Therapy with At-Risk Adolescence Girls

It is important to identify the vulnerabilities among adolescent girls because they are the focus of this study. The issues that adolescent girls deal with differ from those of their male counterparts. As a society, we are more accepting of aggression in males than in females (Rubenstein & Zager, 2002). In the public sphere, girls are taught to be polite and emotionally secure. However, this does not mean that girls are devoid of all feelings.

As adolescent girls develop, they are expected to express themselves as calm and composed. This leads many girls who do have feelings of anger, resentment, assertiveness, among many others, to engage in self-destructive behaviors as a mechanism of burying these feelings (Rubenstein & Zager). Because many young girls are taught to cover up their true feelings, depressive disorders are common (Kuther, Kusumakar, LeBlanc, Legace, & Morehouse, 2004). It is estimated that adolescent girls are twice as likely to have experienced an episode of depression than adolescent males (Kuther et al.). One reason adolescent girls may experience such high rates of depression is due to the influences in Western culture that places unrealistic expectations on them.

Although anorexia is not the clinical diagnosis of the participants in this study, a large portion of the adolescent girls who do participate may struggle with body image issues at some point in their lives. Parente (1989a) stated that although there has been much clinical work accomplished, very little has actually been written about the use of music in treating persons with anorexia nervosa.

The powerful use of musical interventions and its mediating power may offer some initial clues to therapists concerning the complex combination of issues that young people suffering from anorexia nervosa may be experiencing (Robarts, 1994). As these intense emotions begin to surface, along with the demanding societal expectations placed on girls, it may be that drugs are turned to as a way of coping in order to avoid the pain of reality (Freed, 1987). The United States has witnessed a steady increase in drug use among adolescent girls who are now using more illicit drugs than they were in the past (Freed).

The combination of these complex issues may contribute to the powerful motivational force that lead many girls to pursue thinness (Striegel-Moore & Cachelin, 1999). These forces are the combination of the cultural prescript for girls to care about others' opinions, their definition of themselves through their physical appearance, and the particular beauty ideal of extreme thinness. This impractical ideal leads girls to develop negative narratives of their bodies and the behavioral efforts to achieve or maintain a thin body, which contribute heavily to the development of an eating disorder (Striegel-Moore & Cachelin, 1999).

It is important when working with this population to develop preventive efforts to combat eating disorders and depression by understanding the combination of factors that lead to positive body image and healthy eating (Striegel-Moore & Cachelin, 1999). Being able to create and respond to rational thoughts and feelings is a vital prerequisite to recovering from anorexia (Parente, 1989a).

Anorexics have been found to have experienced an increase in stress levels due to the intense urge and demands women place on their bodies to change (Parente, 1989b). Music may be a key indication as a means of reducing these stressors (Parente, 1989b). Not only does music aid in the reduction of stress but it can be a catalyst to increasing self-esteem (Parente, 1989b). Music therapy experiences may further develop her own feelings of self-worth and her belief in her capabilities outside of music therapy. Whether she is acting as the musical leader of the group, or a simple participant in structured musical situations, the participant may experience personal success and accomplishment through something other than weight control. While gaining mastery over this newly

found sense of self-control, she may also experience the esteem of others for the music that it creates between group members (Parente, 1989b).

The overall goal of the use of music with persons struggling with anorexia is to provide clients with a wide range of group experiences and levels of achievement that demand self-organization within a group (Parente, 1989b). Examples of these goals include learning to evaluate her own performance without input from others, continually attending music therapy groups despite insecurity regarding whether others like her, offering critiques of music without fear of rejection from others, taking responsibility for creating modalities within the group experiences and risking the criticism of other group participants, openly communicating with other group participants between musical activities, and sharing herself on a personal level.

Conclusion

Adolescence is a time filled with unique challenges as the transition from childhood to adulthood is experienced. With the new-found ability to conceptualize societal interactions, adolescents engage in deep contemplation of self and others. As music plays a powerful role in our culture as a form of enjoyment, entertainment, communication, education, and expression, it has the unique ability to connect all people across a wide continuum of human differences. In a psychotherapeutic context, music may serve as a means to elicit meaningful and profound verbal dialogues through its experiential elements.

There have been many studies in the field of music therapy that have documented the integration of musical interventions and psychotherapy. However, the field of psychotherapy presents few connections to the field of music therapy as useful in

psychotherapeutic clinical practice. It is my hope that the empirical evidence presented throughout the literature review strengthens the support for creating a co-facilitated intervention model integrating psychotherapy and music therapy.

I believe that the inclusion of music therapy in the context of group psychotherapy with at-risk adolescent girls will produce benefits. These benefits will become apparent as participants report increases in therapeutic outcomes based on information collected through the Therapeutic Factors Inventory (TFI; Lese & MacNair-Semands, 2000). Likewise, the descriptive data collected through informal interviews following the study will create a clearer picture of how the inclusion of musical interventions aid in achieving successful outcomes of the therapeutic process. Overall, the study aims at identifying what therapeutic factors increase the likelihood that participants will experience strong group cohesion and trust leading to increased self-disclosure and enjoyment of therapy.

CHAPTER 2

Method

Participants

Participants for this study were drawn from The Center for Community Justice and Partnerships, also known as *The Center*. The Center is a not-for-profit agency located in Fort Collins, Colorado, whose aim is to provide education and prevention programming to youth and families who reside in Larimer County. The Center's main objective is to develop and foster programming for youth and families who are challenged with drug and alcohol use, anger management, poor life skills, and at-risk behaviors. The mission of The Center is to create programs and support systems to help youth and their families sustain long-term, positive changes and relationships so that young people can see themselves and act as successful and productive citizens.

Adolescent girls age 14-18 were selected from the Expressions and Pathways programs at The Center. The purpose of these programs is to assist young women in achieving leadership and life skills while strengthening their confidence to make sound life decisions. This is particularly beneficial because the co-facilitated group therapy and musical experiential intervention aims to achieve similar goals.

I attended the Expressions and Pathways class at The Center one and two weeks prior to the start of the co-facilitated intervention where an open invitation was given to anyone who was interested in participating in the study. I spent about 20 minutes at the beginning of each class to talk about music therapy, myself, and my therapeutic approach: answered questions: and briefly discussed the purpose of the study in the hopes of gaining the adolescents interest to participate. I explained that choosing to participate

in the study replaces the requirement of the class the participants are currently enrolled in at The Center. Other incentives included two adult movie tickets. The first 10 girls to respond to the invitation were accepted. Each participant was asked to submit a signed agreement from her parents in order to participate in the study (see Appendix A). Because The Center offered a weight training class as a secondary option to attending the study that was not brought to my attention until the day I began recruiting participants, I experienced difficulties in recruitment: only three participants signed up. A lack of support from The Center and poor enrollment resulted in a loss of quantitative data. Thus, from this point on, I had to treat this intervention as a pilot study.

Measures

My goal was to measure the impact of the group through pre-and posttest quantitative data collected using the Therapeutic Factors Inventory-Short (Lese & MacNair-Semands, 2000). Each participant (n=3) completed the TFI-S prior to the intervention. However, posttest data were not collected as a result of poor enrollment.

Although the TFI-S was not used, I believe it would have been a helpful tool in assessing the therapeutic factors contributing to the outcomes associated with the group. The TFI-S was created as an updated extension of Yalom's (1995) widely used scales classifying the therapeutic factors in group therapy. Lese and MacNair-Semands believed that slight improvements and greater development of Yalom's scale would yield a measurement that is easy for participant use as well as provide a useful means of measurement for practitioners and researchers.

The Therapeutic Factors Inventory "was designed to provide a comprehensive, empirically-based measure to determine the presence or absence of therapeutic factors in

a particular group" (Lese & MacNair-Semands, 2000, p. 306). There are two versions of the TFI, a full version containing 99 items (TFI-L) and a short version (TFI-S) that contains 44 items. Both versions includes 11 scales and a 7-point Likert-type Scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

The TFI-S scales along with their reliability coefficients and sample questions include: instillation of hope (e.g., *seeing others change in my group gives me hope for myself*; α=.93), universality (e.g., *in group, I have learned that I have more similarities to others than I would have guessed*; α=.87), imparting information (e.g., *my group gives me suggestions on how to solve problems*; α=.78), altruism (e.g., *helping others in my group makes me feel better about myself*; α=.81), corrective reenactment of the primary family group (e.g., *I find myself thinking about my family a surprising amount in group*; α=.79), development of socializing techniques (e.g., *in my group I find better ways of dealing with other people*; α=.88), imitative behavior (e.g., *I have gotten some good ideas about how to interact by doing the same thing someone in my group has done*; α=.85), interpersonal learning (e.g., *learning how to express myself to others in the group has deepened my relationships*; α=.79), cohesiveness (e.g., *I feel a sense of belonging in this group*; α=.87), catharsis (e.g., *even though being upset is hard, we try to let out our feelings in this group*; α=.78), and existential factors (e.g., *in group, I am encouraged to trust my own feelings and make my own decisions*; α=.82).

Test-retest reliability coefficients on all 11 scales show high coefficients (r=.83). Construct validity has been shown as the levels of therapeutic factors increased as a function of time in group therapy. Scales on the TFI-S are significantly intercorrelated. This suggests that rather than separate dimensions of therapy, the scales tap into a single

global impression of the impact of therapeutic factors. Significant correlations are also seen between the TFI-L and Inventory of Personal Problems (IPP) scale. This correlation revealed that the participants who found it hard to be assertive, as well as participants who often feel responsible for others, perceived the group as significantly higher on the altruism scale following therapy. Overall, MacNair-Semands and Lese (2000) found their results to "provide construct validation of the TFI measure and further our understanding of how the TFI can illuminate perceptions of the group experience in a format beneficial to group leaders" (MacNair-Semands & Lese, 2000, p. 167).

Interviews

To ensure criterion validity, informal interviews served as an alternate form of information gathering. Although interviews were presented in a different form than that of the TFI-S, they measured similar constructs. Interviews were conducted to gain descriptive feedback from the participants involved in the study. As a result of only one participant completing the six-session intervention, only one interview was conducted. The interview lasted for 40 minutes. The interviewer was a trained psychotherapist who was not involved in the intervention. Although the researcher would have liked to interview the two participants who failed to complete the intervention, I was unable to do so as a result of complications concerning their status at The Center. The interview was audio recorded and transcribed. Questions asked include:

1) How well did you feel connected to the therapists? The participant answered this question on a scale from 1 (*not at all true*) to 10 (*very much*). After a number is given, the interviewer gathered more information about why they

chose that number asking the participant to explain and expand upon her answer and possibly provide examples.

2) Do you feel like you benefited from this group in any way?
3) What did you find helpful?
4) What suggestions for improvement do you have?
5) Did you feel comfortable with the other members of the group? If not, why not? If so, why? What do you have in common with them? Did you learn from others in the group? If so, what?
6) What was your favorite activity out of all the sessions? What was so great about it? How did that affect you?
7) What was your least favorite activity in the group? Could you explain why? What could have made it better?
8) Describe the most significant event or activity that occurred in group. What did that particular event do for you? How did it help?
9) Overall, on a scale from 1 (*not much at all*) to 10 (*very much*), how much do you feel you got out of this group?
10) What did you think about the music specifically? What did you think about the use of music?
11) How did this compare to your previous experiences in therapy?
12) If there is anything you would like to add or any overall feedback of the group experience you would like to include?
13) Allow for participants to explore issues that come up.

Procedure

This is a repeated measures design study that followed the structure of the transformational design model (TDM) as outlined by Thaut (2003). The five steps of the TDM (2003) are summarized as follows: (1) diagnostic and functional assessment of the patient, (2) development of therapeutic goals/objectives, (3) design of functional nonmusical therapeutic exercises and stimuli, (4) translation of step three into functional, therapeutic music experiences, and (5) transfer of therapeutic learning to real world applications (Thaut).

In this study, steps one and two were established prior to the first group therapy session. Specifically, each participant receiving treatment at The Center is considered at-risk. According to this study, at-risk refers to individuals who may have one or more of the following: come from unstable or dysfunctional homes, have issues with body image and eating disorders, substance abuse, or have been involved in criminal activity. Therefore, the therapeutic goal, step two of the TDM, is to maintain a safe and empowering environment for the participants to express their thoughts and feelings concerning life's challenges and difficulties, and even accomplishments. In step three of the TDM, the psychotherapists established a protocol for the six-session intervention. Step four of the TDM outlines how the musical intervention will follow the protocol as the established context, while using music as the experiential content for the therapeutic intervention.

The final step of the TDM concerns whether the desired therapeutic goals were met throughout the psychotherapeutic intervention. In this study, the music therapist and the psychotherapist worked together to assess the participants, establish goals and objectives, and help the participants apply their learning to the real world (steps 1, 2 and

5). Meanwhile, it is the third step that outlines the main duty of the psychotherapist and fourth step that outlines the main duty of the music therapist.

Treatment Plan and Session Outline

The following outline is a result of the six week co-facilitated intervention. To examine the original treatment plan and the concepts regarding its creation refer to appendix G. There, steps three and four of the TDM are explained where the psychotherapist and music therapist worked together to establish a working treatment plan to achieve the desired therapeutic goals of the group. However, the following outline will briefly discuss the attendance, interventions, and activities of each session.

Three participants exhibited interest through involvement in the six session co-facilitated music therapy and psychotherapeutic group intervention. Of those three, Participant #1 missed only one of the six sessions. The other two subjects failed to continue. Participant #2 failed to return after attending the first two meetings which may have been caused by a dislocated shoulder, and Participant #3 was disqualified and placed back into the court system as a result of shoplifting. The following outline will briefly discuss the attendance, interventions, and activities of each session.

Session One (4-15-05)

Participants # 1 and #2 attended the session. The Therapeutic Factors Inventory-Short (TFI-S) was administered to each participant. In the hopes of having more than two participants, the session was canceled. As a result, the researcher revisited the Expressions and Pathways classes at The Center to recruit more participants in the hopes of gaining a larger group the following week.

Session One, Second Attempt (4-22-05)

Participants #2 and #3 attended the session. The TFI-S was administered to Participant #3 and the Music Interests Survey (MIS, see appendix H) was administered to Participants #2 and #3. After completing the TFI-S and MIS, group introductions and a discussion on group expectations took place. To introduce the music, the music therapist gave a short lesson on how to use the drums and instruments properly. We then engaged in an active music making improvisational jam session facilitated by the music therapist. Following the jam session the group followed the directions of the music therapist through a *call and response* activity. In this activity, the music therapist would play a beat that the entire group would repeat together. After the music therapist provided a good example of leading the call and response activity, each group member got a chance to take the lead. Following the call and response, the music therapist engaged the group in a *stress relief* activity using the drums. In this activity, the music therapist would instruct the group to recall any stressful events throughout the week. Next, we were instructed to start drumming (with mallets) at a low level. As we drummed, she would have us get louder as she transitioned from a one to a five through the visual use of her fingers. The goal was to get as loud as we could while letting out as much stress as possible when we made it to level five. We concluded the session with a discussion of the musical experience.

Session Two (4-29-05)

Participants # 1 and #3 attended. The MIS was administered to Participants #1. We began the session with active music making using percussive instruments. The same order was followed from session one, as we warmed up with a jam session and transitioned to *call and response* and *stress relief* activities. However, this session we

included a new activity called *lead the group*. In this activity, each participant had the chance to choose any instrument in the room and have the other group members play whatever they wanted. We concluded the session with a discussion of the musical experience.

Session Three (5-6-05)

Participant #1 attended. The session began with a short drum lesson on how to use one's hands (rather than mallets) on the drums. We warmed up with a short percussive jam session. Once warm, the music therapist taught us a traditional Cuban rhythm known as the Rhumba. The group took turns trying our improvisational solos while each member supported them playing the Rhumba together. We concluded the session with a discussion of the musical experience.

Session Four (5-13-05)

Participant #1 attended. We discussed and analyzed lyrics to the song *Video* by India Arie (appendix C). For homework, the participant was asked to bring in her own music. In particular, she was asked to bring in music that helps her get through the day and cope with difficult situations.

Session Five (5-20-05)

Participant #1 attended. Although Participant #1 forgot to bring in her music for the session, each therapist brought in a selection for lyrical analysis. We listened to three songs that included *Answer* by Sarah McLachlan (appendix D), *Digging a Ditch* by Dave Mathews (appendix E), and *Ease My Mind* by Arrested Development (appendix F). For the final session, the request was made for Participant #1 to bring in her own music.

Session Six (5-27-05)

Participant #1 attended and brought in a song by Sublime titled, *What I Got*. The group discussed their reactions to the song, the meanings behind it, and why or how each group member connected with it. After a thorough discussion of the song, we finished the session with an active music making activity using percussive instruments. Starting with a warm up jam, we transitioned to the *leading the group* activity. We concluded the session with some pizza and an informal discussion about the experiences in the group. Following our pizza party, Michelle Ayers, a psychotherapist, arrived to conduct the exit interview with Participant #1.

CHAPTER 3

Results

As a result of low participation, the pre-and posttest quantitative data collected by the TFI-S that was expected to measure the impact of the group intervention on the adolescent participants proved to be unfavorable in testing our first research question, what therapeutic factors contribute to the outcome associated with the group? However, interview data provided insights as to the experiences of the youth who participated. Specifically, the interview with participant #1 elicited three themes as significant contributors to the success of a co-facilitated group intervention using music therapy and psychotherapy. Through the process of content analysis (Strauss & Corbin, 1990), these themes were independently identified by four different professionals who read the transcript.

The first theme supports the idea that music provides a comfortable medium to connect group members and therapists. Through the small and intimate setting of the group it may be easier to connect with others and disclose parts of self.

> Music is the one thing that has always been around to get connected with everyone. It was easy to tell them my problems, or chit-chat, easier than being with all the people at The Center. I like smaller groups better. It was a good group. It was a lot easier to talk about what was going on than at The Center. When you're around a lot of people, you don't get the chance to know them very well. It's hard to get the chance to talk and get your opinions heard at The Center, that was what was nice about coming here.

The second theme supports the conclusions that music aided as an affective tool in promoting the expression of feelings. Specifically, interventions using percussive instruments provided an outlet for the expression of emotions, while listening to music can positively alter or express current mood states.

> Drumming helped because if you're really mad, or whatever you're feeling, you can get it out on the drum. Music really helps people get out their anger or make them feel better. It's easy to get out what your feeling with music just like if you are having a bad day and your feeling really depressed, just take out your instrument or listen to music, and just like that, it's like getting out of that mood. Music really does have that kind of power over people.

The third theme supports the idea that the small group environment created a safe and nonjudgmental atmosphere. Specifically, the participant felt free of restrictions leading to greater levels of self-disclosure and comfort.

> You weren't restricted. You could do what you wanted and no one judged you or told you that you are not doing it right. I'm usually a closed person as far as with people and reaching out at my boundary level, so that helped a bit. It's hard to do stuff in front of other people and get creative because you don't want them to judge you. But I had fun, and met new people and for the most part, it was a really good experience.

The interview with Participant #1 supports the hypothesis that the inclusion of music therapy interventions in group psychotherapy with at-risk adolescent girls contributed to the therapeutic process. Music played a key role in facilitating a fun and creative atmosphere leading participants and therapists to develop a close and trusting relationship. As a result, the participant processed reactions and thoughts related to the intervention that influenced her level of self-disclosure.

CHAPTER 4

Discussion

Co-facilitated group interventions with a music therapist and psychotherapist present great strengths. The complimentary relationship between nonverbal musical interventions and verbal communication through psychotherapeutic dialogue resulted in a unique co-treatment. Despite low and unpredictable participant involvement, the six-session intervention was completed. Although only participant #1 completed the final session, she reported gaining a great amount of benefits from the group. These gains were evident as she communicated through the interview that she was able to express feelings, made friends with others, and did not feel judged. Particularly, participant #1 described her experiences in the co-facilitated group as exceeding those at The Center where she is required to attend group sessions.

Although participant #1's interview results supported the main hypothesis of the study, there are serious limitations that do not allow me to draw general conclusions. The most significant limitation was the size of the group. I was expecting between 8 and 10 participants to attend the co-facilitated group intervention. Therefore, having a total of three participants significantly limited any conclusions that can be drawn from the findings. Furthermore, due to the design of the intervention, in which sessions build on previous sessions, the participants' lack of consistency was an additional limitation. Due to the fact that participants attended different sessions and received different dosages of the intervention, there is no way to know if the intervention had any impact. Therefore, as the purpose of this study was to identify if the intervention is workable, I cannot make any inferences about outcomes because the curriculum did not get a fair test.

The greatest challenge of this study was participant recruitment. To achieve better participation that would have led to greater results, I could have adopted several strategies. First, having a closer relationship with the host agency, in this case The Center for Community Justice and Partnerships, would have assured more cooperation, motivation, and support in recruiting and maintaining participants. Likewise, increased interactions with the host agency's case management staff likely would have ensured more consistent participation among group members. Second, it would be beneficial to begin the recruitment process earlier. Rather than waiting until only three weeks prior to the start date of the treatment, it may be wiser to obtain signed consent forms at least two months prior to treatment. Achieving this may give the researchers and clinicians time to connect with the participants and their parents to ensure their involvement in the study. Third, recruiting from multiple sources may ensure a higher number of participants. Rather than relying solely on one agency, such as The Center, it would be beneficial to include similar agencies among the broader community.

Other considerations to enhance participation may include conducting music therapy demonstrations with the possible recruits. These demonstrations may aid the adolescents in gaining a better understanding of what music therapy actually is. Likewise, using quotes from popular musicians about the power of music and talking more about music in general and how it affects us may enhance the adolescents' understanding of what kind of activities we may implement throughout the program. As part of the recruitment process it may be a valuable icebreaker to split the adolescents into dyads to discuss their favorite types of music and why they like it. An activity such as this may aid

the possible recruits in an interactive discussion rather than attempting to convince them why this therapeutic modality would be so beneficial.

Other than issues surrounding recruitment, there are several changes that could be made from a clinical perspective. First, because I expected 8-10 participants, three therapists were committed to facilitating the group. Although the number of participants showed little promise, we still maintained a three-therapist approach, which was inappropriate and intimidating to the few participants who did decide to attend. However, if the above recommendations are followed and participants have signed consent forms well before the start date of the intervention, issues like these can be taken care of with greater attention. Second, assuming there are enough participants to implement a successful group, more than six sessions would be desirable. In particular, 10 sessions may ensure more time to accomplish therapeutic goal and work towards greater group cohesion.

Although this study lacks outcome data, the lead psychotherapist and music therapist gained great insights as close observers of the co-facilitated therapeutic process. Musical interventions such as active music making and general discussions involving music created an instant rapport among the group that markedly influenced the joining process. To actively engage the participants, we found that it was important for each therapist to actively involve themselves in the therapeutic process as active participants in the musical interventions. By engaging ourselves, we were able to increase trust among group participants, leading them to feel more comfortable in sharing their own thoughts and feelings. Although we were able to involve ourselves through the process of self-disclosure, we were careful not to include too much personal information. Rather,

through music we chose to share personal information that may have reflected possible situations the participants may have connected with such as issues involving peer pressure, parents, and school.

Another important insight gained throughout the group was exploring how to transfer what was learned in the therapy to process the participants' home environment. For example, in the third session, participant #3 reported how much she enjoyed the stress relief activity. In this activity, the group utilized percussive instruments to release any stress before concluding the day's session. Particularly, participant #3 reported that she had worked on using the same means to release stress at home. We were able to explore how music, in this context, could create conflict with other household members. This discussion led us to explore alternative ways participants could translate activities we experienced in the group into their homes.

Experiencing therapy as a co-treatment team yielded many benefits. Together, we were able to compliment each other's professional knowledge in drawing out group participants. Although the training of a music therapist and psychotherapist differ, they were complementary to one another. Creating the curriculum together was extremely important. Cocreating the treatment plan and discussing the interventions clarified our expectations and increased out knowledge of the therapeutic process and group goals.

Overall, it is the belief of the music therapist and psychotherapist who co-facilitated the group intervention that the use of music as a therapeutic medium met our expectations and aided in accomplishing the group goals. Music is an important tool for adolescents at this time in their lives. Music especially helped the participants define and express their individuality. Music allowed participants to express themselves while

creating group cohesion through interventions such as active music making and lyrical analysis. Through the use of such nonverbal communicative interventions participants were able to express themselves, join with the group, make their own choices through leading the group, have control over their environment, and gain a sense of empowerment. While participants expressed themselves through the use of self-selected musical analysis, the therapist were able to gain insight into issues the adolescents were dealing with. The therapeutic medium of music offered a new and different experience with opportunities to connect with group members and express themselves in a new and completely original way. Music interventions gave the participants a chance to create something unique and allowed group participants to feel empowered and able to self-disclose at greater levels than traditionally experienced in the psychotherapeutic setting.

Conclusion

Attempting to provide empirical support in bridging the gap between music therapy and psychotherapy has proved to be a daunting but gratifying task. The inclusion of experiential interventions in the psychotherapeutic context provides a great amount of value. There is much to be said about the power of music. Music as an experiential intervention may take the client on a therapeutic journey as it aids in the discovery of intimate thoughts, feelings, beliefs, and desires.

Although the results of this study are promising, they are based on very limited dosage and exposure of the co-facilitated intervention. Similarly, the results are based on global self-reports rather than empirical outcomes. Therefore, the next step one would take in attempting a similar study is to strive for larger groups. Giving the researcher a

larger group would lead the way to measurable outcomes and more information of the effectiveness on a co-facilitated treatment with a music therapist and psychotherapist.

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Appendix A

Consent to Participate in a Research Study
Colorado State University

TITLE OF STUDY:
The experiences of at-risk adolescent girls in group therapy with a music therapist emphasis.

PRINCIPAL INVESTIGATORS:
David MacPhee, Ph.D.
David Braham
Colorado State University
Department of Human Development and Family Studies
491.5303 (DM)
491.5991 (DB)

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?
A music therapy program may help you become more aware of your feelings of self and others while helping form good relationships with peers. Music is a large part of adolescent culture, so it may be an effective tool when working with many adolescent issues.

WHAT IS THE PURPOSE OF THIS STUDY?
In this study, we examine the process and outcomes when group therapy is co-facilitated by a psychotherapist and music therapist. The main goal of each session is to take part in musical activities. The experiences that you gain from the activities will be explored.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?
The study will consist of six weekly sessions of one hour each. The group will take place at a local music therapy clinic called *Rehabilitative Rhythms* located 2 blocks from *The Center*.

WHAT WILL I BE ASKED TO DO?
You will be involved in various musical activities. These activities may include:

- Active music making, such as group drumming.
- Bringing your own music to share with the group
- Lyrical analysis of a music selection by one of the therapists
- Free association to music in the form of drawing or writing
- Writing songs as a group
- Exploring different kinds of instruments and how to care for them
- Music storytelling
- Using instruments and music to express your feelings and play your name
- Sessions will be video taped

Other than participating in the musical activities, you will be asked to explore the outcomes of these experiences in a group dialogue. If you feel uncomfortable with any activity, you do not have to do that activity.

You will also be asked to complete a short survey before and after the intervention that

asks about your experiences in therapy. We will share the general results of the study with the people who wrote the scale and guarantee that all identifying information will remain confidential.

Following the intervention, you will be asked to take part in a short interview regarding your experience in the group. The interview will take place following our last session when it is convenient for you. The interview should only take about 15-30 minutes depending on how much or little you would like to share.

ARE THERE REASONS WHY I SHOULD *NOT* TAKE PART IN THIS STUDY?

If you are not between the ages of 14-18 and you are not female, this study is not for you. Because this intervention is highly structured using music, it might not be the best fit for those who do not feel any connection to music.

You do not need to know anything about music to participate in this study. You do not need to know how to play or read music in any form. The intervention is created so that people who know nothing about music can feel safe, comfortable, and be able to participate.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

This study presents very few risks. The only potential risks are related to self-disclosure and interaction between group members, which happens in the typical sessions you attend at The Center.

Throughout the intervention you will be encouraged to contribute personal ideas, thoughts, beliefs, and feelings. It is possible that any of these situations may create a sense of discomfort. However, the job of the therapist is to assure that you will be treated with care, respect, and comfort. We will never force you to do anything against your will. Although we will stress participation and involvement, it is not required.

It is not possible to identify all potential risks in research procedures, but the researcher's have taken reasonable safeguards to minimize any known and potential, but unknown, risks.

WILL I BENEFIT FROM TAKING PART IN THIS STUDY?

The primary benefit of participating in this study is one of mental health. These outcomes may include:

- A sense of self-worth
- A decrease in feelings of depression
- Increased levels of trust
- Enhanced coping skills for life's difficult moments
- Relaxation skills
- Development of new and healthy communication patterns
- Increased understanding of self and others

- Development of healthy and increased skills in self-expression
- Increased level of respect toward other people
- A renewed sense of security
- A healthy sense of independence
- Increase in self-sufficiency
- Increased sense of hope
- Feelings of empowerment

There are no known benefits in participating in this study, but we hope the data will show that music therapy will benefit other teenagers who are going through similar situations.

DO I HAVE TO TAKE PART IN THE STUDY?

Your participation in this research is voluntary. If you decide to participate in the study, you may withdraw your consent and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.

WHAT WILL IT COST ME TO PARTICIPATE?

No costs are associated with this study. However, if you feel that you would like to continue treatment following the study, it is up to you to fund it on your own. Referrals from the therapists will gladly be given upon request.

WHO WILL SEE THE INFORMATION THAT I GIVE?

We will keep private all research records that identify you, to the extent allowed by law. Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be identified in these written materials. We may publish the results of this study; however, we will keep you name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your name will be kept separate from your research records and these two things will be stored in different places under lock and key.

You should know, however, that there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court. In the process of therapeutic interventions, any disclosed information that reveals situations of child abuse, or the possibility that you pose a threat of danger towards yourself or someone else, we may have to disclose that information to the proper authorities.

CAN MY TAKING PART IN THE STUDY END EARLY?

If you continually show disrespect for the space and feelings of other members in the group, including the therapists, you will be asked to leave as to not hinder any possible benefits obtained by any other participants in the group.

WHAT HAPPENS IF I AM INJURED BECAUSE OF THE RESEARCH?
The Colorado Governmental Immunity Act determines and may limit Colorado State University's legal responsibility if an injury happens because of this study. Claims against the University must be filed within 180 days of the injury.

WHAT IF I HAVE QUESTIONS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions about the study, you can contact the investigator, David Braham at 970-491-5991. If you have any questions about your rights as a volunteer in this research, contact Celia Walker, Director of Regulatory Compliance, at 970-491-1553. We will give you a copy of this consent form to take with you.

Your signature acknowledges that you have read the information stated and willingly sign this consent form. Your signature also acknowledges that you have received, on the date signed, a copy of this document containing 3 pages.

_____

Signature of person agreeing to take part in the study Date

_____

Printed name of person agreeing to take part in the study

_____ _____

Name of person providing information to participant Date

_____

Signature of Research Staff

PARENTAL SIGNATURE FOR MINOR

As parent or guardian I authorize _____ (print name) to become a participant for the described research. The nature and general purpose of the project have been satisfactorily explained to me by _____ and I am satisfied that proper precautions will be observed.

_____
Minor's date of birth

_____
Parent/Guardian name (printed)

_____ _____
Parent/Guardian signature Date

Appendix B

Human Research Committee
Regulatory Compliance Office
University Service Center
601 South Howes Street

To: CSU Human Research Committee
From: Laurie Klith

I am the executive director at *The Center for Community Justice Partnerships*. I am writing to express my agency's willingness to collaborate with David Braham in his thesis study.

We are pleased that David has chosen to implement his study at our facility. I believe the adolescent girls who participate in the music therapy and psychotherapeutic group intervention will experience great benefits. As an organization, we pride ourselves on implementing unique programs and creative learning experiences that aim to meet the needs of a challenging population. I believe that this study will help the adolescents who choose to participate.

I agree to allow David to recruit participants from *The Center*. Teen girls' refusal to enroll in his study will not jeopardize their access to other services we offer. Any of our clients who wish to participate will do so out of their own free will.

David will work alongside Kandy Moore, executive director at *ChildSafe*. Kandy is a Licensed Marriage and Family Therapist (LMFT) and an approved Clinical Supervisor who will work closely with David as they co-facilitate this exciting group. Not only will there be two highly qualified psychotherapists, but the adolescent group will benefit from the music therapy expertise spearheaded by Sarah Lawton MT-BC, NMT. Sarah operates a local music therapy clinic called *Rehabilitative Rhythms*.

I am aware that David has done everything possible to create a safe and positive environment for the subjects who participate in this study. It is my hope that the success that follows will lead *The Center* to have more interaction with interventions such as this one. I believe that the integration of music therapy with a psychotherapist will be a great benefit to the adolescent population. If you have any questions or concerns, please do not hesitate to contact me. Thanks for your time.

Warm regards,

Laurie Klith
The Center
495-0084

Kandy Moore
ChildSafe
493-4333

Appendix C
India Arie - *Video*

Sometimes I shave my legs and sometimes I don't
Sometimes I comb my hair and sometimes I won't
Depend on how the wind blows I might even paint my toes
It really just depends on whatever feels good in my soul

Chorus:
I'm not the average girl from your video
And I ain't built like a supermodel
But, I learned to love myself unconditionally
Because I am a queen
I'm not the average girl from your video
My worth is not determined by the price of my clothes
No matter what I'm wearing I will always be india aria

When I look in the mirror the only one there is me
Every freckle on my face is where it's supposed to be
And I know our creator didn't make no mistakes on me
My feet, my thighs, my lips, my eyes; I'm lovin' what I see

Chorus

Am I less of a lady if I don't wear pantyhose?
My mama said a lady ain't what she wears but, what she knows
But, I've drawn a conclusion, it's all an illusion, confusion's the name of the Game
A misconception, a vast deception
Something's gotta change
Don't be offended this is all my opinion
Ain't nothing that I'm sayin law
This is a true confession of a life learned lesson I was sent here to share wit Y'all
So get in where you fit in go on and shine
Free your mind, now's the time
Put your salt on the shelf
Go on and love yourself
'cuz everything's gonna be all right

Chorus

Keep your fancy drinks and your expensive minks
I don't need that to have a good time
Keep your expensive car and your caviar
All I need is my guitar

Keep your crisp style and your pistol
I'd rather have a pretty piece of crystal
Don't need your silicon I prefer my own
What God gave me is just fine

Chorus

Appendix D

Sarah McLachlan – *Answer*

I will be the answer at the end of the line
I will be there for you while you take the time
In the burning of uncertainty I will be your solid ground
I will hold the balance if you can't look down

If it takes my whole life I won't break I won't bend
It'll all be worth it in the end
'cause I can only tell you what I know
That I need you in my life
When the stars have all gone out
You'll still be burning so bright

Cast me gently into morning
For the night has been unkind
Take me to a place so holy
That I can wash this from my mind
The memory of choosing not to fight

If it takes my whole life I won't break I won't bend
It'll all be worth it in the end
'cause I can only tell you what I know
That I need you in my life
And when the stars have all burned out
You'll still be burning so bright
Cast me gently into morning for the night has been unkind

Appendix E

Dave Mathews – *Digging a Ditch*

Unto your dreaming when you're alone
Unplug the TV turn off your phone
Get heavy on with digging your ditch
Cause I'm

Digging a ditch where madness gives
Digging a ditch where silence lives
Digging a ditch for when I'm old
Digging a ditch where stories told

Where all these troubles that weigh down on me will rise
Run to your dreaming when you're alone
Where all these worries Weigh heavy on my heart
Will rise, will rise, will rise...

Unto your dreaming when you're alone
Unplug the TV turn off your phone
Get heavy on with digging your ditch
Cause I'm

Digging a ditch where madness gives
Digging a ditch where silence lives
Digging a ditch for when I'm through
Digging a ditch I'm digging for you

Where all these worries wear down on me will rise
Where all these habits pull heavy at my heart will die

Run to your dreaming when you're alone
Not what you should be or what you've become
Cause I'm

Digging a ditch where madness gives a bit
Digging a ditch where silence lives
Where all these disappointments that grow angry out of me will rise
Will die, will, die, will, die

Run to your dreaming when you're alone
Unplug your TV and turn off your phone
Get heavy on with digging your ditch

Appendix F

Arrested Development – *Ease My Mind*

I need some time to ease my mind
Thrusted in a world that I don't know
from my mamas lips between my mamas hips
I'm cuddled by her hands because she understands
it's that bond that keeps the movement movin' on.
Life is surrounded with so many insecurities
back stabbin' is like breathing when in poverty.
I try to make my sanity, with the insane
God is secondary to most, when they scrap for money.
But, then again money can cause even more death.
when a African becomes a nigger step n fetch n all.
I dare say when price is right U can buy us all.
well not me, cuz I don't truly give a care about you.
I'll move in poverty, in wealth but I'll surely move!
Ain't syncopated with your beats or your wack grooves
my break beat is to break away from yo thang
All these things you put on me makes this brother sing...

Chorus:
I need some time to ease my mind.
Mind & soul is even more important then body
money can put my body in all exotic spaces
meanwhile my mind & soul remotely dwells
within that fine spot between all messed up & hell.
And so I move on with confidence of harmony
And do my thang to resist this wack society
Cuz if you don't resist, & I mean consciously
you'll fool your sub-conscious into accepting it.
I ain't acceptin' it - I keep my focus
I keep my focus - I ain't acceptin'it.
Give me a face pencil to draw a smile on me.
Answer my prayer to give my Earthly body inner peace
Answer my prayer to give my Earthly
body inner inner peace. Until that day upon which my souls released!

Chorus

I need some time need some time
when the sista's say it then you know it's gotta be real!
Thrusted in a world that I don't know
from my mommas lips between my mamas hips
I'm cuddled by her hands because she understands
It's that bond that will keep the movement movin' on

It's that bond that will keep the movement movin' on.
And so I gotta be ready to relinquish
gotta be ready to relinquish, my breath of life for struggle.
That is why I tell you...
I need some time to ease my mind.

Appendix G

Treatment Plan and Session Outline

The following outline is a result of steps three and four of the TDM where the psychotherapist and music therapist worked together to establish a working treatment plan to achieve the desired therapeutic goals. The following interventions are not only the result of the ideas created by the music therapist and psychotherapist who facilitated the group, but also result from information presented throughout the music therapy literature when working with the adolescent population. The order of sessions is designed to start off with musical interventions that are simple and fun, while moving towards more emotional and personal topics as the final sessions approach. This will help to ensure that the group has a chance to create positive cohesion and trust. We expected but were not committed to the following list because interventions may vary according to feedback from the participants' music interest survey (Appendix H) as well as issues and interests that may have surfaced throughout the week or in session. For a more complete literature review and discussion of these interventions, see Appendix I. The group will take place over the course of six weeks. Sessions will be one hour and a half hours and will be held once a week.

Session 1.

- Therapist and group introductions
- Active music making with percussive instruments
    - Introduction to drumming. How to use the drum properly.
    - Improvisational percussive jam session.
    - Call and response
    - Stress relief

- Experiencing musical instruments while learning how to properly care for them. This will unfold naturally as participants explore instruments they would like to use in the active music making sessions.
- Discussion of musical experience
- Music Interest Survey

Session 2.

- Active music making
    - Improvisational percussive jam session (warm up)
    - Call and response
    - Stress relief
    - Lead the group
- Discussion of musical experience

Session 3.

- Active music making
    - Drumming to recorded music by, Christine Stevens, entitled *Women's Empowerment Drumming*
- Lyrical analysis
    - India Aries song, entitled *video*, (See Appendix D for lyrics)
    - Discuss song
    - Explain instructions for participants to bring in a song for next weeks session. Use *Video* as an example.

Session 4.

- Self-selected music

- Participants will bring in an example of their own music that has positive messages that help them to cope and relax.
- We will give participants a chance to play their song selection and leave time to discuss it with the group.

- If there is anytime left, we will continue our discussion and relate their song selections to overall societal themes, or transfer what we have learned from their song selections into an active music making activity.

Session 5.

- Group Check-in
  - Feedback
  - Check in on their week
  - Link current issues that come up within the group to writing a song about it. (e.g., struggles communicating with parents, peer pressure, relationships, etc.)
- Group songwriting
  - In this activity, depending on the primary issues of the group participants, the therapists will create a theme for the song to make sure that the activity is appropriate and beneficial.

Session 6.

- Group Check-in
  - Talk about this being their last session
  - Praise group for hard work
  - Our goal will be to make this session fun, but very important

- Write on a sheet of paper for 3-5 minutes about how you have used things you have learned throughout our time together that you have utilized outside of our sessions.

- Discussion
  - Talk about triggers for eating problems, drug abuse, acting out, etc.
  - Using music to cope and process their feelings. (e.g., isoprinciple – the participants start by selecting music that reflects where they are emotionally. Music is then chosen that gradually reflects a more positive emotional state. If a participant is very angry, it is acceptable for them to listen to music that expresses their present emotional state. However, they are then encouraged to change their music selection to begin to reflect more positive emotional states.
- Music and relaxation
  - The music therapist will provide live music while the psychotherapist directs the group using deep breathing and guided imagery relaxation exercises.
- If we have time, we will close with an active music making percussive jam session.

Appendix H

Music Interest Survey

Name:_____ **Date:**_____

(1) Have you ever played any musical instruments? Please circle: Yes or No

If "yes", please list all the instruments you have played, and how long you played them:

_____
_____
_____
_____
_____
_____

(2) Have you ever played or sang in a group? (e.g., choir, band, etc.)
Please circle: Yes or No

If "yes", please list:

_____
_____
_____
_____
_____
_____

(3) List your favorite style of music (e.g., rock, hip-hop, rap, country, etc.)

_____
_____
_____
_____

(4) List your 5 favorite bands

1._____
2._____
3._____
4._____
5._____

(5) How often do you listen to music? Please circle one of the following:

Never		**Sometimes**		**Very Often**
1	2	3	4	5

Appendix I
Music Therapy Interventions

Active Music Making

Listed in the following pages are music therapy interventions that have been used in past studies. Many of these interventions may be relevant to the current study. Musical interventions to be chosen for the purpose of this study will be co-facilitated by a music therapist and psychotherapist. Therefore, the interventions are designed to achieve two goals. The first goal involves engaging the adolescents through nonverbal musical experiences employed by the music therapist. The second goal, facilitated by the psychotherapist, is to assist the participants in verbal discussions in reaction to those experiences. As Rio and Tenney (2002) suggest, there is no one music therapy method or technique that taps into adolescents' needs better than one or another, except that which is meaningful to the person receiving treatment. Once a meaningful musical experience is achieved, contributions to the development of interpersonal relationships and even significant attachments may be experienced (Rio & Tenney). It is important to understand that the list that follows will serve as a template for interventions which may or may not be used depending on the interests of the adolescents involved in the study.

In the process of developing a positive power structure and the trust of the group, the therapists must engage as much as possible with the activities introduced to the group. This means that while the music therapist facilitates the musical interventions, the psychotherapists must actively engage as much as possible in the process. By doing this the psychotherapist will develop his or her own thoughts and feelings that can be contributed. The hope is to set a positive example for the group as we model relevant, positive, and engaging disclosures in reaction to each experienced activity.

The music therapy interventions commonly used with adolescent groups include, but are not limited to: active music making, bringing self-selected music, lyrical analysis, song and creative writing, music and the creative arts, experiencing proper care for musical instruments, musical storytelling, playing your name, and playing your feelings.

Active Music Making

A positive way to introduce and engage group members in therapy when music will be used is to start off with fun and engaging active music making. The purpose of active music making is to create a playful atmosphere where the adolescent participants and therapists can get to know each other and build a sense of trust. To achieve this, the music therapist will facilitate a successful jam session leaving the subjects with a sense of excitement. To achieve a successful jam session, the music therapist should strive to actively engage all group participants in maintaining a steady rhythm. This can be done by asking each participant to play the same beat or allow them to explore different instruments and experiment with their sounds. In fact, Wyatt (2002) emphasized that allowing adolescents to improvise their own beats on rhythmic instruments provides the clients with the opportunity for immediate success and enjoyment. Wyatt further stated that adolescents tend to respond well to percussive instruments and recommends Babatunde Olatunji's *Drums of Passion* Songbook (1993), which contains many songs and rhythms that adolescents can learn to play in a relatively short period of time. In particular, Wyatt identified the song *Fanga Alafia* as a good example because the beat is exciting and the melody can be played on the metallophone to accompany the drums and the singers. A metallophone is a marimba that has metal bars instead of wood bars. Metal bars create a sharper sound than would be experienced on a wooden marimba which

would produce deeper sounds. Marimbas are categorized as an Orff-type instrument. In the field of music therapy, an Orff-type refers to melodic instruments, such as marimbas that have bars that can be removed in order to create various scales and modes.

Using a wide range of percussive instruments, Richard and Watkins (2003) encouraged group participants to support each other throughout the active music making activity. Richard and Watkins also encouraged participants to solo. To solo means participants are given permission to diverge from the common rhythm of the group and improvise with their instrument of choice. Richard and Watkins also achieved engagement with their participants through call and response rhythm games, rhythm ensembles, and creative improvisations, all with the use of percussive instruments.

Winkelman (2003) declared that the program *Drumming Out Drugs,* provided evidence that drumming can play a substantial role in addressing addiction. According to counselor Mark Seaman, drumming provided shut down, angry, and disenfranchised youth an avenue for expression (Winkelman, 2003). Seaman begins his program with drumming as soon as the subjects enter the group allowing them to play spontaneously as he lays the groundwork for non-verbal communication. Rather than assuming they are willing to share information about themselves verbally, Seaman asks participants to show how they feel through playing a rhythm on the drum. Seaman is one of many counselors who claims that drumming has the ability to pull a group together, creating a sense of community and connectedness (Winkelman). Mikenas, a music therapist and substance abuse counselor, asserts that drumming not only emphasizes self-expression, but has the ability to teach the building blocks of healthy relationships while addressing issues of violence and conflict through expression and integration of emotions. Mikenas asserts

that drumming gives each subject the opportunity to learn and experience leadership and discover one's own potential (Winkelman). Overall, Mikenas considers the use of drumming to include many benefits. These benefits are: a) increased sensorimotor coordination and integration, b) increased bodily awareness and attention span, c) anxiety reduction, d) enhanced nonverbal and verbal communication skills, e) greater group participation, f) enhanced leadership skills, g) positive relationship building, and h) skills for self conscious development along with social and emotional learning (Winkelman).

Wyatt (2002) utilized a percussive rhythmic intervention utilizing a method of improvisation. Improvisation has been effective with adolescent groups. This occurs when one participant begins the piece by playing a simple rhythm. As this participant maintains a simple beat, each participant, usually in clockwise order, will then add a rhythm to the first rhythm, using a variety of percussive instruments, until everyone is playing at once. All of the above mentioned activities accomplish the first goal, allowing each participant in the group to non-verbally experience the power of music.

In the process of eliciting verbal discussions based on these musical experiences, Wyatt identified useful questions asking each participant things like: What were you thinking or feeling when you were making the music? Were you aware of the other group members during the music? Did you feel that you were playing with a specific person in the group? Did you notice when a specific person stopped playing? Of course any therapist can add whatever they feel will help the members reach deeper into their thoughts and feelings concerning the experience. Questions which come to my mind focus on each members experienced feelings, rather than the adolescent's perception of other people in the group. Examples of these questions may include: What feeling came

to you as you were playing? Where did you feel it in your body? Have you felt those at any other time outside of therapy? What was the best part of this experience for you? The second goal may be achieved by engaging in an active discussion as each participant will be given the chance to articulate what about the experience was meaningful to them.

Bringing Self-Selected Music

After the participants get the chance to engage in active music making and explore many of the musical instruments available, it will be important to give each participant a chance to express her personal and individualized connection to music. This can be accomplished by allowing each participant the chance to bring in self-selected music that has pertinent meaning to her self. To create a safe and appropriate atmosphere, Wyatt (2002) believes it is important for the therapist to communicate to the group exactly what type of music is acceptable, and preview the lyrics of any unfamiliar song before it is played in session.

Montello and Coons (1998) asserted that not all music therapy focuses on active music making. Rather, it is common with adolescents that any recorded music they bring to the therapist or group may give them the chance to share their own interests, feelings, and life story through the selections they share. As they share their selections with the therapist or group, they may find that they are not alone in their suffering and soon begin to feel a sense of comfort in the musical sharing which can provide a safety net for them when they use the music more creatively in active music therapy interventions (Montello & Coons, 1998). Bednarz (1992) emphasized that the presence of structured listening activities encouraged group members to share their musical tastes. Through rating popular songs and developing the groups own top 10 list, an opportunity for individual

sharing was developed as the group formed its identity surrounding their musical interests.

Rickson and Watkins (2003), encouraged group participants to bring his or her favorite music to share with the group in the hopes of stimulating discussion. One student per week would play his or her chosen piece to the group and then be invited to talk about why he or she chose that music. Other group participants would then be asked individually to make a positive comment about their peer's choice. Through this activity the first goal is achieved, as group members get to experience the fun of listening to music in a setting where there is usually little room for such an activity. Of course this is assuming that they do find it to be a fun activity. Regardless, as each participant shares his or her personal music selection with the group he or she will in fact be sharing information that may have pertinent meaning in his or her life. The second goal will be achieved as the group engages in an active discussion about the song selections and their meaning to the participant who brought it in as well as getting feedback from the group.

Lyrical Analysis

The difference between self-selected music and lyrical analysis is that lyrics which will be discussed and analyzed will be selected by the therapist. Wyatt (2002) encourages the therapists to select music for lyrical analysis that will encourage progression towards the client's therapeutic goals. To engage group participants, Wyatt (2002) suggests that in order to focus the discussion about the song lyrics, it would be helpful to create a written questionnaire concerning the song for the adolescents to answer on their own, making sure that each question is worded in simple clear language. Wyatt identified two valuable internet sources in locating lyrics for lyrical analyses.

These websites are: The Original Hip-Hop Lyrics Archive, located at www.ohhla.com, and www.azlyrics.com, which catalogues song lyrics from a wide variety of genres.

Cooke (1969) used recorded music that acted as a successful tool in aiding his participants towards establishing a meaningful and positive relationship with the therapist and to express their confused, often sad, and anxious feelings. More importantly, the participants were able for the first time to maintain some control over these feelings as a result of the structure and order involved in the musical experience. Overall, according to Henderson (1983), listening exercises which emphasis mood recognition and awareness have been effective in enhancing self-esteem and group cohesion. Bednarz (1992) used Billy Joel's *You're Only Human*, a song about suicide, to stimulate discussion about what each group members reasons were for continuing along life's hard lived path.

Parente (1989b) claims that the best songs to use with anorexic clients include affirmations stated in songs, writing songs with strong affirmations, and listening to music whose personal associations generate the thoughts and feelings stated in affirmations. Songs such as *I am a Woman,* or lyrics about learning to love yourself from *The Greatest Love of All* by Whitney Houston can be effectively used to demonstrate socially conscious and positive affirmations (Parente, 1989b). Another song that incorporates socially conscious and positive affirmations is *Video* by India Arie. The premise of *Video* is to examine the societal expectations women are taught to assume and how these expectations are dealt with. The song asserts that women should feel proud of their bodies and personal decisions no matter what anyone else may think. Lyrical analyses of *Video* may be especially useful for women who struggle with issues surrounding body image and eating disorders.

Clendenon-Wallen (1991) concluded that song discussion and listening were important, safe and non-threatening. In this safe environment, adolescent subjects were able to empathize with the principal characters experience or feelings, and in doing so, project their own personal feelings and experiences into the discussion. Through the discussion of songs, adolescent subjects appeared to facilitate self-disclosure by creating a non-threatening environment for verbal interactions.

The goals in these activities are very similar to those presented in the activity of bringing in self selected music. The difference in this activity is that the therapist picks out what they would like the group to listen to. If the therapist chooses what music selection to bring, song selections may be more relevant to the group goals of exploring feelings and coping skills.

Song Writing and Creative Writing

Skaggs (1997) concluded that in some cases where youths are unfamiliar with the medium of art or music, or may be reluctant to express themselves through these modes, the use of writing with the presence of music may aid as a familiar alternative. The process of writing unspoken thoughts and feelings, according to Skaggs (1997), can lead to greater self-understanding. Furthermore, Johnson (1981), concluded that songwriting activities aimed at clarifying values were found to have positive effects on socially disadvantaged adolescents' self-concept.

In light of psychotherapeutic narrative techniques, Freedman and Combs (1996) would suggest that recognizing this form of an alternative story would give the therapist an understanding that will help identify a side of each participant that does not fit their dominant persona. It is often the case that the adults and people of authority in the

adolescent's lives tend to view the adolescent as trouble or the problem. Using the narrative approach, an attempt is made to change that negative story into a positive one. As a psychotherapeutic technique, written stories are just one way to achieve this goal.

Similarly, Skaggs (1997) assert that writing songs can aid as the medium for creating stories that can heal or stretch the adolescent imagination into more universal concepts. In other words, writing activities can aid group participants to find deeper meaning in evaluating the impact the music had on them. The duo of musical experience and writing activities will also aid the psychotherapist in eliciting these thoughts through verbal discourse and therefore achieve both the goals of non-verbal and verbal experiences.

A good example of this type of narrative is when Skaggs (1997) read a story to group participants about the heroic Greek God, Theseus. After the reading, the group discussed what it means to be a hero in this modern world. Following the discussion, each participant was asked to create a story about a hero. Although this particular artistic activity was used without the use of music, it can certainly be adapted.

In a study conducted by Rickson and Watkins (2003) the use of song writing was employed to elicit active participation as participants each contributed to creating a song to the widely used 12-bar blues pattern. This activity provided a useful structure as the 12-bar blues musical form accommodates short repetitive ideas that can be built on or be resolved in the final phrase. The 12-bar blues pattern can also be beneficial as is provides a predictable structure for the group participants to know when the song transitions, repeats, and ends.

Many of the female adolescents involved in this study will likely have issues with chemical dependence on methamphetamines as a means of weight loss. Freed (1987) emphasized that the initial goal of songwriting with chemically dependent clients is to encourage the expression of feelings based on the individual's situation. According to Freed (1987), in the process of creating an environment where songwriting will lead to success, the therapist should aim to implement the following techniques. These techniques are: a) to create a non-threatening environment, b) to lead-in activities, c) to use cloze procedure technique or the fill-in-the-blank method, and d) to write new words to pre-existing melodies. I will briefly describe in more depth what each of these techniques mean by providing examples.

To create a nonthreatening environment Freed (1987) maintains that the therapist should assure the clients of the following, a) as long as they are honest with themselves, anything written will be acceptable, b) the therapist will assist at any time, c) songwriters will not have to perform their songs, d) they need not worry about spelling or phrasing, and e) the song does not have to be perfect to have value or to be therapeutic placing the value on the person rather than the product. Freed (1987) described lead-in activities as a bridge to prepare group members to feel comfortable in writing songs. This can usually be done by engaging in discussions that may influence the subject to identify a topic to write about. In the cloze procedure, Freed (1987) explains that fill in the blank techniques can aid group members to write the songs about themselves, their situation, and their feelings. Two examples Freed (1987) uses are Neil Young's *Heart of Gold* and Kerry Livgren's *Dust in the Wind.* In both songs, some of the lyrics are blanked out so the subjects can add their own words and share them with the group. In the last technique,

creating new words for pre-existing melodies, Freed (1987) declares that using familiar tunes for songwriting has specific advantages that, a) it does not require extensive compositional skills, b) the song can be written within one session, and c) songs written to familiar tunes can easily be performed by the group members or music therapist for immediate reinforcement.

Music and the Creative Arts

With the goal of using music to influence adolescents self-confidence and self-esteem, Clendenon-Wallen (1991) conducted a study using a variety of music related activities. One activity combined the use of music and art activities. Specifically, participants contributed in session by designing record album covers. Participants chose titles that portrayed their personalities for the front cover and listed songs that expressed their feelings and emotions for the back cover.

In another activity, Clendenon-Wallen (1991) facilitated a music and art activity to help engage her adolescent subjects in their journey for self-exploration and understanding. In this activity participants were asked to draw their picture in a diagram of a mirror while listening to *Man in the Mirror*, by Michael Jackson. On the front they listed their personality attributes and on the back, they listed those things they wanted to change about themselves. Support was given to each subject who shared their personal insights from participants leading to an effective activity.

Experiencing Musical Instruments While Learning how to Properly Care for Them

Rickson and Watkins (2003) assert that group participants should be encouraged to have the opportunity to experience care for musical instruments and to share these with each other in appropriate ways. Rickson and Watkins (2003) encouraged group members

to explore unfamiliar sounds, to listen to the creative sounds with their peers, and ask for and to receive instruments in a respectful manner. In this intervention, the knowledge of the music therapist will be elicited by the group through the explanation and demonstration of each instrument. While the music therapist attempts to educate the group concerning the instruments, the psychotherapist will assist in setting behavioral limits while working with group members on respectful communication among the group as well as respectful behavior towards the music therapists and their instruments. This is a helpful activity as adolescents are be given the opportunity to work on their communication skills with other people and their possessions of value.

Musical Storytelling

In a study conducted by Haines (1989), the use of musical storytelling was used as a gateway to engage adolescent participants in the therapeutic process. In this intervention, the role of the music therapist is to play a piece of music that is fitting to the participants of the group. While the music is being played, each participant may contribute to the creation of a story. In this intervention the therapist may experience more success if the group decides prior to the activity what topic they would like to explore. In this activity, non-verbal and verbal experiences are drawn out simultaneously.

Music and Names

Haines (1989) asked her clients to sing or improvise a song about their name. This activity gives each participant the chance to experience the full attention of the group. Each participant will maintain complete control as he or she can use the time to create music individually or use the group for assistance. It would be helpful for the therapist to

elicit group dialogue by asking the group what positive things they noticed about each participant's contribution.

Playing Your Feelings

In a study conducted by Skaggs (1997), using an assortment of Orff-type instruments, each participant was encouraged to select the strongest feeling that was present within themselves on that particular day. As the participant played his or her feelings, the other participants task was to help in identifying the feeling that was being played. According to Skaggs (1997), this activity not only gave participants the chance to express feelings in a way that was non-threatening, but it encouraged focused listening, respect, and validation of feelings from peers.

Conclusion

All of the interventions outlined above have proven to successfully demonstrate the therapeutic benefits musical interventions play in adolescent treatment. As all of the interventions mentioned above were facilitated solely by a music therapist, imagine the outcome when music therapists and psychotherapists are given the chance to work alongside one another. Interventions will be chosen prior to each group session based on the therapist's goals. Interventions will also be chosen from feedback collected from the group.