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Adjudicated Adolescents

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Chapter 18

Adjudicated Adolescents

Susan C. Gardstrom

INTRODUCTION

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This chapter highlights music therapy practice with adjudicated adolescents, also referred to as *juvenile offenders* or *delinquents*. In 2008 alone (the most recent year for which statistics are available), juvenile courts in the U.S. took action on more than 1.6 million petitions of delinquency. Some of these cases were dismissed; some were waived to adult, or criminal, court; still others resulted in *adjudication* (a determination of guilt) with subsequent dispositions of community service, restitution, fines, probation, and/or mandatory placement in treatment programs of varying levels of security (National Center for Juvenile Justice, 2009).

The American Music Therapy Association (AMTA, 2010) reports that 18.5% of its members are employed in mental health settings and that 13.4% serve teens, which could include delinquent youth. A smaller percentage (less than 2%) report working in corrections, although it is unclear whether this means adult or adolescent correctional facilities. Thus, at this time, the percentage of credentialed music therapists in this country who treat adjudicated adolescents (as opposed to adult criminals or adolescent clients of a different demographic) is unknown.

Definitions of terms and descriptions of judicial processes related to delinquency are offered in the following section. These are intended to provide a context for the information in this chapter and to help the reader delineate between adjudicated adolescents and other adolescent clientele described in another chapter in this same volume. (Note: The clinical profiles and treatment needs of juvenile sex offenders are thought to differ notably from those of non-sex offenders. Thus, music therapy with young sex offenders is addressed separately in another chapter of this volume.)

Juveniles and Delinquency

According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the U.S. Justice Department, juveniles, or minors, are commonly thought of as individuals under the age of 18 years. However, the legal definition of *juvenile*—and thus the upper age of juvenile court jurisdiction (vs. criminal court jurisdiction)—differs depending on the state. Whereas most states consider the upper age to be 17 years, at the time of this writing, 16- and 17-year-olds in some states may be tried in criminal court for all offenses committed. On the other hand, one state extends the upper age to 18 (OJJDP, 2011a).

From a legal standpoint, a juvenile is said to be *delinquent* when found to have engaged in behavior that, were she or he considered an adult in the state in which the act was performed, would have been tried in criminal court. Examples of delinquent acts include offenses against persons (e.g., assault), property (e.g., larceny-theft), and public order (e.g., disorderly conduct) and drug offenses (e.g.,

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possession of narcotics). Only 3% of all juvenile arrests in 2008 were related to violent offenses, such as homicide, rape, robbery, and aggravated assault (Puzzanchera, Adams, & Kang, 2009). *Status offenses* refer to acts that are illegal for juveniles but not for adults, such as consumption of alcohol, violation of curfew, and truancy from school (OJJDP, 2011a).

Juvenile Justice Processes and Treatment Options

Terminology, policies, and procedures pertaining to the U.S. juvenile justice system have changed considerably over time and presently vary from state to state, as is neatly chronicled by Barton (2011a). In general, though, when a juvenile is alleged to have committed a delinquent act or status offense, a petition is filed with the juvenile court in the proper jurisdiction. Once the allegation has been made, the case is referred to a probation department, where a *predisposition report* is prepared. This report typically contains a summary of the facts related to the case and a recommendation for corrective measures (Barton, 2011a). A judge reviews the report and, in a *disposition hearing*, may adjudicate and then render a decision regarding correction. The particular disposition imposed usually depends upon the nature and severity of the adolescent's offense(s), his or her criminal history (including prior dispositions), the philosophy of the juvenile court in which the individual is tried, and the options available for remediation, among other factors. Often, after arrest and during court proceedings, youth may be sent to reside in local or regional jails or, increasingly, in temporary, secure *detention centers*. Nonsecure, interim *shelters* may also be employed for adolescents who pose low social risk or who have no other safe place to stay while they await adjudication, disposition, or another placement (Barton, 2011b; Puzzanchera, 2009). In this country, adolescents are not typically incarcerated for status offenses alone.

Serious and repeat offenders receive the most severe sanction—commitment to a *residential program*. Some examples are training schools/long-term secure facilities, group homes/halfway houses, boot camps, and ranch/wilderness therapies. OJJDP custody data for 2007 indicated that nearly 87,000 detained and committed juveniles under the age of 21 years were held in residential placements around the country, 86% of whom were male residents (OJJDP, 2011b). Most of these programs are privately operated and small (20 or fewer youth), yet about 70% of all juvenile offenders reside in large, state-operated facilities (OJJDP, 2011c). Some are same-sex and some are coeducational, and they vary in level of security. If published materials are any indication, most music therapists who work with adjudicated adolescents do so in some type of residential program.

Treatment Approaches

Since its inception in the early 20th century, the juvenile justice system has struggled with the tension created by the need to punish young offenders for their actions and the need to rehabilitate them. The demonstrable outcome of this struggle has been a vacillation between lenient policies and programs and the “zero tolerance” and “get tough” stance of the 1990s, prompted by unprecedented high rates of youth violence and *recidivism* (a return to offending after a period of intervention). Since that time, principles of *risk*, *protection*, and *resilience* have emerged and figured prominently in the vocabulary of policy-makers and providers. In spite of these ever-shifting perspectives, traditional policies and programs have been consistently deficit-based, that is, the emphasis has been on identification and reduction of a young person's deficits or problem behaviors through incarceration (to protect public safety), imposition of sanctions, and rehabilitation designed to reduce recidivism (Barton & Butts, 2008).

The effectiveness of this problem-based model of juvenile justice, with its “one size fits all” approach to programming, has been questioned, however. Barton and Butts (2008) write,

[Practitioners] are adopting a perspective that focuses on what is right with youth rather than on what is wrong with youth. This approach involves working with families and communities to enhance the positive social supports and opportunities that may improve a youth's chances of developing to his or her fullest potential. The new perspective arises from two innovative frameworks for working with youth—*positive youth development* and *strength-based practice* (p. 1).

In spite of organizational resistance and myriad challenges of implementation, strength-based practices, which tailor treatment to individual profiles, needs, and interests, are beginning to take hold in juvenile justice settings around the country (Barton & Butts, 2008). Some jurisdictions have adopted positive youth development and strength-based practices based on the managed care system model developed for children and adolescents in mental health, special education, and welfare systems. The term *wrap-around services* has been used to describe a highly individualized and interagency approach to prevention, treatment, and aftercare of youth who are in or at risk for residential placement. At the heart of the wrap-around approach is a supportive care team, as depicted in the following description of one such best-practice, strength-based program in Indiana:

If the child meets eligibility criteria and is accepted, a service coordinator is assigned to organize and facilitate a Child and Family Team (CFT) that includes natural supports in the community. The team develops and implements an individualized service plan using a wrap-around approach focused on the needs of the child and building on the strengths of the family. At the service-delivery level, the team works across agencies to integrate school plans, court orders, probation requirements, and mental health plans into one coordinated plan that is manageable for families. Utilizing the full array of community resources, the service plan is specific to the child and is flexible, evolving with the child's progress. The Dawn Project's philosophy is that "families don't fail, plans do" (National Center for Education, Disability and Juvenile Justice [NCEDJJ], 2007, p. 9).

One compelling argument for individualized, synchronized care is that wrap-around services appear to be more effective in reducing typically high levels of recidivism than coordinated, interagency treatment (Barton & Butts, 2008). Cost-sharing by multiple agencies is clearly a financial advantage.

CLIENT PROFILES AND NEEDS

Adjudicated adolescents face myriad challenges, owing to a complex constellation of biological/genetic, psychological, familial, peer-related, school-oriented, and societal factors and risks. Underlying psychiatric disorders, neglectful and abusive family systems, gang involvement, repeated conflicts and failures in academic and social relationships and tasks, and poverty are just some of the customary features of the lives of many young offenders. (The reader is directed to Barton [2011a] for a comprehensive, referenced list of internal and external risk factors for and predictors of delinquency.)

Delinquent youth present for treatment with a plethora of needs, perhaps the most salient and urgent of which orbit around their emotional functioning. Compared to nondelinquent youth, young offenders have been shown to exhibit more negative and less positive trait and state emotion (Plattner et al., 2007). Whereas some youth are able to regulate even frequent and intense feelings, others are unable

to do so; this incapacity is thought to contribute to the development of internalizing disorders (e.g., anxiety, depression, and somatic complaints) or maladaptive externalization of emotion, in which high levels of anger and impulsivity lead to antisocial behaviors and, often, diagnoses of oppositional defiant disorder or conduct disorder. Emotional self-awareness and regulation, including opportunities for healthy externalization of potent traumatogenic feelings, common among these youth (Carrion & Steiner, 2000), are thus critical needs of juvenile offenders. In this way—by virtue of similar early life circumstances, events, and experiences that mold who they become as teens—adjudicated adolescents resemble other clientele described in this volume, such as youth in inpatient treatment for psychiatric disorders.

The relationship between delinquency and long-standing and serious mental disorders is, in fact, well established. Abram and colleagues (2003) and Marker (2006) discovered significantly elevated rates of several psychiatric illnesses and a wide variety of symptoms among detained and incarcerated adolescents. Such illnesses include not only oppositional defiant and conduct disorders, but also mood and anxiety disorders, ADHD, substance use and addictive disorders, and in a minority of cases, psychoses. In a more recent multi-state prevalence study, Shufelt and Coccozza (2006) found that over 70% of youth in the juvenile justice system—female and male—met criteria for at least one psychiatric disorder and that 79% of these individuals met criteria for two or more disorders.

Girls appear to be differentially affected by certain risk factors, such as early onset of puberty, sexual abuse and related trauma, substance abuse problems, and depression and anxiety (Hubbard & Pratt, 2002; OJJDP, 2010). Rio and Tenney (2002), in a rare article describing music therapy programming for young female offenders, noted in their clients high incidences of depression, dissociative reactions, and intrusive somatic symptoms and complaints, suggesting the presence of posttraumatic stress disorder (American Psychiatric Association [APA], 2013).

In addition to mental health services, youth may require special education services. While it is a thorny task to establish accurate rates, it is estimated that more than one in three adolescents in correctional facilities has a disability that warrants special instructional services. The most frequently reported disabilities are emotional or behavioral disorders, ADHD, learning disabilities, and mild mental retardation (NCEDJJ, 2007).

Interpersonal issues among young offenders can be quite complex. Many adolescents “generalize deep-seated fear and mistrust to relationships outside the family system” (Gardstrom, 2002, p. 185) and thus find it difficult to establish positive and meaningful connections with others. Relationships with peers, adults, relatives, and community members—some of whom may have been victims of the offenders’ criminal activities—are often strained. Trust, healthy boundaries, communication, conflict resolution, and intimacy are just some of the multifarious interpersonal needs to be considered.

Systematic inquiry regarding the connection between low self-esteem and delinquency has produced mixed results. Some researchers have suggested that, rather than acting on feelings related to low self-regard, delinquents are driven by antisocial attitudes/characteristics such as a lack of empathy, sense of entitlement, and egotism, which suggest an inflated rather than a diminished perception of the self (Costello & Dunaway, 2003). On the other hand, outcomes of a series of interrelated and rigorous studies (Donnellan et al., 2005) support a positive correlation between poor self-regard and externalizing responses such as the aggression that, more often than not, is a core feature of delinquency. Whether or not low self-esteem figures prominently in the etiology of antisocial behavior, by the time adolescents enter a residential placement—and sometimes as a result of their interactions with the juvenile justice system and subsequent treatment—most delinquent youth will have accrued a host of personal and social failures which, when combined with poor personal resilience and/or a lack of external support, may contribute to low self-regard. The need for opportunities to succeed in meaningful endeavors, develop interpersonal/social confidence, and form realistic perceptions of self-efficacy thus should not be overlooked.

Juvenile offenders may present for treatment with a variety of physical needs as well. Serious medical and/or dental complications and conditions stem from physical abuse (e.g., substance use, sexual abuse, etc.) and neglect of fundamental health needs (Gardstrom, 2002). In particular, female offenders often have unique somatic issues related to their experiences with sexual victimization, prostitution, and pregnancy.

While similarities between adjudicated and nonadjudicated adolescents have been noted above, juvenile delinquents have a handful of needs that do not necessarily overlap with other adolescent groups. For instance, a young offender who has committed serious crimes against other people may already have a heavy dose of guilt and/or shame, or these adverse feelings may surface during the “work” of treatment. Issues of remorse and forgiveness—both the victim’s exoneration of the offender and the offender’s own exoneration of other perpetrators—may need to be explored. Restitution for criminal and hurtful acts, whether mandated by the court or not, may help to restore emotional and interpersonal balance and allow the adolescent to move forward.

Regardless of the specific philosophy undergirding delinquency programming, effective treatment for adjudicated adolescents must include a robust mental health component in order to accommodate the needs of young offenders with concomitant psychiatric illnesses. Pharmacological intervention, group, individual, and family counseling, and drug/alcohol education and treatment are just some of the services that could mean the difference between success and failure—or even life and death—for a young offender with serious mental health needs.

CLIENT RESOURCES

It stands to reason that identification of clients’ resources and strengths at intake and throughout their residence can assist treatment providers in setting a course for change and in helping youth to engage fully with the treatment process. Toward this end, increased interest in and knowledge about protective factors and resilience among young offenders has come about in the last few decades. Protective factors can be conceptualized as those personal, familial, and environmental factors that “shield” an individual from certain risks and thus help her or him bypass or break free from a delinquent trajectory. Personal protective factors include having an easy temperament, a high IQ, and highly developed social skills, for instance. Familial protectors include factors such as positive parental discipline, strong extended relationships, and racial pride. Environmental factors relate to things like prosocial peers, low crime neighborhoods, and academic success. Many of these factors are malleable (either before or during treatment), while others are not (Barton, 2011a). Identification and fortification of protective factors may help the adolescent develop greater overall resilience, defined in this context as “the ability to recover strength and spirit under adversity in both internal (self) and external (family, school, community, and peer relation) domains for a positive outcome” (NCEDJJ, 2011, *Resilience*, para. 2).

Some adolescents in custody have qualities that could be viewed as protective factors, in a sense, but that, ironically, seem to have developed as a result of the very life circumstances that one would hope these youth are able to circumvent upon their release. For example, this author encountered some of the most creative individuals she has ever known while employed to run an intergenerational music program at a state-operated training school. The youth involved in the program had come from extremely chaotic—even lethal—homes, schools, and neighborhoods in which they needed to be able to generate new ideas and do so quickly in order to stay alive. The challenge for staff at the training school was to find ways to help these adolescents channel their creativity toward constructive endeavors, for, as Spooner (2008) notes,

Creativity can be employed for socially positive or socially negative outcomes. Creative people can use their creative minds to generate positive, as well as negative, ideas that may be channeled to good or to sinister outcomes. To a large extent, it is where, when, and how one chooses to apply one's creative thinking, together with who is making the judgments on them, that determines the nature of one's creative offerings and how they are perceived (p. 129).

Closely related to the concept of creativity is resourcefulness, defined here as being able to make something of value out of "next to nothing." Youth who come from the most severely impoverished families and communities seem the most able to fashion a workable product from very few material resources. An example that comes to mind for this author are the beautiful, gossamer dance skirts that one 15-year-old girl made for a choreographed performance of Tracy Chapman's "Mountains o' Things" from a box of old, sheer window panels that had been placed by training school staff at the back door dumpster.

A discussion about the resources and strengths of adjudicated adolescents would not be complete without mention of their profound curiosity about and personal connection to music and the arts. To be sure, not all youth share a passion for music, but most seem motivated to experience the arts and produce artistic works, and most use music listening on a daily basis. Even youth who have had little experience and/or training in artistic production can use their interest as a positive resource—not only as a channel for creativity, but also for emotional expression, as one form of healthy recreation/leisure, to develop interpersonal relationships, as an outlet for psychophysiological energy, and as a way to make positive and meaningful connections in and contributions to their home communities upon their release.

MULTICULTURAL CONSIDERATIONS

In that delinquency is found among all types of people, it is critical that the music therapist give careful attention to diverse cultural traditions in his or her manner of working and in the selection of music and music interventions. In general, the music therapist should work to foster a safe, respectful, and interculturally responsive clinical environment. In particular, music selection for receptive and re-creative experiences should demonstrate sensitivity not only for client musical preferences but also for gender, race, ethnicity, socioeconomic class, physical abilities or qualities, sexual orientation, religion, etc. As Gardstrom and Hiller (2010) note, "With access to the Internet, a therapist can locate a varied and ever-increasing supply of recorded music selections from around the globe" (p. 150), which makes it is easier than ever to accommodate and honor diverse identities and characteristics.

MUSIC THERAPY TREATMENT

The author has drawn heavily upon her own and her colleagues' experiences in composing this chapter because, although music therapists are known to have worked with adjudicated adolescents in a variety of settings, including court diversion programs, detention facilities, shelters, and short- and long-term residential treatment programs, published literature about the use of music therapy with young offenders is extremely scarce in comparison with that about other clientele. That which does exist mostly depicts small group music therapy as one component of residential programming. Same-sex groups are common, in keeping with configurations of living units (e.g., cottages or halls). A few examples of coed groups also are presented in this chapter. Treatment duration varies, but it appears as though multiple sessions (vs. single sessions) are the norm, as would be expected in long-term residential treatment.

In some residential facilities, music therapy is viewed as a component of academic programming and, in this case, may resemble adaptive music education. In others, it may be aligned more with treatment programming, for example, as one of several expressive arts or experiential therapies. In still other facilities, music therapy may be viewed as part of the recreational or recreational therapy offerings, or as a separate entity, with no formal affiliation with other services.

REFERRAL AND ASSESSMENT PROCEDURES

Naturally, how referrals for music therapy are made and who makes them is largely dependent upon the role and function of music therapy in the treatment facility. In some settings, music therapy is seen as a required component of treatment, that is, no referral is necessary because all youth experience music therapy as a routine feature of their care and rehabilitation. In other facilities, music therapy is viewed as a privilege to be earned by youth, that is, only adolescents who have met and can sustain some predetermined standard (e.g., level of trust or behavioral stability or competence) are allowed to participate in individual or group music therapy. When referrals for music therapy are made, they may come from a variety of sources, including teachers, other therapists, or program administrators.

For individual treatment, an adolescent may self-refer according to facility policies and procedures (e.g., request adaptive music lessons, ask his or her treatment team for permission to work with the therapist to complete an original song, etc.). One or more team members may refer an adolescent for music therapy in order to target some aspect of that youth's individualized care plan. Teachers who work at the facility may ask for the music therapist's help with a particular individual in order to engender academic motivation and/or achievement. When whole residential groups are referred, referrals typically come from one or more members of a treatment team because they perceive that group members could benefit in some way from the structure, processes, or products afforded by music therapy.

An extensive search revealed no published music therapy assessment protocols or tools for young offenders. However, although developed for and implemented with adolescents in an inpatient psychiatric facility, Wells's (1988) protocol works well for the assessment of delinquent youth. In fact, Wells notes that conduct and oppositional disorders—established above as prevalent among delinquent youth in residential placement—are chief diagnoses among the youth for whom her assessment was designed. The assessment protocol consists of a series of music-related, projective tasks that, when completed, provide the therapist with insight to the adolescent's assets, deficits, and overall functioning in a variety of domains, such as anxiety, frustration tolerance, self-image, and ego boundaries, among others. In Task One, the youth selects a song from a list generated by the therapist and discusses it (called *song choice*). In Task Two, the individual is asked to choose an instrumental piece from a list of titles, listen for a moment, and then begin composing a written story with the music in the background. The individual then reads the story to the therapist. Task Three consists of a multipart instrumental improvisation, which includes as one feature a symbolic representation of the youth's family members and their communication patterns. A dyadic improvisation or singing a song with the therapist provides for insight into comfort with interpersonal intimacy and for closure of the assessment process. With minor adaptations, these tasks can be implemented with individuals within a group treatment setting.

OVERVIEW OF METHODS AND PROCEDURES

Receptive Music Therapy

- **Song Discussion:** involves the client and therapist listening to a song together and finding its meaning and relevance to the client's life.

- **Song Communication:** involves a client and/or therapist choosing a song to share with others as a way to express or disclose something about self or about the therapeutic relationship or process.
- **Music-Assisted Relaxation (MAR):** Two basic types of MAR are presented. Autogenic relaxation involves suggestions of mental and sensorial imagery to support deep breathing and total relaxation, and progressive muscle relaxation involves alternately tensing and releasing tension in various muscle groups toward physical relaxation.
- **Eurhythmic Listening:** is the use of music listening to rhythmically organize motor behaviors, e.g., structured and creative/free movement or aerobic exercise routines.

Improvisational Music Therapy

- **Individual Improvisation:** involves one client and a therapist or therapists creating sounds and music extemporaneously together or alone.
- **Group Improvisation:** involves clients creating music together extemporaneously as a group with or without the therapist.

Re-creative Music Therapy

- **Individual Lessons:** involve teaching a client how to play an instrument in order to evoke and work through therapeutic issues.
- **Small Performance Ensembles:** consist of small vocal and instrumental groups that are formed for the purpose of choosing, practicing, and performing repertoire to work through therapeutic issues.
- **Large Performance Groups:** engage 12 or more adolescents in practicing and performing music in formats such as choirs and instrumental ensembles in order to address therapeutic goals.
- **Group Percussion-Based Experiences:** Adolescents collectively learn, internalize, memorize, and re-create discrete rhythmic/motoric patterns and sequences using drums and other percussion instruments.

Compositional Music Therapy

- **Individual Songwriting:** involves the client creating new lyrics in whole or in part to existing songs or composing original music and lyrics with the therapist's help.
- **Group Songwriting:** Clients collaborate to create new lyrics in whole or in part to an existing song or compose an original song with assistance from the therapist.

GUIDELINES FOR RECEPTIVE MUSIC THERAPY

Although adolescents spend a great deal of time listening to music, the use of receptive, or listening, methods in music therapy appears to have been chronicled less often than the other three methods. Two of the most popular receptive variations are Song Discussion and Song Communication. Examples of Eurhythmic Listening and Music Relaxation, less frequently mentioned, also will be presented herein.

Song Discussion

Overview. Song discussion (Bruscia, 1998a) and related experiences—referred to in the literature by various names (e.g., lyric analysis, lyric discussion, etc.)—essentially involves the client and therapist listening to a song together and finding its meaning and relevance to the client's life. Song discussion has been used as a music therapy method with teens in both individual and group therapy (Cassity & Cassity, 1994; Clendenon-Wallen, 1991; Dvorkin, 1991; Frisch, 1990; Gardstrom, 2002; Mark, 1988; Skewes McFerran, 2000; Skaggs, 1997; Wyatt, 2002).

One rationale for using song discussion with adolescents is that nearly all teens listen to popular songs on a daily basis (Christenson & Roberts, 1998; McFerran, 2011), and the familiarity of this genre may decrease the sense of alienation experienced during this difficult developmental phase (Mark, 1988). Obviously, because song discussion involves listening to and discussing song material, the clients need to be able to hear and to use some form of language to express and communicate their thoughts and feelings. Additionally, their capacity to abstract from language (e.g., understand metaphor and other literary devices, which, according to Piaget, begins to appear at around age 12) and to relate musical and lyrical material to aspects of the self will greatly assist the process. Clients in the concrete operational stage of development will fare better with literal presentation of ideas and themes and palpable connections between lyrical material and the clients' life circumstances.

Song discussion targets a variety of clinical aims, such as “the identification and authentic expression of difficult feelings, increased self-insight, the exploration of beliefs and values, and improved communication and group cohesion” (Gardstrom & Hiller, 2010, p. 148). Gardstrom (1990) notes that song discussion promotes self-disclosure among adolescent offenders while exploring risky topics, such as their criminal behaviors, sexuality, relationships with others, and drug and alcohol use and abuse. Wyatt (2002) states that the purpose of this intervention within cognitive behavioral treatment for young offenders is “to challenge the clients to think differently and to make connections between their experiences and their feelings, thoughts, and behaviors” (p. 85). Edgerton (1990) used song discussion as a precursor to song composition with adjudicated youth with emotional impairments. In this case, the intervention was didactic rather than psychotherapeutic in nature, that is, clients analyzed lyrics in order to understand how a songwriter communicates and how to create various rhyme schemes.

Song discussion as described herein aligns with Bruscia's (1998a) augmentative level of practice, in which the music adds to existing services and programming, and the relationship formed between client and therapist is based on the music/activity, rather than seen as a primary agent of change.

Preparation. Sharing out loud can be difficult for adolescents for a number of reasons. Even some “typical” adolescents—perhaps boys more than girls—resist sharing personal thoughts and feelings with peers for fear of being ridiculed or ostracized in some way. Add to this the fact that many offenders carry guilt and shame related to their crimes, as well as fear and anxiety from having been badly or repeatedly abused and betrayed by others. These feelings lead to a tendency to withdraw or to maintain a “tough guy” façade, rather than expose their vulnerabilities and thereby risk being negatively judged or hurt emotionally. It is thus critical that the therapist adequately prepare the environment and the client(s) for song discussion in order to minimize resistance stemming from this overly self-protective demeanor. The physical environment should be free of external disruptions. It should be private, in the sense that no one outside the room/group would be able to hear what is shared. A circle seating formation allows for eye contact, a sense of equality, and the potential for “we-ness” to develop. If used, lyric sheets should be prepared in advance.

In readying the clients for self-disclosure, it is important to thoroughly explain the purpose and process of song discussion and to mention that they will not (and cannot) be forced to share. It may be important to stress certain “group rules” pertaining to the experience in order to promote freedom and

authenticity of expression. Consequences for disregarding group rules should be clear, fair, and consistently applied. In this author's experience, when the clients themselves create three or four meaningful rules and consequences (with the therapist's guidance, perhaps), the rules are more likely to be respected. Some examples of these behavioral parameters may include maintaining confidentiality outside of the group session and avoiding "put-downs," ridicule, and verbal interruptions.

What to observe. Regardless of the level of structure or song material used, during the listening and discussion phases, it is important for the therapist to take note of emergent paraverbal and nonverbal reactions that can provide clues to the teens' inner experiences, such as tone of voice, breathing, shifts in posture, changes in facial affect, etc. In particular, emotional responses should be noted. The author has learned that the obvious presence of a box of tissues can promote the healthy release of tears during the intervention.

Procedures. Procedural steps for the facilitation of song discussion with young offenders, in particular, have not been fleshed out in the literature. However, song discussion typically involves a series of sequential decisions about (1) song choice, (2) song and lyric sheet preparation, (3) introduction of the experience, (4) establishment of a "listening set," (5) listening and observing, (6) verbal processing, and (7) closure. The reader is referred to an article by Gardstrom and Hiller (2010) in which clinical decisions pertaining to the preparation and facilitation of song discussion are outlined in highly detailed fashion. Some of the decisions surrounding song choice include who chooses the song and what type of genre is selected. When working in delinquency programs, the music therapist may need to align with agency/facility rules pertaining to the use of so-called *controversial* music styles and lyrics or may need to educate staff and administrators about the value of such media (Gardstrom, 2000). Regarding song and lyric preparation, the therapist must consider a variety of factors, such as whether she or he can re-create the song well and confidently enough to facilitate a solid listening experience and whether lyric sheets will hamper or enhance the clients' experience and response. It is this author's experience, for example, that listening without a lyric sheet helps to bypass resistance from individuals who have difficulty reading and puts all listeners on a more equal footing.

Song discussion—what it is, why it is being used, and how it typically unfolds—should be explained. A listening set is issued prior to the listening and springs from the established clinical aim(s) of the experience. Examples include, "As you listen to this song, take notice of your emotions" or "Listen and then be ready to talk about if and how this song relates to your own life story." The level of structure imposed before and after the listening depends on the goal(s), the dynamics of the group, and the therapist's approach to treatment. Wyatt (2002) describes her behavioral approach to "lyric analysis" with small groups of six to eight delinquents in a residential treatment program. She advocates for a highly structured facilitation in which preestablished questions function as the listening set and clients write or—in the case of those who have difficulty with written language—illustrate their answers prior to discussing them with other group members. Edgerton describes her use of a structured listening set to heighten awareness of interpersonal and racial dynamics within cottage groups of adjudicated boys (personal communication, February 10, 2012). Using the song "Across the Lines" by Tracy Chapman, Edgerton directed the boys to answer questions such as "How do you feel as you listen to the song?," "What is the theme of the song?," "How do you think Tracy feels?," "What are the 'lines' in the song?," and "How can your group cross their 'lines'?" The boys were encouraged to think, write, and then discuss their responses.

Sometimes the youth will request to hear a song again after having discussed its relevance to their lives or treatment issues. A second hearing can spur further discussion or serve as closure of the intervention or session.

Adaptations. Song discussion may be used at the intensive level of therapy as a form of music psychotherapy (Bruscia, 1998b) in which the client receives support to learn new ways to solve problems

and in which verbal communication is an important dimension of the intervention and the client-therapist relationship. Song discussion has been described as a projective experience within music psychotherapy (Bruscia, 1998b; Gardstrom & Hiller, 2010; Nolan, 1983) through which unconscious material may surface and promote insight and self-discovery. When song discussion is used as music psychotherapy, the ambiguity of music and the written word are valued; clients can imbue their own meaning into the characters, objects, events, feelings, etc., portrayed in the song through the formation of unique identifications and objects of empathy. In this sense, a more relaxed and client-driven approach to facilitation may be used, based on the notion that such flexibility may diminish resistance and assist individualized projection. Gardstrom and Hiller (2010) point to one example with delinquent boys, in which misogynistic raps were used to stimulate the uncovering of unconscious material, which led to emotionally potent realizations and disclosures surrounding the clients' own and others' victimization.

Song Communication

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Overview. Song communication involves a client and/or therapist choosing a song to share with others as a way to express or disclose something about self or about the therapeutic relationship or process. In the section that follows, the focus is on client song communications within the context of group therapy. It is important that the client understand that his or her song choice could be but may be more than a *favorite* song; most importantly, it should somehow represent something about the adolescent's *life*, past or present, which he or she wants to convey to the therapist and his or her peers.

Song communication in a group setting is indicated when clients are perceived as being able to benefit from personal sharing and receiving, through which several therapeutic mechanisms may be activated, the most central being cohesiveness (Yalom & Leszcz, 2005). Clients need to have access to prerecorded music or be able to re-create or rely on the therapist to re-create the selected piece. They also need to be able to articulate why they chose their song and what they intended to convey about themselves with their selection.

At one group home for delinquent boys in which the author has supervised undergraduate students, song communication was introduced in the inaugural sessions as a way for the therapists to gently initiate the process of personal sharing in a music therapy group, to learn about the clients and assess their musical proclivities, and to convey interest in the boys' musical offerings as a way to build rapport. In keeping with this last aim, Rio and Tenney (2002), who worked with adolescents in residential treatment, reflect that "Having youth choose music that was important to them was an almost certain way of developing rapport; it allowed them to share part of themselves with others in the group" (p. 91).

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In this author's experience, song communication is typically used with adjudicated adolescents in the same way as song discussion, at the augmentative level of practice (Bruscia, 1998a).

Preparation. Preparation for song communication entails the same considerations as for song discussion, that is, the environment should be private and free of interruption. All clients should be assisted in feeling comfortable sharing at whatever breadth or depth they are able, and all relevant contributions should be valued. Equipment necessary for song communication may include some or all of the following: CDs and/or MP3 player and playback system, accompaniment instrument, and sheet music (for live re-creation, if needed).

What to observe. As with song discussion, the therapist needs to pay close attention not only to the client's verbalizations, but also to paraverbal and nonverbal actions during the music listening. Additionally, the therapist may listen for congruence or a lack thereof between what the song seems to reveal and how the client draws a connection between the song and self.

Procedures. Each client is invited to select a song to play in the present or a subsequent session. Again, clients are reminded that the song is to communicate something about themselves or about the

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therapeutic relationship or process. If a “library” (playlist) of prerecorded music is available and the adolescents are willing, they may be invited to look through the selections and choose a song in the moment. If a music collection is not available, or if the clients need time to consider their selections, song communication can occur in the following session, in a more planned way. During the intervention, each person takes a turn at will, speaking either before or after the listening period (or both) about the personal significance of the song. No lyric sheets need be used; in fact, it is often impossible to provide lyrics on short notice. Other clients in the group may be asked to offer their opinions and insights about and associations with each song and, at times, to make their own personal connections with the meaning that was disclosed by the individual who shared the song. If possible, audio versions of songs should be used, as video versions may direct the sharer and the listeners away from the individualized meaning of the song.

Adaptations. In addition to the “typical” use of song communication, as described above, this author has used the intervention as a way for groups of young female offenders to say good-bye to individuals who have “graduated” from the program and were returning to their home communities or starting new lives in other places. A song was selected by the individual’s peers and shared in live or recorded fashion during the graduate’s final group therapy session or cottage meeting with accompanying verbal sentiments. In similar fashion, this author has used song communication to help young male and female offenders communicate something of importance to a deceased loved one in a carefully orchestrated memorial service involving a music therapist, chaplain or spiritual guide, group therapist, family member, and/or trusted peer. In this way, the music functioned as a *container* for feelings (Hiller, 2011) such as grief, anger, love, and forgiveness.

Music-Assisted Relaxation (MAR)

Overview. Two basic types of MAR are presented here: autogenic relaxation (AR) and progressive muscle relaxation (PMR). AR involves suggestions of mental and sensorial imagery to support deep breathing and total relaxation, whereas PMR involves alternately tensing and releasing tension in various muscle groups toward physical relaxation that may, in turn, lead to psychological comfort.

Gladfelter (1992) asserts that “adjudicated adolescents with behavior disorders, such as those in a residential treatment setting, need to be exposed to techniques which will help them to decrease their anxiety so they can function more effectively in life” and notes that “much research has been done using relaxation techniques to reduce anxiety, although very little has focused on the adolescent population” (pp. 1–2). Indeed, the use of music relaxation with delinquent youth is mentioned only sparingly in the literature.

MAR is indicated when clients self-report or are observed to have distressing or intrusive levels of anxiety, when they need opportunities to relax after particularly anxious events or circumstances (e.g., a difficult family therapy session or court appearance), and when it seems that they could benefit from learning relaxation techniques to implement as part of a self-care plan. Occasionally, clients are too agitated to participate due to a clinical condition or diagnosis (such as PTSD or hyperactivity) or medication effects. In these cases, psychophysiological energy might be better directed into music therapy methods with the potential for physical catharsis, such as drumming, improvisation, or music-supported movement.

The primary goal of MAR, as the name implies, is to induce deep physical and psychological relaxation. MAR is ordinarily used at the augmentative level of practice (Bruscia, 1998a) and is addressed herein as a group intervention. Ideal group size ranges from 3 to 10 members. Depending on the size of the group, it may be wise to conduct this intervention with a cofacilitator (see below). In this author’s experience, same-sex groups are more effective in that clients are less defended and thus more likely to

relax deeply.

Preparation. The physical space for MAR should be quiet and comfortable, with the possibility of dimming the lights. Interruptions and external noise should be kept to a minimum. Floor mats should be made available. Clients may bring blankets and pillows for added comfort. In this author's experience, younger or regressed clients would often ask and were allowed to bring a stuffed animal or similar comforting object.

MAR typically requires a relaxation script and prerecorded, instrumental music to support the script. Commercial scripts are available, or the therapist may craft a script that takes into consideration the idiosyncratic needs and vocabulary of the adolescents. The music selections should be static rather than dynamic, that is, the music should be repetitive and highly predictable, as abrupt changes in rhythmic, tonal, expressive, and formal elements can serve to arouse, rather than relax, the listener and may elicit traumatogenic reactions (American Music Therapy Association, 2012). The sound source should be as centralized as possible, and the therapist should have immediate access to the volume control during the experience.

What to observe. While the clients are engaged in the experience, it is helpful to watch them carefully in order to adjust the pace of the therapist's verbalizations, moving more quickly or lingering in response to perceived needs. It is also crucial that the therapist watches and listens intently for possible signs of client distress, such as facial grimaces, tears, constant physical shifting, and anguished vocalizations or verbalizations. Often, clients who are sleep-deprived or depressed will fall asleep early in the procedure. While viewed as the ultimate, conscious state of relaxation, sleeping may not be desirable, as it will prevent the client from learning relaxation techniques. If such learning is one aim of the experience, these clients may be encouraged to sit upright rather than recline on the floor mat.

Procedures. Sessions generally last between 30 and 45 minutes. To begin, the therapist may conduct an introductory discussion with the group (5 to 8 minutes), wherein she assesses the clients and describes for them the expectations of the relaxation experience. Assessment should be geared toward identifying any emotional issues that may be immediately important for any individual or that may impede an adolescent's ability to participate fully or safely in the relaxation experience. If any contraindication is identified, the therapist should suggest that the client not participate. The introductory phase is also a time to develop rapport with the clients, to begin establishing a peaceful and positive environment for the experience—using an engaging tone of voice and comfortable pace of speech—and to answer any client queries. The clients should be told that, although not a focus of the experience, vivid imagery may occur in response to the music and that opening one's eyes can usually halt the disturbing imagery. If troubling imagery persists, a client can beckon for support from the therapist or cofacilitator and may be ushered out of the room or asked to sit upright next to the therapist or cofacilitator.

After the introductory phase, the clients are instructed to assume a comfortable position on the floor mat and to close their eyes as they are able. The lights may be dimmed to enhance relaxation. A brief (3- to 5-minute) verbal induction follows; this may be the presentation of focal imagery (AR) or a guided breathing exercise designed to help the client focus on internal, bodily experiences (PMR). After the induction, the therapist begins the core phase, during which the music plays and the relaxation script, whether AR or PMR, is recited (10 to 12 minutes). Once the script and music have ended, a period of silence may ensue prior to the reentry phase, which is when the therapist guides the adolescents to return their attention to the surrounding environment, move their bodies gently, open their eyes, and prepare to discuss the relaxation experience. Verbal processing should first include the clients' reflections on their own experiences followed by the therapist's feedback and guidance.

Adaptations. Adolescents who have been sexually molested or traumatized may have difficulty relaxing in a reclining position. In this case, comfortable chairs may be substituted for floor mats. Additionally, some teens find that closing their eyes puts in them in a more vulnerable state than they are

ready to experience. Although perhaps not as effective, PMR can be conducted with the client's eyes open and is, in this case, a preferred alternative to autogenic, or imagery-based, relaxation. Additionally, the suggested time frames for each procedural phase may be shortened or lengthened, depending on client need. For instance, some clients may need to practice MAR repeatedly, with a gradually increasing number of minutes devoted to the induction and core phases.

Eurhythmic Listening

Overview. Eurhythmic listening, defined as the use of music listening to rhythmically organize motor behaviors (Bruscia, 1998a), can be used with adolescent offenders toward a wide variety of clinical aims. Experiences addressed here include structured and creative/free movement and others such as aerobic exercise routines.

Eurhythmic listening experiences can enhance the identification and healthy expression of emotions, improve self-esteem (especially body image), improve physical health (e.g., strength, endurance, coordination, and balance), and promote cognitive development (Gardstrom, 2002). Movement may also address adolescents' needs for increased cardiovascular exercise aimed at weight control (a concern in residential facilities) and increased comfort in their bodies (Brooks, 1989). As with all movement protocol, caution should be taken to minimize the risk of physical injury. Clients who have serious or chronic illnesses or those with obesity or physical challenges should be screened for participation and monitored closely during the intervention. The eurhythmic listening interventions described here occur at the augmentative level of therapy (Bruscia, 1998a), as an adjunct to other services and programs. Same-sex grouping may help to minimize inhibitions associated with movement.

Preparation. Movement requires dedicated space, which could be a gymnasium, empty classroom or clinic, or outdoor area. It is important to consider that a private space for the group may help reduce embarrassment and shame attached to moving one's body. Recorded music is used. Typically, the therapist selects the music, but clients may also suggest musical material; this can aid in their motivation to participate. Instrumental or song material should be selected based on its specific elemental properties. For instance, if the desired movement is rhythmic in nature and stability is important, a pulse must be clearly discernible throughout the piece.

Above all, the music used must support the desired energy level and intended movement sequences. Careful attention should be paid to tempo, phrasing, and meter, all of which should match and support the desired procedural phases (see below). Music with a clear formal structure (e.g., ABAB) can assist in the recall of choreographed movement sequences that are paired with each musical section. The music playback system should be powerful enough to "fill the space." Digital music media is preferred, as this facilitates precise cuing for modeling or repetition of movement sequences.

What to observe. In that groups of adolescents will come to a movement experience with varying levels of motor skill and comfort, it is imperative that the therapist carefully observe their reactions to the movement directives. Some youth may have difficulty with directionality (left vs. right), balance, endurance, or strength, suggesting that certain accommodations must be made in order that the youth can be successful. Adolescents who "give up" and stop moving with the group may be voicing resistance that stems from feelings of embarrassment or bodily shame and may need to process what is happening in the moment in order to move forward.

Procedures. Described here are suggested procedures for music-supported group movement based on the author's leadership of eight-week modules of biweekly sessions with adjudicated girls. The author has facilitated three different types of modules, dependent on identified educational and clinical aims: aerobic exercise, structured choreography to preselected pieces, and creative/free movement. Sessions generally last 30 to 45 minutes.

Regardless of the type of movement—aerobic, choreographed, or creative/free—sessions should adhere to the following procedural sequence: (1) *gentle movement* (walking, reaching, bending, etc.) for warming up the large muscle groups; (2) *stretching* of major muscle groups (legs, arms, torso, neck and shoulders) to avoid subsequent strain or injury; (3) *working phase*, composed of movement sequences of increasing aerobic or motoric demand (depending on the type of movement); (4) *cool down* with a gradual lessening of energy output; (5) *final stretching* of major muscle groups; (6) *verbal processing* of the experience; and, when indicated, (7) *summary and future planning*.

Verbal processing of eurhythmic listening experiences may focus on any and all related treatment issues, such as bodily or sensorial experiences, emotions that surface during the intervention, group dynamics, learning points, future aims, and so forth.

Adaptations. Movement sequences can be adapted to accommodate client idiosyncrasies and capabilities. Adaptations include simplifying patterns (e.g., removing fancy footwork and concentrating on upper-body movements only, or vice versa), “halving” the tempo (e.g., presenting a sequence over 16 rather than 8 beats), and “featuring” (e.g., relying on certain clients to perform difficult sequences while other clients perform simpler sequences or step to the beat). Most structured and creative/free movement experiences can be adapted for a seated position in the event that clients are unable to stand and move through space.

GUIDELINES FOR IMPROVISATIONAL MUSIC THERAPY

Improvisational Music Therapy, or Clinical Improvisation, has been defined in numerous ways in the professional literature. In this chapter, this method is viewed as the extemporaneous creation of sounds and music for purposes of assessment or treatment. The sounds and music are created by the client(s) or the client(s) and the therapist(s) together, using the body, voice, and musical instruments or other objects that are capable of producing sound. An important distinction between *clinical music improvisation* and *music improvisation*—the latter referring to the type of improvisation found in jazz genres, Baroque music, Orff Schulwerk activities, etc.—is the *relational* essence of clinical improvisation; in clinical improvisation, client(s) and therapist(s) create and develop relationships with self (intrapersonal), with others (interpersonal), with their own music (intramusical), and with the music of others (intermusical). It is in and through these relationships that personal transformation occurs. Also, in clinical improvisation, both the *processes* of creating and the *products* that result assume value, whereas in music improvisation, the salient aim is most often to create a product of aesthetic value (Hiller, 2009).

The method of clinical improvisation, hereafter referred to simply as *improvisation*, revolves around the use of two types of improvisation, often categorized as *referential* and *nonreferential*. Referential improvisation is extemporaneous music that refers to or depicts something outside of the music, such as an emotion, a life event, or a relationship. Nonreferential, on the other hand, is improvisation without a theme; the music is created “for music’s sake” without referring to anything outside of itself. Improvisation may be applied in individual or group formats and from a variety of theoretical models and practical approaches. The improvisations themselves can be structured in multiple ways through the use of various “givens” (Bruscia, 1987) or play rules that help to focus the experience of improvising. Three types of givens are *vocabulary givens* (which specify the musical/sound media used or the theme to be portrayed), *procedural givens* (which refer to the procedures or time elements of the improvisational process), and *interpersonal givens* (which specify roles and relationships between players). For a detailed compendium of improvisational models, the reader is referred to Bruscia’s *Improvisational Models of Music Therapy* (1987).

Individual Improvisation

Overview. Individual improvisation involves one client and a therapist or therapists creating music extemporaneously. Typically, the client and therapist(s) improvise together, although the client may also improvise alone, depending on the clinical aim. Although most adolescent offenders are housed and treated in group settings, certain individual treatment modalities may be indicated, particularly if a teen needs to develop dependence on a reliable adult, having been denied this essential relationship in his or her childhood within the family of origin. Additionally, some teens have a deep fear or distrust of peers, and others find that social situations produce unbearable anxiety.

Individual improvisation may be used at the intensive level of therapy as a form of music psychotherapy (Bruscia, 1998b) in which the adolescent receives support to learn new ways to solve problems and in which verbal communication is an important dimension of the process. Improvisation may also be used at the reconstructive, or Primary Level of practice (Bruscia, 1998a), with a focus on “altering basic structures within the client and between the client and the environment” (p. 162), and getting to the “core” of the client’s condition. Improvisation can support an abundance of clinical aims: help a young person modify behaviors, find an authentic “voice,” release “toxic” emotions and resolve past trauma, reflect on and learn about self through improvisational products and processes, develop intimacy through a musical relationship with the therapist(s), tap into creative potential, and develop a stronger and more positive self-image.

Preparation. Preparation for the session is based on an intentional assessment of what the client needs at the particular time of treatment. As available, a wide variety of percussion and tonal instruments should be arranged for easy access. If sessions are to be audio- or video-recorded for playback and reflection, recording equipment should be ready to operate.

What to observe. What the therapist observes during individual improvisation is, of course, filtered through the therapist’s theoretical approach and the expectations placed upon him or her by the employer. For example, from a behavioral perspective—many residential facilities for young offenders adopt the mission of altering delinquents’ maladaptive behaviors through the use of behavioral principles of modeling, reinforcement, punishment, and so forth—the therapist will watch for how well the individual’s responses match stated or implicit expectations for use of the musical instruments, relating to the therapist, and following the rules peripheral to the experience (e.g., arriving on time to the session, respecting the meeting space, etc.). From a humanistic perspective, the therapist will be concerned about how to help the client actualize personal potential within the improvisation experience. From an existential perspective, the therapist will attempt to understand the client’s inner experiences, watching and listening for clues into the physical, psychological, and social “worlds” of the client. From a psychoanalytic perspective, what emerges as important is how the client’s improvised music serves as a symbol or projection of aspects of the self that are hidden, such as feelings, impulses, and conflicts buried in the unconscious. Transference, countertransference, and resistance become important dynamics to observe within the musical and personal relationships that emerge in the session.

Specific protocols for the process of listening to, analyzing, and interpreting client improvisations have been described elsewhere (e.g., Arnason, 2002; Bruscia, 1987, 2000; Lee, 2000); descriptions of these protocols lie beyond the scope of this chapter. Again, the reader may find Bruscia’s *Improvisational Models of Music Therapy* (1987) to be useful—in particular, the information about the *Improvisation Assessment Profiles*.

Procedures. In that individual improvisation typically is geared toward meeting the immediate and emergent needs of the client, it is difficult to specify procedures ahead of time that would apply to every client and every improvisational experience. However, in general, the following steps will occur, either as predetermined by the therapist before the meeting or by the therapist and client at the time of

the session: (1) play or talk as a way to elucidate client need and determine a focus or theme for the session; (2) determine parameters for the ensuing improvisation, including musical media, thematic focus (optional), and whether the client will improvise alone or with the therapist; (3) decide whether or not to record the improvisation, securing necessary permission to do so; (4) decide whether or not to process the improvisation verbally or through some other modality, such as art or movement; (5) improvise; and (6) process the improvisation in the predetermined manner (optional), which may involve listening to and reflecting upon the recorded improvisation.

Adaptations. In a sense, each improvisation experience is itself an adaptation. The freedom and flexibility afforded by not having to rely on any prescribed or preselected music opens the door to infinite possibilities for ongoing modification to whatever is occurring at any given moment. And, through the use of in-the-moment musical, verbal, and gestural facilitation techniques (Bruscia, 1987; Gardstrom, 2007), the therapist can make adjustments, accommodations, and alterations in the course of action at any point during an actual improvisation.

Group Improvisation

Overview. Group improvisation involves clients creating music together extemporaneously as a group with or without the therapist. It is indicated when the peer culture is seen as the primary agent of therapeutic change (Gardstrom, 1987) or when youth need opportunities for positive leadership and healthy interaction with peers. As with individual improvisation, group improvisation can aid adjudicated adolescents in altering counterproductive behaviors, expressing their thoughts, feelings, and creativity; learning about themselves (particularly in relationship to others); and developing confidence and a sense of self-worth. In this country, group improvisation is used at the augmentative level of practice, as an addition to other services and treatment modalities.

Preparation. Preparation for group improvisation sessions begins with the question, "How can I best structure this time in order to meet the immediate and emergent needs of the youth?" The structure of the session may refer to the "big" picture of *what to do when* throughout the entire session or to the "little" picture of which parameters or givens to use in facilitating *specific improvisational experiences as discrete but interrelated components* of the session. The types of structures that are clinically indicated should inform the therapist's decision about which particular instruments and equipment will be necessary to arrange in advance of the clients' arrival (vs. the other way around). A general guideline for the setup of the physical space is to arrange chairs in a circle with instruments in the center. A circle can convey a sense of equality and "we-ness" and enable group members to see and hear one another.

In that improvisation can call forth the "raw" expression of internal experience, it is crucial that the participants are prepared for this possibility, using whatever language and preparatory experiences are developmentally appropriate. The use of structured rhythmic activities such as Guided Interactive Drumming or Traditional Drumming (see below) may be used as a way to introduce the notion of being in musical community with others and employing instruments as a form of personal self-expression. As with other interventions, it may be useful to establish group rules so that members feel free to share authentically without fear of derision.

What to observe. As group members enter the playing space, check in musically, and engage in music improvisation with others, the therapist may become overwhelmed by the sheer number of clinically relevant responses that are occurring at any given time. This is because each client in the group is likely simultaneously responding to his or her own music (intramusical relationship) and his or her own nonmusical experiences (intrapersonal relationships), as well as the connections between his or her music and the music of others (intermusical relationships) and his or her nonmusical experiences and those of others (interpersonal relationships). As a guiding principle, then, the concept of *salience* can help the

therapist to attend to the most critical aspects of a group improvisation processes and products (Bruscia, 1987). Saliency refers to the most prominent or commanding feature of an improvisation, and may include a *musical element* that dominates the improvisation, such as meter or volume, or a *profile* that “jumps out” as significant, such as the degree to which the group’s rhythms integrate with an underlying pulse (rhythmic integration), the degree to which volume changes over time (volume variability), or the role that each player assumes in relationship to other players (autonomy).

Other important observations may include which instruments the members select (if given a choice), how well the teens work together to depict a given theme (in referential improvisation), and what they reveal about the processes and products after the fact (if processed).

Procedures. While it is impossible in this chapter to outline all of the possible procedures that may emerge as useful in the facilitation of group improvisation, one general procedure has proven to have great utility in this author’s experience with percussion-based improvisation with adjudicated adolescents. The essential steps of this procedure are as follows: (1) *Greeting*—Clients and therapist greet one another and settle into their seats; (2) *Check-in*—A drum is passed around the circle/room and all are asked to (a) say, “This is how I am feeling right now” (as a way to help identify and take both personal and public ownership for present emotional state), (b) play a brief improvisation that depicts inner experience, and (c)(optional) put a word or phrase to the feelings; (3) *Review and Rules*—The therapist and clients discuss (a) the “gist” of improvisation (i.e., what it is and why it is used), (b) the importance and acceptance of authenticity of expression, (c) the expectation that all authentic expression (musical and verbal) will be valued, and (d) rules about instrument use, interactions, etc.; (4) *Exploration* (optional, as needed)—The therapist introduces the available instruments by name and demonstrates both conventional and nonconventional ways to play them, and the clients are encouraged to freely explore several instruments; (5) *Givens*—Helpful parameters for the group improvisation are stated by the therapist or created by the group and affirmed by the therapist, with attention to clinical issues that may have been made apparent during the *check-in*; (6) *Improvisation*—The group improvises according to the preestablished parameters; and (7) *Processing*—The therapist makes opportunities for verbal processing or processing using other modalities, such as art or movement. Steps (5) through (7) are repeated, according to group goals, individual client needs, interests, remaining time, etc.

Edgerton (personal communication, February 10, 2012) shares a specific structure that she used to facilitate tonal improvisation with small groups of youth, employing bass guitar, electronic keyboard, and other instruments capable of harmonic or melodic renderings. She began by introducing drums and other percussion instruments. Players established a beat and added unique rhythmic figures. A bass guitar joined the beat, with strings tuned to E-A-E-A. Keyboard players were then encouraged to improvise freely on the white keys, using just two or three designated, consonant pitches at first and gradually expanding the melodic possibilities. With the aim of promoting awareness of group “issues,” improvisations were recorded and members of the improvisation ensemble listened to the recording, self-reflected, and provided feedback to other members. Edgerton believes that troublesome or healthy group dynamics became apparent to the therapist and the improvisers while listening to the recording, stating, “It all came out in the music. It wasn’t me telling them what was going on in the group; they heard it in their own music!”

Adaptations. One adaptation of the author’s procedure (above) includes varying the *check-in* prompt from “This is how I am feeling right now” to “This is how I *want* to feel right now,” or “This is how I feel about myself right now,” or even “This is how I feel about the group right now” or “This is what I would like to say to my victim[s] right now.” Obviously, the choice of which prompt to use should be considered carefully, as this has the potential to influence the tenor of the session. Additionally, although *group improvisation* most often means that all or most members of a group are creating music simultaneously, sometimes an individual may improvise in solo fashion for the group as a way to have his

or her expressions heard, communicate something of a personal or individual nature, develop confidence among peers, and so forth.

GUIDELINES FOR RE-CREATIVE MUSIC THERAPY

At the core of re-creative experiences in music therapy is the vocal or instrumental performance of precomposed music. In residential settings for juvenile offenders, this may take the form of individual lessons, individual performance, or small and large ensembles, such as a chorus, handbell group, popular music “combo” (guitar, bass guitar, keyboard, drums, vocals), or any number of other performance ensembles (Edgerton, personal communication; Gardstrom, 2002; Johnston, personal communication; Rio & Tenney, 2002; Wyatt, 2002). Small- or large-group drumming, which does not have a performance focus, is another common re-creative intervention. When adjudicated youth are detained in school programs, they may have opportunities to perform music in school assemblies or other similar venues; these individual and ensemble performances may or may not involve the music therapist. Examples of individual, small-group, and large-group re-creative experiences are described below.

Individual Music Lessons

Overview. Individual lessons involve teaching a client how to play an instrument in order to evoke and work through therapeutic issues. One of the responsibilities of this author and a colleague (Edgerton, personal communication, February 10, 2012) in a residential school for male felons was to provide individual music instruction to select adolescents. Weekly, 30-minute lessons were given to boys who had successfully petitioned their treatment team for the privilege and whom the team believed could make specific clinical or educational gains through music instruction.

As supported by findings of a meta-analysis by Gold, Voracek, and Wigram (2004), treatment personnel may see individual music therapy as a way to bolster the adolescent’s self-esteem through individual, adult attention and musical mastery. They may refer youth who need opportunities for positive self-expression through active music-making. Individual music therapy also may improve an offender’s ability to form and sustain interpersonal relationships: In individual therapy, the music therapist is likely to be “working toward building a positive, caring, reciprocal relationship with the youth in hope that relationship-building skills will generalize to other authority relationships, such as parents or teachers” (Gardstrom, 1987, p. 22). Gardstrom (2002) writes, “Besides learning care, maintenance, and basic playing technique on a particular instrument, a sense of responsibility and cooperation is fostered ... Finally, music is a viable leisure pursuit for students who have few nondelinquent interests” (p. 188).

Sometimes youth are referred not because they are trustworthy, but so that they might learn and demonstrate trustworthiness (Gardstrom, 1987). To that end, certain clients may need support, accountability, or supervision in the form of a specific behavioral contract or a staff member or trusted peer who accompanies them to their individual lessons. Adolescents who are an immediate danger to self or others may not be indicated for individual lessons unless these lessons can take place in a setting in which such a risk can be appropriately managed. Lessons are provided at the augmentative level.

Preparation. Drum set, acoustic and electric 6-string guitar, bass guitar, piano or electronic keyboard, and voice tend to be the most requested instruments in individual music lessons. In rarer cases, students may have had prior training on band and orchestral instruments (e.g., violin, saxophone, trumpet, flute, etc.) and may express their desire to continue with these. Ideally, the music therapist would have access to these instruments and a comfortable space in which to work individually. Some students may be able to understand traditional music notation, in which case the therapist should have access to an array of conventional beginning and intermediate instructional materials. (Many of these

resources are now available free of charge on the Internet.) Other students may need special adaptations (see below); these should be prepared in advance, as the therapist is able.

What to observe. During the assessment phase, the therapist will want to establish the teen's musical interests and prior experiences and abilities. During the lessons, signs of frustration or boredom may indicate a need for alteration of the lesson content or the pedagogical methods or pace. Clients who do not progress as expected or in comparison to their peers may have a learning disability or similar difficulty that requires additional attention or testing. Clients who progress rapidly or show unusual determination may be good candidates for typical music lessons or ensemble participation upon return to their home communities.

Procedures. Because each client has idiosyncratic needs and abilities, it is difficult to "prescribe" a sequence of procedures for individual music lessons. However, the therapist would likely (1) welcome the client; (2) introduce or review any and all expectations for the individual session; (3) establish at least one learning objective for the lesson, with or without the client's input; (4) begin the music instruction with a review of material covered in the previous session; (5) move forward in the learning sequence, offering guidance, correction, and encouragement as fitting; (6) assign "homework" (practice material), if relevant; and (7) close the session with a brief summary and confirmation of the next lesson day and time.

Adaptations. Numerous instructional adaptations may need to be applied in an attempt to meet teens' unique needs and capabilities. Adaptive lessons are designed to maximize the adolescent's abilities and minimize learning deficits. Some students learn best by rote/imitation or via some form of modified notational system, for example, using colors or numbers to indicate certain concepts. Free or improvisatory play may be used as a "jumping off point" for instruction. Often, simplified chords and riffs will be used on guitar and piano. And, as is common in music therapists' work with other clientele, experiences need to be structured for immediate, small successes upon which the adolescents can build sequentially and over time. This author has found it helpful for youth who have difficulty engaging or for whom learning is problematic to build in opportunities for "mini-performances" for peers or staff (e.g., "Can you demonstrate for Mr. Grant what you accomplished today?") in order to stress a sense of accountability for the learning process and, at the same time, bolster confidence that can come from taking small risks and succeeding.

Small Performance Ensembles

Overview. Small performance ensembles consist of small vocal and instrumental groups that are formed for the purpose of choosing, practicing, and performing repertoire to work through therapeutic issues. Such groups can assist the juvenile offender in developing a number of personal and interpersonal skills. As outlined by Gardstrom (2002), "Youths learn to give and accept constructive feedback about their playing from their peers. A successful performance in the community may help the young offender and the citizens of that community feel more positively toward one another" (p. 188). Case in point: Edgerton (personal communication, February 10, 2012) and Gardstrom (1993) describe the use of handbells with adjudicated adolescents in residential treatment. Cottage groups of 10 to 12 boys rehearsed on a weekly basis and performed in Sunday chapel services and for special events, both on the residential campus and in the surrounding communities. Community members who attended these events were appreciative and complimentary; this provided some redress for the youth, who experienced a fair amount of shame attached to the delinquent acts that they had perpetrated in those communities.

This author also rehearsed with small groups of delinquent youth in residential treatment toward a special performance in a historic theater in the community in which the treatment facility was located. Musical drama, small instrumental combos, cottage choirs, and other "acts" were included in a culminating production, which was open to the public. While the inherent challenges of the preparation

(e.g., learning and memorizing music and scripts, cooperating with other group members, overcoming performance anxiety, etc.) were the focus of treatment, the product—in this case, the public performance—provided added value for the youth, contributing to their individual and collective sense of accomplishment.

There are many responsibilities that run peripheral to, yet enhance, the musical performance. Designing printed programs, making costumes, operating the sound system and stage lights—all of these tasks provide additional opportunities for youth to assume and carry out important responsibilities, as well as develop new skills or demonstrate existing nonmusical yet equally valued skills.

Youth who feel overwhelmed in large groups but who need social experiences with peers may benefit from small group involvement. Re-creative experiences such as those described above can promote identification and empathy and enhance interactional skills (Bruscia, 1998a). Additionally, successful performance in a group can lead to an understanding and acceptance of one's role in the greater endeavor, improved group cohesion, and a sense of group pride. Students who physically aggress toward others or who have severe impulsivity may not be well suited for small performance groups, especially if formal presentations for external or public audiences are planned. Performance groups would be considered an augmentative level of practice (Bruscia, 1998a), employed in tandem with other therapeutic and academic programming.

Preparation. With both instrumental and vocal performance groups, musical repertoire needs to be selected and scores (if used)—whether commercially prepared or created/adapted by the music therapist—need to be prepared ahead of time so that rehearsals run smoothly. The rehearsal room must have adequate space for the task at hand. Requisite equipment could include music stands, music folders, tables, chairs, etc. A recording and playback device may help clients more efficiently learn their parts or refine their collective renderings. With instrumental groups, high-quality instruments should be available to the clients. Gardstrom (2007) writes, “Well-constructed instruments tend to be more durable and predictable over time. Perhaps most importantly, the investment in well-manufactured instruments conveys an attitude of respect for one's self as a professional, for the client as a musical human being, and for the music itself” (p. 35). Depending on the nature of the performance, special costumes or attire may be indicated.

What to observe. As with any ensemble, the members of a small performance group of adjudicated adolescents will assume certain roles and affects during rehearsal sessions: Who assumes responsibility and who avoids it? Who comes prepared for the work and who is ill-prepared? Who appears curious and engaged in the learning and rehearsal process and who seems bored or disengaged? Interpersonal relationships will also emerge: Who assumes leadership, and in what way? How do others relate to this leadership? Who is supportive and who is diminutive of others' contributions? How well do the players listen to and “groove” with one another's playing? How well do they cooperate with one another in peripheral activities such as selecting repertoire and giving verbal feedback?

Procedures. Specific procedural steps depend on the type and size of the performance group. In general, though, sessions might include (1) a welcome and review of what was accomplished in the prior session, (2) a verbal overview of the rehearsal plan or strategy, (3) a warm-up period (vocal or instrumental), (4) focused rehearsal of performance repertoire, including troubleshooting or “finessing” of certain sections, (5) verbal feedback about the performance from the therapist and other listeners, and (6) an opportunity for questions or comments from group members. If possible, a “dress rehearsal” in the performance space is recommended so that the actual performance runs more smoothly; this also may alleviate some of the anxiety that many youth experience when displaying their talents for public consumption.

Adaptations. Cornhill (personal communication, September 4, 2012) provides beginning and advanced levels of adaptive guitar lessons to same-sex groups of four to six adjudicated youth. Teens

petition their treatment teams and are rewarded for solid academic performance and effort with the weekly lessons. After a brief “check-in” with group members about the events of the day, Cornhill begins the lesson, purposely using tunes with lyrics that may spark meaningful discussion about clinical themes. Charts are used to teach open chords in the beginning group; advanced players may learn some barre chords and a bit about tablature notation. The groups aim for performances at facility events, such as Family Days.

Many adjudicated adolescents will not have had enough prior music instruction or experience to embrace traditional notational systems. As with adaptive music lessons, then, rote instruction or simplified written systems are often used in order to accommodate the disparate levels of music ability among group members. Video-recorded performances may be used in place of live music performances in certain situations. For example, this author recorded a cottage band in advance of a school assembly because (1) there would not have been enough room on the stage for all of the instruments and players involved, and (2) two of the teens were planning their release from the program just prior to the assembly, and none of the other boys were equipped to assume their parts. Watching oneself perform, while quite different from performing live, affords different benefits, such as being able to relax and enjoy the moment, critique one’s singular performance, and notice aspects of the ensemble that are overlooked when one is focused on a particular part.

Large Performance Ensembles

Overview. Large performance groups engage 12 or more adolescents in practicing and performing music in formats such as choirs and instrumental ensembles in order to address therapeutic goals. Such groups are popular in residential programs that have an educational focus. In these programs, funds permitting, administrators often attempt to offer academic and arts training on par with typical school systems. Not only does this provide for “normalizing” experiences for the adjudicated youth, but it also makes for an easier transition to regular schools upon release. Additionally, some program administrators choose to involve bands and choirs in their public relations endeavors as a way to showcase program benefits or demonstrate funding needs. In these cases, performance standards may be dictated by administrators rather than emerge organically from within the group itself. It takes a skilled music therapist to manage such externally imposed expectations and the complex logistics and dynamics of a large ensemble—particularly if it includes both male and female clients—while maintaining a clinical focus.

As one example of a large performance ensemble at the augmentative level, Cornhill (personal communication, September 4, 2012) describes his work with a coeducational choir of 25 to 30 adolescents from a variety of educational/treatment programs operating under one umbrella agency. The agency serves troubled preteens and teens, many of whom have been adjudicated. The youth audition for the choir, just as they might in a typical school system. Cornhill states that choir participants experience a boost in self-esteem but, more importantly, report an unprecedented “sense of belonging to a group” and “feelings of normalcy that they so desperately need.” He states that some clients—no matter how musically talented or eager—are not ready to be placed in a coeducational group; on the other hand, the customary challenges of blending girls and boys in this age range seem to diminish when music-making is the primary focus; furthermore, youth need opportunities to practice healthy interaction with the opposite sex.

Preparation. With a large ensemble, the therapist needs to be as musically prepared as possible before the session, which may be called a *rehearsal*, begins. Warm-ups should be preselected. Music should be chosen with consideration given to the teens’ abilities and interests. Cornhill (personal communication, September 4, 2012) takes care to select songs for his choir with lyrics that have a

therapeutic message. If published/copyrighted songs will be performed or rearranged (unison vs. parts, solo vs. tutti, etc.), the therapist may need to secure necessary permission. Keys may need to be altered to accommodate the awkwardness of changing male adolescent voices. Once musical selections are finalized, the accompanist(s) will need to rehearse and, perhaps, memorize the parts. This is particularly important if the therapist is also an accompanist; a therapist whose eyes are riveted to the musical score will overlook important signals from the group and will not be able to provide visual cues for the ensemble.

For groups involving girls and boys, some forethought should be given to seating/standing arrangements. Rules pertaining to interaction between boys and girls and consequences for violation of the rules should be clear and in concordance with facility rules.

What to observe. Roles and affects are important here (as with small performance ensembles; see above), but the intricacies of interactions among large groups are, naturally, more difficult to observe. In most cases, a music therapist who works with a large group will have staff assistance so that responsibility for certain aspects of behavior management—which can be a critical corequisite of musical and interpersonal development—is shared.

Procedures. Depending on the type of group and the clinical aims, social activities may be built into the beginning or ending of a rehearsal. Instrumental or vocal warm-ups are introduced to gather the group together, stimulate musical sensibilities, and, particularly in the case of a choral ensemble, avoid vocal strain or injury. The therapist or clients may state hopes for what the group might accomplish during the session. The “core” of the rehearsal follows, with the use of traditional notation, adapted notation, or (in most cases) rote instruction. During this phase of the rehearsal, the therapist may use techniques such as modeling of musical lines, error detection and correction, repetition, verbal praise, and small sectional rehearsal. After rehearsing each song or at the end of the session, clients should have an opportunity for private or public self-appraisal: What went well? What problems were encountered and how were they addressed? What needs further attention or improvement? What was learned or gained through the experience?

Adaptations. Cornhill takes his choir into the community to perform for various audiences. Song material is interspersed or even strategically linked together with scripted or impromptu individual testimony from youth about their criminal history and their processes of change.

Group Percussion-Based Experiences:

Guided Interactive Drumming, Traditional Drumming, and Drum Circle

Overview. Adolescents collectively learn, internalize/memorize, and re-create discrete rhythmic/motoric patterns and sequences using drums and other percussion instruments as a way to develop in physical, cognitive, interpersonal, and affective domains of functioning. Several different types of percussion-based experiences have been used with adjudicated adolescents. Percussion instruments have great appeal and seem to be highly valued by adolescents (Gardstrom, 2004). Additionally, these are instruments on which teens with little or no prior musical training can be successful with relatively little instruction. Three percussion-based experiences will be highlighted in this section. Note: The term *drumming*, used here and elsewhere in the literature, actually refers to the use of drums and a variety of other percussion instruments. (A helpful taxonomy of percussion-based experiences used in clinical practice is found at the following site: <http://musictherapydrumming.com/a-taxonomy-of-drumming-experiences-2/>.)

Percussion-based exercises demand that teens work together as a musical ensemble in the production of rhythmic patterns, thereby providing occasions for the strengthening of group ties. Other relevant clinical goals of such exercises include lengthening attention span, decreasing impulsivity and improving frustration tolerance, and increasing personal sense of mastery through musical success. And,

while distinctions are made between Recreational Music-Making (RMM) with adolescents (Bittman, Dickson, & Coddington, 2009) and music therapy, it is important to note that a music therapist may design percussion-based experiences as a way to help adjudicated adolescents to have “good, clean fun” together—something that many of them need to learn or relearn. Such interventions are typically indicative of the augmentative level of practice.

Preparation. It is important to have a variety of hand drums, such as tubanos, djembes, doumbeks, gathering drums, and so on. Auxiliary and so-called *ambient* percussion instruments, including shakers, tambourines, agogos, ocean drums, and others are also recommended. Space for drumming is necessary, and ideally the group should be arranged in a circle formation, either standing or sitting as the experience requires; if sitting, use armless chairs. When groups of teens are playing percussion instruments together, the cumulative volume demands consideration; the sound may need to be contained somehow. Depending upon the particular experience, the therapist may need to predetermine the specific rhythmic patterns that will be used, and written notation may need to be prepared ahead of time.

What to observe. Percussion-based experiences give the therapist a chance to assess sensorimotor skills, handedness, auditory discrimination, rhythmic memory, and a host of other aspects of motoric and cognitive functioning. As with other instrumental interventions, it is important to be on the lookout for clients who have difficulty with coordination. Clients who are unable to synchronize with a steady beat or repeat a simple rhythmic pattern—even without prior drumming experience—may be delayed in some way.

Such exercises also enable the therapist to learn about dynamics in the group: Who is engaged? Who emerges as a leader? How does the group as a whole deal with the “outliers” who struggle with the exercises? Adolescents who do not blend in with the group’s musical tempi or dynamics but rather “do their own thing” may be demonstrating problems with structure or authority or may be attempting to call attention to themselves. On the other hand, clients who stop playing prematurely, blend into the background, or refuse to take a leadership role in the circle, no matter how small a part, may be struggling with low self-esteem or social anxiety.

Procedures. In one example of *Guided Interactive Drumming*, the group members stand in a circle, shoulder to shoulder, holding a frame drum in the left hand and a soft-headed mallet in the right. The therapist first directs the teens to synchronize their own drums with a pulse that she provides. The pulse is then organized into a measure of 4/4 time, and players are instructed to count out loud and place an accent on beat 1. Once the group is able to accomplish this, beat 2 is moved to the drumheads of the players to the right. With success at this task, the players are directed to place beat 4 on the drumheads on their left, resulting in a *center-right-center-left* pattern. From here, simple patterns (including subdivisions) can be sequenced for greater challenge and interest. Once simple patterns have been mastered, increased tempi and progressively more complex rhythmic figures can be introduced, as well as more sophisticated playing configurations involving each player and his or her “neighbor.” In this author’s experience, clients draw great satisfaction from creating and contributing their own rhythms to the mix.

In the *Traditional Drumming* experience, adolescents are introduced to and re-create established “grooves” from a variety of music traditions such as Afro-Cuban (e.g., salsa), Brazilian (e.g., bossa nova), American jazz (e.g., boogie-woogie), etc. The following general procedures assist with this intervention: (1) introduce the groove using recorded examples; (2) demonstrate basic playing techniques on each of the instrumental components that will be used in the re-creation; (3) distribute instruments according to interest and skill; (4) arrange the players in small groups according to instrument or instrument group; (5) instruct each of the small groups, troubleshooting and rehearsing difficult parts; and (6) layer parts together and sustain the “groove.” Song material may be added once the rhythmic foundation is secure.

Verbal processing is often a feature of this experience as well; questions may be oriented around difficulties overcome, moments of pride, lessons learned, etc.

Dal and Matney (2010) describe a *Drum Circle* as a “group interactive process where individuals use a variety of drums and percussion instruments with the intent of producing a musical product of *recreational and community value*” (<http://musictherapydrumming.com/a-taxonomy-of-drumming-experiences-2/>). In the last decade—parallel to increased interest and involvement in community-based drum circles—the use of facilitated drumming with various music therapy clientele has grown in popularity. In that the motivation and ability to choose, participate in, and derive enjoyment from social and community activities is a valid clinical aim for adjudicated adolescents, a drum circle (also called *community drumming*) may be considered a legitimate intervention. In treatment programs espousing the primacy of the peer group, especially, such community-building activities are highly valued. The role of the therapist (or facilitator) is to help the youth “form, express, and share ideas and impulses that support the goals of the group” (Dal & Matney, 2010, n.p.). While a drum circle may have improvisational components, it is essentially re-creative in that the players are re-creating rhythmic patterns that are suggested, assigned, or directed by the facilitator.

Often the process of community drumming begins with the facilitator establishing the pulse (and, hence, the tempo), the meter (which is usually duple), and the dynamic level. Synchronized playing is common at first, although drum circle facilitators may also engage the players in rhythmic imitation and call-response forms in which one player or subgroup of players will initiate a rhythmic pattern or phrase and the other players will imitate or respond in kind. An ostinato may serve as undergirding during rhythmic exploration and improvisational moments within the larger, structured experience.

Adaptations. Thanks to performing artists such as *Stomp* and *Blue Man Group*, youth are well familiar with and may even be drawn to alternative ways to create percussive sounds using various household items such as milk jugs, trash can lids, and so forth. With a bit of creativity, objects found in residential facilities can serve as viable substitutes for percussion instruments. Likewise, body percussion may be used; with the right technique, certain body sounds can approximate conventional percussion instruments (e.g., foot stomp for a bass drum, hand clap for a snare drum, etc.). In this author’s experience, groups of adolescents appreciate the chance to create a meaningful musical product using the resources at hand, are additionally pleased to see a video recording of their creation, and can gain critical insights from watching it.

GUIDELINES FOR COMPOSITIONAL MUSIC THERAPY

The use of composition with adjudicated adolescents is frequently noted in the literature. Both individual and group songwriting is described, and some detail relating to goals and procedures is provided. No examples of instrumental composition with delinquent youth were located in this author’s search.

Songwriting can be accomplished in a number of ways. In this day and age, many compositional tasks are completed with the help of technology. Products such as Smart Touch™, GarageBand™, and Finale™, have opened up a world of possibilities for clients with little or no musical “language” or skill.

Individual Songwriting

Overview. Individual songwriting involves the client creating new lyrics in whole or in part to existing songs or composing original music and lyrics with the therapist’s help. In educational programs for delinquent youth, one may see the blending of clinical and educational aims. For example, this author and a language arts teacher at a residential school for delinquent boys worked together on a unique grant project involving individual songwriting. Clinical goals of the project were to enhance each boy’s creative

self-expression and to improve a sense of mastery through completion of an original composition. Educational aims were to decrease resistance to creative writing and to improve each client's understanding and use of certain literary structures and techniques. (Grant monies supported several trips to a local recording studio in which each boy had the chance to work with a sound engineer to arrange and eventually record his song.)

The aforementioned program was not unlike that of *Genuine Voices*, a not-for-profit organization in Boston, MA, whose mission is "to teach music, musical composition, and computer-based music 'sequencing' to youths in juvenile detention centers and other educational and institutional settings" (*Genuine Voices*, www.genuinevoices.com). Volunteer musicians meet with program participants once per week to assist them in creating, arranging, and recording their original material. Although this is not music therapy, per se, music therapy students and faculty from Berklee College of Music appear to have been directly and peripherally involved in the program.

As an augmentative practice, individual composition can be one of many ways to help access and release feelings associated with adolescents' criminal histories and the familial, sociopolitical, interpersonal, and personal factors that may have contributed to their delinquency. For example, her treatment team referred one young woman to this author in order to complete a song she had begun about her grandfather, whose death had spiraled her into a period of intense grief that was manifested in angry gestures and illegal acts.

Preparation. One advantage of composition is that it can be a beneficial treatment intervention without the need for extensive resources. In fact, it is quite possible to lead individual composition experiences with adjudicated youth with nothing but a voice. If more sophisticated instrumentation is desired, the environment must be prepared accordingly. This may mean having a portable keyboard on a stand or a guitar at the ready to support melodic and harmonic exploration and accompaniment. In the case of computer-assisted composition with the use of commercial tools (e.g., GarageBand™), the necessary electronic components will need to be set up and in working order. If music listening is incorporated as a way to stimulate and refine ideas (see procedures, below), a suitable playback system must be accessible.

The environment should be private and free of distractions and the therapist's demeanor accepting of whatever material the client initially presents.

What to observe. Individual composition—particularly song composition—can provide useful data about a client's cognitive and emotional functioning, particularly in that lyrics may reveal the composer's personal ideas, beliefs, attitudes, values, fantasies, feelings, and so forth. The structure of creative output is also telling; youth who are unable to synthesize their expressions into a coherent lyrical or musical package may be revealing internal disorganization. The therapist may gather important information not only from viewing the products, but also from observing the process—that is, the "how" of composition, or the manner in which the client moves through the various tasks associated with the method. A teen who is unable to complete a certain section of a song may be revealing resistance or instability.

It is important in any individual music therapy with adjudicated adolescents to watch for "splitting" and manipulation that can easily occur in the intimacy of a one-on-one musical relationship. As with song discussion and song communication, the therapist should be knowledgeable about the types of themes/lyrics that are allowed expression within the facility and should communicate frequently with other staff about the individual sessions. Case in point: This author recalls nearly being "duped" by Timmy, who requested that she help him compose a song about his rage toward a sexual perpetrator, a topic that the verbal psychotherapists had denied expression in group sessions on the grounds that Timmy was using the victim role as a defense against the shame associated with his own incarceration for predatorial and pedophilic offenses.

Procedures. As with other individual music therapy interventions, it is difficult to pinpoint a specific sequence of procedures for composition. However, a general protocol might encompass helping the youth to: (1) choose a personalized theme for the song; (2) decide on a song style and form; (3) construct lyrics; (4) craft melodies and harmonic accompaniment for the different formal components; and (5) determine instrumentation. In that the task of melodic and harmonic construction may be quite challenging for someone with little or no music training, the therapist may employ a variety of assistive techniques, three of which are music listening (i.e., the client and therapist listen to song examples in order to generate ideas), modeling (i.e., the therapist presents several different options from which the client may choose or which the client can modify), and improvisation (i.e., the client creates spontaneous music and subsequently shapes these creations). In some cases, “homework” on a particular song might be assigned or encouraged between scheduled sessions. One extension of the composition process is the recording of the client’s original song, as described above, a process that may interface with re-creative variations.

Adaptations. In some cases, teens may elect to perform an original song for others or share a recording as a gift or communicative gesture. Potential audiences may be peers, members of a treatment group, family members, or people who have been victims of the teens’ criminal activity. The music therapist may suggest this additional step in the compositional process when a topic of clinical significance arises and suggests further development. Careful preparation for the performance or sharing of an original song involves not only rehearsing the song itself, but also readying the clients for a variety of responses from the receivers, including the unfortunate but real possibilities of rejection and ridicule.

Group Songwriting

Overview. In group songwriting, clients collaborate to create new lyrics in whole or in part to an existing song or compose an original song with assistance from the therapist. In relevant publications, one finds reference to goals that can be accomplished through the use of songwriting with adolescents, such as to increase self-expression, develop group cohesion, improve self-esteem, and develop decision-making skills (Edgerton, 1990). No contraindications are noted. The literature describes group songwriting as what would be considered an intervention at the augmentative level.

Preparation. Before adolescents arrive at a group composition session, the therapist must prepare several musical and nonmusical materials. For Edgerton’s procedure, described below, this involves (at the least) (1) selecting a song for lyric analysis as the first step in the process and preparing a lyric sheet, as relevant, (2) providing a large, visible surface upon which to record group members’ verbal contributions, and (3) arranging musical instruments and equipment so that the music composition process can be aptly facilitated. Additionally, students may need instruction in the care, tuning, and manipulation of the instruments in order to be successful.

What to observe. Group members’ roles and relationships will become evident in the process of creating a song in collaborative fashion. The therapist might take note of which teens take charge of certain pertinent tasks and whether their leadership is positive (i.e., supportive, productive) or negative (i.e., critical, bossy, counterproductive). Which members are easily able to identify and verbally express their reactions as the process unfolds? Which members seem reluctant to share or appear to have difficulty organizing the expression of thoughts, feelings, and creative ideas? How do the clients work through creative lulls or the negotiation that is a necessary feature of any collaborative endeavor? Ideally, the music therapist will be on the lookout for opportunities to “draw out” less verbal members and, in general, ensure that all members have an opportunity to contribute to and feel some sense of accomplishment in the compositional process and product, no matter what the typical role relationships and interpersonal relationships within the group.

Procedures. Edgerton (1990) describes her original procedure, called “Creative Group Songwriting,” which she used to help adjudicated youth with emotional impairments increase self-expression, develop group cohesion, and improve self-esteem. Six procedural steps comprise the procedure. During *Lyric Analysis*, the clients listen to and discuss a song selected by the therapist, with attention to the overall form, techniques used by the songwriter to communicate the theme, and thoughts and feelings elicited by the song. In the second step, *Music Analysis*, the listeners review the form and focus on compositional techniques, identifying the “hooks,” instrumentation, and creative techniques such as word painting. In *Theme and Style Selection* (as the name implies), the group members choose a theme for the song and agree upon the overall style and mood. The fourth procedural step is *Lyricwriting*, in which brainstorming by all members is encouraged and the various sections of the song (i.e., chorus, verses, and bridge) are fleshed out by combining multiple ideas related to the selected theme.

Music Composition occurs next. In this important step, group members assign instruments and vocals and then improvise or “add on.” In adding on, the drum machine lays down a beat, and then the rhythm guitar, trap set, lead guitar, other instruments, and voices add on, each in turn. The therapist provides foundational music instruction at this point—for example, demonstrating open tuning barre chords and teaching single note names on the frets. After a period of exploration and improvisation, the group’s creation is recorded, played, and discussed until the clients agree on the musical construction for each of the sections of the song. In the final step, *Culmination*, the song is rehearsed in preparation for recording or performance, and the adolescents are given an opportunity to reflect on and converse about the entire compositional process.

Adaptations. A useful format for group composition is the 12-bar blues, in which three lyrical lines make up one verse. After listening to live and/or recorded examples of blues songs, a theme for the group composition is determined through majority or consensus, and clients brainstorm words and phrases pertaining to the theme. One group member may serve as scribe. The first lyrical line of each verse is selected by the teens or suggested by the therapist (e.g., “When I woke up this morning, I was feeling ___”). This first line is then repeated (occasionally with slight modification) for the second line; the third line relates to or “finishes” the idea from the previous lines and may rhyme. Once the group has completed the entire blues, which can be as short or as long as desired, the song can be fairly easily re-created with bass guitar (three different pitches), keyboard or 6-string guitar (three simplified chords), and a vocalist, with optional percussion.

CLOSING REMARKS ON METHODOLOGY

Whether delinquent youth receive individual or group music therapy (or both) depends upon factors too numerous to list in their entirety, the most obvious of these being the type of setting and program philosophy. Both treatment options have advantages for these youth. But if a residential facility espouses the primacy of the peer group, as some do, there likely will be few opportunities for individual therapeutic intervention. Or, if a program operates on a levels system in which “good” behavior is rewarded and music therapy is viewed as a reward, only certain groups or individuals will be “eligible” for treatment. Other factors that may influence the provision of treatment include affordability, safety, and feasibility issues, such as the available space and personnel or material resources.

When individual sessions are an option, in the best-case scenario, one or more treatment team members will refer an adolescent for music therapy in order to target some aspect of that youth’s individualized care plan. In some circumstances, an adolescent may be allowed to self-refer according to facility policies and procedures (e.g., request music lessons, ask his or her treatment team for permission to work with the therapist to complete an original song, etc.). Finally, teachers and other professionals who work at the facility may ask for the music therapist’s help with a particular individual in order to

engender academic motivation and/or achievement or to address another problematic area of functioning.

Group treatment is indicated when group members could benefit in some way from the structure, processes, or products afforded by group music therapy. In their theoretical treatise, Yalom and Leczsz (2005) outline curative factors that are unique to group psychotherapy, such as altruism and universality; although originally applied to verbal therapy, these principles pertain to creative arts therapies as well.

As stated in the introductory comments, if music therapy is viewed as a regular feature of an academic program, it is likely that music therapy will be group-oriented, with group size determined by classroom or “cottage” census. In this author’s experience in residential facilities, group treatment (sessions lasting 50 to 60 minutes) occurred during the school day and individual or dyadic sessions (lasting 30 minutes) were considered a privilege that was earned through responsible behavior and that took place at the end of the school day or in the evenings, much like music lessons for teens in regular education programs.

Whether one intervention or multiple interventions are used during each individual or group session will also depend upon a multiplicity of factors. At the very heart of this decision are the clinical aims of the session: It may be that certain therapeutic goals can be addressed with only one method (e.g., receptive) or one variation (e.g., song communication), whereas others may require a combination of methods or variations, in that each variation poses unique challenges and opportunities befitting of certain aims. Time is also a consideration, in that shorter session durations will naturally allow for fewer music experiences. Whether or not verbal processing is indicated—and, if so, to what extent—will also influence the configuration of methods and variations within a single session.

Music therapists who work with adolescent offenders generally report that a flexible approach to session planning and facilitation is necessary and that this flexibility must extend to both the number and sequence of session events. There is no magic session format for delinquent youth! That said, in general, this author has found that the 4-phase session structure suggested by Stephens (in Bruscia, 1987) for improvisation has benefitted her work with many male and female adolescent groups, even when improvisation is not employed: *warm-up*, *verbal discussion (during which areas of potential therapeutic focus are determined)*, *working through (“core” music experiences)*, and *closure*. Any of the aforementioned methods and variations may serve as a warm-up or working through (core) experience. Again, the decision of what methods or variations to use when stems from the session aim(s). Warm-ups should be relatively brief, do not necessarily need to be processed (verbally or otherwise), and should bring the group members together somehow and “warm them up” to the content of the core experience. During the working through phase, music experiences are used to more fully explore the treatment issues identified in the discussion, generate solutions, release physical and psychic energy, and collect insights. Closure may be musical or verbal in nature and should be a time to acknowledge what has occurred in the group.

Following is one sample session structure designed to target the identification and healthy release of emotions, a common focus of treatment for young offenders:

Session 1

- Warm-up: Clients collectively imitate therapist’s rhythm patterns on tubano drums to warm up their hands, arouse their senses, and bolster their musical/ expressive confidence.
- Discussion: Each group member will say, “Right now, I feel (emotion) and this relates to (circumstance, person).” She may choose to follow this statement with a musical statement on her drum.

- Core: Using the tubanos, the group will improvise collectively, exploring preestablished referents based on feelings shared during the discussion (e.g., anger, loneliness, pride, etc.).
- Closure: Each group member will share one thing they learned about their own emotions or the emotional lives of other members.

RESEARCH EVIDENCE

Receptive Music Therapy

Using a three-group comparison design with pretest and posttest measures, Gladfelter (1992)—a music therapist who worked in a private, residential school for male offenders, ages 15 to 18 years—researched the impact of progressive muscle relaxation (PMR) only, music listening only, and PMR with music listening on state and trait anxiety of 65 residents at his place of employment. Residents were asked to lie down in a reclining chair. Prerecorded classical (instrumental acoustic), New Age (instrumental electronic), and jazz (accompanied saxophone) selections were used in the music conditions. The State Trait Anxiety Inventory (STAI, Spielberger, 1983) and a subjective numerical measure of discomfort were used to collect data pertaining to the dependent variable. Gladfelter found that both the PMR and the music listening conditions significantly reduced the boys' self-reported state anxiety. The combination of the two techniques, however, did not yield consistent or significant pretest-posttest changes in state anxiety. Trait anxiety was unaffected by PMR and the combined techniques but was significantly reduced in the music listening condition. There was a positive correlation between enjoyment of the music selections and self-reported relaxation. Jazz was the most preferred genre. Contact with Gladfelter confirmed this author's hunch that music relaxation was not used as a feature of treatment but, rather, was unique to this particular research protocol (personal communication, February 9, 2012).

In a case study within a descriptive article about their work with delinquents in residential treatment, Rio and Tenney (2002) cursorily illustrate their use of music-assisted relaxation with Cody, a 16-year-old with a criminal, gang, and substance abuse history. The authors indicate that one of Cody's goals was to learn ways to relax and meditate. Tenney met with Cody for multiple individual sessions, and "[s]ome form of relaxation with music took place during almost every session" (p. 95). Progressive muscle relaxation (PMR) with music was used as a precursor to song composition. Initially, therapist-selected solo piano music was paired with PMR, which led to some degree of self-reported relaxation. When Cody chose his own music (rap), he reported feeling even more relaxed. He also indicated that, upon termination of treatment, he would continue to use MAR techniques when his anger flared up.

In a pilot program with one cottage group of 12 delinquent girls at a state training school, this author (Gardstrom, unpublished) used eurhythmic listening for increased cardiovascular exercise aimed at the girls' weight control and improved body image. At the start of the eight-week program, the movement experiences were met with resistance from many of the girls. Issues uncovered during the verbal processing included fear and embarrassment related to obesity and a perceived lack of coordination, and the triggering of potent emotions related to physical and sexual abuse. In time, and with encouragement from the author, certain residents in this author's group emerged as motivational leaders who were able to help other girls break through defenses. Confidence increased and a sense of group pride surfaced. Eventually, the group requested permission to perform a choreographed piece for other male and female residents at a school assembly, which was met with great praise from staff and peers alike, contributing to the girls' reported feelings of mastery and gratification.

Rio and Tenney (2002) describe their use of structured movement to music with girls in a residential treatment facility as a way to help them focus and to heighten body awareness. Similarly, they

found that movement to music for their client, “Caroline,” revealed inhibition and discomfort related to her history of promiscuity and prostitution—feelings that were subsequently explored through instrumental improvisation.

This author was able to unearth just one example of projective listening with juvenile offenders. As part of a larger creative project involving lyric interpretation and video interpretation, Edgerton (personal communication, February 20, 2012) played instrumental music for delinquent boys in a residential school program and asked them to respond to multiple, open-ended questions about the music, such as “What name would you give the piece?,” “What would the piece be about?,” and “What colors, feelings, adjectives, etc., would you use to describe the music?” Working in tandem with an art therapist, Edgerton helped the boys interpret what they heard using various art media. Eventually this projective handiwork became part of a group collage that was shared during a special “family day” at the school.

Improvisational Music Therapy

Edgerton (personal communication, February 10, 2012) describes the use of improvisation with young male offenders as part of a larger group documentary project involving music and art media. Cottage groups of 10 to 12 youth created sketches that were eventually sequenced as slides with music accompaniment. The boys could select instrumental music to accompany the presentation of their slides or could improvise a “sound track.” In order to introduce the concept of improvisation and build improvisational fluency, Edgerton asked half of the cottage residents to improvise together using the referent of a particular emotion (e.g., anger, joy, loneliness, etc.). A variety of instruments were used, including electronic keyboards with certain scales and arpeggios (e.g., Middle Eastern, natural minor) marked with tape for easy recognition. The other half of the cottage group, through discussion, guessed the referent and talked about how the improvised music reflected the referent. Edgerton describes this experience as developing verbal and nonverbal communication skills, promoting group cohesion, and unleashing creative potential.

Re-creative Music Therapy

In one of the earliest published examples of the behavioral application of music in delinquency treatment, Madsen and Madsen (1968) write about the procedures they used to extinguish one young man’s abusive and antisocial behaviors. Individual guitar lessons were provided, contingent upon the client’s completion of short work tasks. No specific information was provided as to the length or content of these lessons.

Gardstrom (1993) writes about the use of handbells with male and female delinquents in an intergenerational music-based program. In this program, youth from a state training school and older adults in community “senior centers” served as participants. Rehearsals occurred weekly for two hours, with youth taking responsibility for transporting all necessary equipment to the center (i.e., bells, gloves, tables, foam pads, sheet music, etc.), setup, and teardown. The youth and their senior “partners” worked side by side to re-create simple hymns, patriotic songs, and folk songs. Snacks and socializing concluded each session. Culminating performances in nursing homes and other community venues allowed all participants to experience the joy of working together and giving to others, as well as the pride that accompanies a job well done and enthusiastically applauded. A somewhat unexpected but welcomed by-product of this particular program was the exposition and working through of the offenders’ feelings of guilt, shame, and remorse attached to their prior victimization of vulnerable older adults in their home communities.

Using a randomized controlled crossover design, Bittman, Dickson, and Coddington (2009)

explored the impact of the *HealthRHYTHMS* adolescent drumming protocol on quality of life of youth from a secure residential treatment facility. This protocol is a 6- or 12-week program that blends Recreational Music-Making and counseling techniques and targets “at-risk” youth in residential treatment and community programs, including court-referred adolescents with histories of trauma, substance abuse, gang-related activity, and mental health diagnoses. Participants in *HealthRHYTHMS* programs are youth between the ages of 12 and 18. The protocol is publicized as having myriad biological and psychosocial benefits, as demonstrated in preliminary systematic studies (*HealthRHYTHMS* website, 2012). The adolescent program is designed to facilitate communication and personal expression toward improved quality of life. No contraindications are identified. While not conducted by a certified music therapist, music therapy faculty from Berklee School of Music appear to have been peripherally involved in the project.

Participants in the study were status offenders, and many had mental health diagnoses. Intervention groups of 6 to 12 male and female participants were involved in a specific sequence of expressive activities, including unstructured jam sessions on drums and handheld percussion instruments, structured rhythmic activities, nonverbal/musical portrayal of responses to specific questions, a shaker pass activity, and a “wellness” activity involving breathing, movement, and a tactile object, and performed to acoustic Clavinova music. Open and supportive discussion was a regular feature of every one of the sessions during the six-week intervention period. Treatment and control groups differed significantly and in desired directions in school/work performance, anhedonia/negative affect, negative self-evaluation, and instrumental anger (i.e., delayed emotional responses including revenge and retaliation), as reflected through standardized dependent measures.

Compositional Music Therapy

Neforos and Willenbrink (2012) describe group songwriting with five or six clients in a group home for at-risk and adjudicated boys, ages 15 to 18. The therapists used this method to address identified needs among the clients: emotional expression, creative control, supportive peer relationships, identification of personal strengths, and recognition of opportunities for positive life changes. Originally, Neforos and Willenbrink planned a single session built around individual compositions within a 12-bar blues structure, using open-ended lyric stems. However, the group members rejected this structure as musically unfamiliar and restrictive of their creativity. At this point, individual composition was abandoned for a group process, which spanned several sessions. The group composition procedure was fluid and reflexive. Clients made decisions about the title, lyrics, music, and form of the piece; the therapists facilitated the experience primarily by asking questions to help clients refine their ideas and by suggesting and modeling harmonic and melodic material that could be incorporated into the end product. Therapists also provided encouragement for participation, “ran interference” when communication became strained, and praised group members who made valuable contributions and who demonstrated desirable traits and behaviors during the process. Lyrics were constructed first and, without a doubt, the lyric writing emerged as the core focus of the experience. Subsequent musical decisions regarding style, rhythm, and instrumentation were made by means of group discussion and negotiation. The resulting product was a two-verse rap with a melodic chorus, based on the theme of overcoming struggles and making positive life changes. The clients recorded the rap and had an opportunity to listen to and critique their creation. The level of involvement differed from member to member, depending on individual cognitive and social functioning and maturity. Neforos and Willenbrink note that the experience seemed most beneficial for the group members who invested fully in the process, sharing meaningful personal experiences (including traumatogenic material from their past) and providing emotional support for others when this type of sharing occurred (personal communication, February 3, 2012). While the compositional product was a

necessary focus and provided ongoing motivation for the group members, the therapists identify the primary agent of change as “the evolution of group dynamics through this working process,” from a place of isolation and conflict to a cohesive unit, in which all members felt a sense of belonging and validation, as described by Yalom and Leczsz (2005).

SUMMARY AND CONCLUSION

The purpose of this chapter was to provide guidelines for the selection and facilitation of music experiences with adjudicated adolescents. Group and individual experiences within each the four music therapy methods were identified and sequential procedures offered. The author drew from her own history as a clinician, her colleagues’ expertise, and published literature about music therapy with adjudicated youth, the last of which is limited in comparison to publications about certain other adolescent clientele.

The process of adjudication ultimately involves a disposition hearing during which a court representative passes judgment on an adolescent’s behavior and renders a decision regarding corrective action. In the case of severe or repeat offenders, residential placements (e.g., training schools, boot camps, group homes, etc.) are often mandated. Whether residential placement serves as incarceration toward guaranteeing public safety, as punishment or retribution for criminal behavior, or as an opportunity for rehabilitation and a welcome return to society depends on the national zeitgeist and, in some cases, on the particular jurisdiction in which the adolescent is adjudicated.

Without a doubt, young offenders—while often demonstrating profound resilience—typically come into residential treatment with a host of significant deficits, challenges, and needs: Many have been witnesses to and victims of abuse; other youth have been neglected, abandoned, or invalidated at critical points in their development; some teens have psychiatric and substance use disorders that have gone undetected or unaddressed; and still others have learning difficulties that have led to failure in typical educational systems. Dysfunctional peer groups (e.g., gangs), family systems, and communities contribute to the myriad challenges of rehabilitation.

These complex issues demand a team approach. Music therapists who work with adjudicated youth most often share the responsibilities of rehabilitation with several other clinical personnel, such as counselors, social workers, psychologists, residential staff, and—in the best of circumstances—other creative arts therapists. Each team member makes unique contributions to the treatment process. The music therapist with knowledge about and working facility within the four music therapy methods—receptive, improvisational, re-creative, and compositional—will be able to offer an attractive, experiential modality through which adjudicated adolescents can experience personal growth, with the prospect of enduring change.

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