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Pepperdine University
Graduate School of Education and Psychology

USING MUSIC-BASED INTERVENTIONS WITH ADOLESCENTS
COPING WITH FAMILY CONFLICT OR PARENTAL DIVORCE:
A RESOURCE MANUAL

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Lori Meono

July, 2015

Shelly Harrell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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DEDICATION

“When the pain penetrates, the music resonates.” - Unknown

This work is dedicated to all of those who have experienced loss and pain, and who have found their sole sense of solace in music.

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ABSTRACT

Listening to music is an activity that provides a range of physical and psychological benefits (e.g., tension relief, decreased depression) for people across cultures and age groups.

Adolescents, specifically, are among the most active consumers of music, and music appears to be a natural coping strategy for this age group. Research suggests that both music and the family context play important roles during the developmental phase of adolescence. Family transitions such as divorce have become increasingly common experiences for adolescents and may have long-lasting negative effects on an adolescent's emotional well-being. However, research regarding music-based interventions for use with adolescents experiencing family conflicts or transitions is limited. Thus, this project involved the creation of a resource manual designed to help mental health professionals implement music-based interventions in their work with adolescents coping with family conflict or parental divorce. The development of the manual was informed by a review of the literature about music therapy, adolescents, and families, as well as by questionnaires completed by three certified music therapists, and this author's own clinical experiences. The data was then integrated and synthesized into a comprehensive resource manual, which was evaluated by three clinicians who are not trained music therapists for its efficacy, relevance, and user-friendliness. Feedback for the manual was collected via an evaluation form. Results indicated that the manual may be a useful supplemental tool for mental health professionals. Strengths, weaknesses, and suggestions for improvement are also discussed.

Chapter 1: Introduction and Review of the Literature

Music is loving. It is committed, it is genuine, and it is the only relationship you can always depend on.

– AJ McLean, Backstreet Boys (personal communication, October 13, 2012)

Music has long been considered a leisurely activity in which people of all ages can partake. Those who enjoy music often derive some sense of pleasure from it, whether by listening to it or by performing. People may experience a range of benefits from music, such as the relief of tension, reduction of feelings of loneliness and worries, creating a sense of acceptance and belonging with their peers, or feeling understood and comforted (Bruscia, 1998; Carmichael & Atchinson, 1997; Mark, 1988; Miranda & Claes, 2009; North, Hargreaves, & O'Neill, 2000; Saarikallio & Erkkila, 2007). Some research has found that music can have positive physiological and healing effects, and the value of music as a positive influence on physical and psychological health can be observed across a variety of cultures (Aluede, 2006; Dufrene & Coleman, 1994; Nelson & Weathers, 1998; Stuckey & Nobel, 2010). Access to diverse musical expressions also has become more easily available and music's popularity continues to grow. For example, revenues from music streaming services exceeded \$1 million for the first time in 2012, and streaming services saw a 39% increase from 2012 to 2013 (Recording Industry Association of America, 2014).

Adolescents typically identify music listening as a primary activity, while adults rarely identify it as a primary activity (Larson, 1995; Larson & Richards, 1994). Teens are among the most active consumers of music and research suggests that music plays an important role during the developmental phase of adolescence (McFerran, 2010; North, Hargreaves & O'Neill 2000). For instance, music allows adolescents to engage in a process of self-exploration and to create a

sense of independence and separation between themselves and their parents (Larson, 1995). It can also provide a sense of stability that may serve as a substitute for the lost sense of preadolescent stability previously provided by parents (Larson, 1995).

The family context also plays a significant role in adolescent development (Larson, 1995). Research by Larson and colleagues suggests that adolescents experience greater emotional variability than preadolescents and that spending time with the family is a mediating factor for such emotionality. Also, adolescents spend less time with their families than their preadolescent counterparts (Larson, 1995; Larson, Csikszentmihalyi, & Graef, 1980; Larson & Richards, 1991). Furthermore, family transitions such as divorce have become increasingly common experiences for children and adolescents, and the number of single-parent households have increased worldwide (Amato, 2000; DeLucia-Waack & Gellman, 2007; Huure, Junkkari, & Aro, 2006). Family transitions may have a significant effect on an adolescent's emotional well-being, and these effects can last well into adulthood (Amato, 2000; Huure et al., 2006; Roustit, Chaix, & Chauvin, 2007). Huure, Junkkari, & Aro (2006) found that women who experienced parental divorce during adolescence also experienced higher rates of depression and minor psychiatric disturbances, as well as lower satisfaction with their social network, than women from non-divorced families. Adults whose parents divorced during their adolescence also tend to have lower education levels, and higher rates of unemployment, divorce or separation, hazardous alcohol consumption, smoking, interpersonal problems, and negative life events (Amato, 2000; Huure et al., 2006). Given that music appears to be a natural coping strategy for adolescents, it could serve a valuable role in psychological interventions with adolescents experiencing family transitions.

Music therapy is the evidence-based application of music interventions by a credentialed professional (i.e., a music therapist) within the context of a therapeutic relationship, for the purpose of reaching a client's individual therapeutic goals (AMTA, 1998). As a clinical intervention, it has a rather recent history (Bruscia, 1998; Bunt, 1994; Stuckey & Nobel, 2010). Despite its novelty in the field of psychology, studies indicate that individuals who have received music therapy as a form of treatment show marked improvements in several areas of their lives (Bruscia, 1998; Gold, Voracek, & Wigram, 2004; Keith, Russel, & Weaver, 2009). Research further suggests that music therapy techniques can be applied to children and adolescents struggling with various psychological difficulties, including family conflict, divorce, and loss (DeLucia-Waack & Gellman, 2007; Hilliard, 2001; McIntyre, 2009; Montello & Coons, 1998).

Despite the demonstrable benefits achieved through the application of musical interventions, the therapeutic utilization of music appears to be largely neglected by professional psychology. The limited studies that do exist regarding adolescents experiencing family conflict, parental divorce, or loss have found several benefits in engaging in music therapy, whether individually, in groups, or with the family (Carmichael & Atchinson, 1997; McIntyre, 2009; Nelson & Weathers, 1998). However, few resources exist to assist mental health professionals in the application of music-based interventions (McFerran, 2010). Thus, the purpose of this project was to design a resource manual for clinicians to use music-based interventions in their work with adolescents struggling to cope with family conflict, parental divorce, or other difficult family transitions. The development of the manual was intended to provide non-music therapists with theoretical and research support for the therapeutic use of music, as well as suggestions for integrating music into their work with adolescents. Creating a resource manual that addresses these areas has the potential to add to the clinicians' tool belt by providing adjunctive

intervention strategies to supplement their practice.

The specific objectives of this project included: 1) a comprehensive review of the literature on music therapy, family conflict and transition during adolescence, and the therapeutic use of music with adolescents, 2) development, implementation, and analysis of brief interviews with music therapists to further obtain information about current music-based interventions, 3) development of the resource manual, and 4) a critique of the manual by a panel of experts (registered music therapists) and non-experts (non-music therapist clinicians) to evaluate its accuracy and relevance towards the intended population.

Music Therapy

Overview. One of the greatest strengths of music therapy is that it can be effectively applied to various populations. Children, adolescents, adults, and the elderly can all benefit from music therapy (Bruscia, 1998). Music therapy can also be used in a variety of settings, including but not limited to: psychiatric hospitals, rehabilitative facilities, hospitals, outpatient clinics, day treatment centers, agencies serving developmentally disabled persons, community mental health centers, drug and alcohol programs, senior centers, nursing homes, hospice programs, correctional facilities, halfway houses, schools, and in private practice (AMTA, 1998; Bruscia, 1998). Music has also been found to be effective for mood enhancement and improving family relationships (Arnett, 1995; Bakagiannis & Tarrant, 2006; Choi, Lee, & Lim, 2008; Gantz, Gartenberg, Pearson, & Shiller, 1978).

Another benefit of music therapy is that it can be used with clients who have difficulties with verbal expression. Verbal communication is only one way in which individuals express themselves and some individuals lack the verbal, intellectual, or affective abilities to communicate using their words (Lefevre, 2004). Lefevre (2004) studied the use of music with

children and found that children often communicate symbolically through the use of singing, song writing, or playing instruments. Based on these results, Lefevre recommends that clinicians facilitate and encourage this type of symbolic communication in order to allow the child to engage in a process of self-exploration, expression, and growth. Using musical instruments also provides for the development of social skills, such as using cooperative and creative play symbolically to interact with the therapist (Lefevre, 2004; Moreno, 1985).

A case study conducted by Moreno (1985) illustrated the benefits of using music symbolically. Moreno used music therapy with a 17-year old boy who struggled with mental retardation, hyperactivity, and isolation in order to help him increase his communication and socialization skills, as well as decrease his hyperactive and destructive behaviors. The boy was initially resistant to music therapy, and he often ran around the investigator's room and struck the keys of a piano aggressively in an effort to communicate his opposition to the therapeutic process. According to Moreno (1985), the boy was allowed to make his own choices about whether he would play with any of the instruments, how, and when. After several weeks of behavioral outbursts and resistance, the boy eventually sat next to the investigator and the two began to play together. The boy became increasingly open to learning new melodies, and his tendency to socially isolate and become destructive decreased. New skills translated into the boy's classroom environment, as he became more attentive to the teacher and refrained from running around and destroying the classroom.

History. The use of music as a healing practice can be traced back thousands of years. Ancient African cultures often relied on herbalists, medicine men, and faith healers, all of which used music and natural remedies such as plants, herbs, and animal bones to treat both physical and psychological ailments (Aluede, 2006). In the Western world, the ancient Greeks also valued

the healing powers of music, and Aristotle wrote about the importance of music in emotional release (Munro & Mount, 1978). Shamans in ancient Aboriginal cultures often incorporated art into their healing practices, and music continues to be widely used as a healing mechanism in Native American cultures (Dufrene & Coleman, 1994).

In the 20th century, the development of music therapy as a healthcare profession in the United States began to mobilize after World War II (Bunt, 1994). Musicians began playing for veterans in hospitals around the country. Thousands of veterans, who were traumatized both physically and emotionally by the wars, began to exhibit positive physical and emotional changes in response to the musicians, so doctors and nurses from these veterans' hospitals requested that the hospitals hire more musicians (AMTA, 1998). However, the medical and scientific communities began to question and challenge the efficacy of music-based interventions, as the apparent evidence for positive changes in the veterans was largely based on anecdotes, as well as the fact that musicians were not specifically trained in therapeutic practices (Bunt, 1994). These challenges to the validity of music therapy led to the establishment of the world's first music therapy degree program at Michigan State University in 1944 (Bunt, 1994).

Around the same time that the demand for musicians grew for war veterans, music also began to gain recognition in its effectiveness with children. Unlike with the veterans, who showed improvements after listening to music, children were encouraged to take a more active role in music interventions by using musical instruments to play their feelings (Moreno, 1985). Music was identified as a valuable technique that could be used in conjunction with traditional play therapies (Bender & Woltmann, 1941). Play therapy was described as a natural medium of expression for children, similar to the way adults use spoken language to communicate (Moreno, 1985). According to Moreno (1985), children should have the ability to use musical instruments

in order to help them play their feelings, much like they would use toys to play their feelings in traditional play therapy. The simultaneous use of music and play therapy was believed to be especially helpful to children who struggled with behavioral problems, retardation, and delinquency, as well as “chorea, hyperkinesia, neurosis, or emotional disturbances” (Bender & Woltmann, 1941, p. 28).

Music therapists. Currently, a certification process is required to identify oneself formally as a music therapist. Candidates must complete an approved college music curricula and gain internship experience. Once those steps are completed, the candidate is eligible to take the required national exam. This exam is administered by the Certification Board for Music Therapists (CBMT, 2003; AMTA, 1998). The Certification Board for Music Therapists is the only organization that certifies music therapists to nationally practice music therapy. It has been accredited by the National Commission for Certifying Agencies since 1986 (Certification Board for Music Therapists, 2003). Once the CBMT exam has been passed, the candidate has earned the music therapist-board certified credential, or the MT-BC (AMTA, 1998).

The techniques used by music therapists can be passive or active. Passive music therapy, which involves listening to music, is used as a relaxation technique. As the client rests, the therapist plays soothing music. The client is then instructed to imagine peaceful images to induce relaxation (AMTA, 1998). In active music therapy, the client and/or therapist create music using either musical instruments or his/her voice. The client may also write songs and discuss songs with the therapist or with a music therapy group (Choi, Lee, & Lim, 2008). Research suggests that active music therapy is particularly effective for improving self-esteem, peer relationships, and group cohesiveness (Montello & Coons, 1998). The therapist must take caution to tailor the approach of the session for each individual client.

Healing functions and applications. Music has long had an appeal as a universal form of language (Carmichael & Atchinson, 1997). McClary (2007) described music therapy from the Jungian perspective as an effective form of treatment for clients who have difficulties with self-awareness and/or self-expression. Music therapy can provide clients with a safe environment to express what they had previously been unable to express. By creating music, clients are first able to symbolically represent their symptoms, and then use the music to alleviate those symptoms. Clients gain new insights about their ailments and are then able to incorporate that knowledge into a new self-awareness through this process. Jungians believe that when clients become aware of the different parts of their selves and their psyche, they are able to integrate those parts into a whole and thus individuate (McClary, 2007).

Empirical Support Across the Lifespan

Research consistently supports the use of music therapy across the lifespan. Keith, Russell, and Weaver (2009) found that music could be used to soothe crying premature infants. Their study included twenty-four preterm infants in a neonatal intensive care unit. These infants exhibited the same behaviors found in most premature babies. They displayed stress and pain responses, as well as a lack of self-regulation abilities. In order to treat the excessive crying from these babies, music therapists used recorded music to limit the infants' exposure to unpleasant auditory stimuli. Nurses recorded the duration of the infants' periods of inconsolability and their physiological responses, both with and without the application of the music intervention. The study found a significant difference in the number and amount of time the infants spent crying between the two conditions. Results indicated that without the music, infants excessively cried on average 7 times per day for approximately 23 minutes each, whereas the rate fell to 4 times per day for 5.5 minutes each with the music intervention. Furthermore, the recordings found

improved heart rate, respiration rate, and oxygen saturation for premature infants. The study suggests that music can have positive health effects for infants, allowing them to cope with their own stress responses.

In addition to soothing infants, music therapy techniques have been successfully used to treat children. Carmichael and Atchinson (1997) described two case studies in which they used music therapy techniques effectively with children who were exposed to parental conflict and abuse. Child participants were given a choice of musical instruments with which to play. In the first case study, a 6-year old girl chose to play familiar tunes on a keyboard after initially displaying hesitance in both speaking with the therapist and playing with toys. The therapist noticed that when the girl began to discuss emotionally charged topics, she would often interrupt herself to play the familiar tunes again before proceeding. The researchers hypothesized that she used music as an anxiety-reduction technique that eased her initial reluctance and allowed her to communicate difficult emotional material. The second case study described a 5-year old boy who exhibited aggressive and oppositional behaviors. The boy began to learn self-control, as he started to correct his own undesirable behaviors. When the therapist later integrated music, the boy asked to use scarves in order to dance along with the music. Soft music was initially used, and the boy used gentle movements to correspond to the songs. Similarly, he learned to be gentler with his peers. According to the researchers, his awareness of his own movements coincided with his emotional awareness and his increased self-control (Carmichael & Atchinson, 1997).

Studies also suggest that music therapy may be effective in treating adolescent depression (Field et al., 1998; Hendricks & Bradley, 2005), as music is a behavior that helps regulate mood (Saarikallio & Erkkila, 2007). Listening to music is associated with certain physiological

responses, such as a decrease in stress hormones (i.e., cortisol) and a shift toward left frontal EEG activation in the brain, which is associated with positive affect (Field et al., 1998; Saarikallio & Erkkila, 2007). Saarikallio and Erkkila (2007) specifically studied adolescent use of music in mood regulation. They suggested that all types of musical engagement, including listening to music and songwriting, are used to reach mood-related goals and that adolescents tend to choose different music for different types of activities. More specifically, when attempting to regulate their moods, adolescents tend to choose what they believe to be mood-congruent music and to engross themselves in the feelings conveyed by the music. Doing so provides them with a greater sense of understanding of their own emotions (Saarilallio & Erkkila, 2007).

In their study, Saarikallio and Erkkila (2007) found that across participants, self-selected music generally resulted in mood changes in the adolescents toward a positive direction. However, when music was used to reflect on negative feelings, adolescents temporarily reported feeling worse. This may raise ethical concerns for clinicians working with adolescents. Music therapists must use sound clinical judgment and be able to provide justification for focusing on negative feelings that result in the adolescent clients' negatively altered mood state. It may be argued that proceeding with music interventions that focus on negative feelings eventually helps the adolescents shed their negative emotions in favor of more positive feelings, thus allowing them to discharge and/or resolve their conflicts over time (Saarikallio & Erkkila, 2007).

Further research has also demonstrated that music therapy also benefits elderly populations. Hanser and Thompson (1994) found that listening to music as a therapeutic intervention was related to increased self-esteem and reduced symptoms of depression, pain, and anxiety in older populations. In their study, three groups of clinically depressed elderly

individuals were evaluated. The first listened to music and received weekly home visits from a music therapist. The second also listened to music but only had contact with a music therapist by phone. The third group was placed on a wait list and had no contact with a music therapist. For participants in the music conditions, music was presented as a positive stimulus for body relaxation and positive imagery. Results indicated a significant difference between the groups exposed to music and the group that was not. Those exposed to music experienced a greater reduction in symptoms of distress, depression, and anxiety compared to the no music group. There was no significant difference between the two different music condition groups. Furthermore, at a 9-month follow-up, the individuals assigned to the music conditions reported a continued adherence to music therapy techniques, suggesting that music as an intervention is, in fact, effective in this population. Following up after a longer period of time would lend increased validity to the results.

Applications to Adolescence

Developmental issues and challenges. Adolescence can be a time of growth, identity development, and internal conflict (McFerran, 2010; Morgan & Roberts, 2010), as well as a time for separating from parents (Larson, 1995). Music is incredibly valuable during this stage because it assists adolescents in the identity development process (North, Hargreaves & O'Neill, 2000). Identification with a particular genre of music often suggests an adolescent's values, beliefs, and attitudes. Music therapy can also enhance the adolescent's expression of feelings, positive associations, and socialization (Gladding, 1999; McFerran, Roberts, & O'Grady, 2010).

According to the literature, human beings have four basic needs pertaining to their well-being: "to connect, to feel capable, to count, and to have courage" (Lew, 2002, p. 134). Lew (2002) posits that adolescents in particular often have a tendency to minimize their concerns and

find value in feeling connected to their peers. Mark (1988) argues that music gives adolescents a sense of catharsis and helps them feel more connected to the outside world. Furthermore, listening to music allows adolescents to infiltrate social groups based on musical subcultures, thereby creating a sense of belonging during this phase of transition (Bakagiannis & Tarrant, 2006; Miranda & Claes, 2009). Based on such studies, it can be inferred that sharing a musical preference likely contributes to the adolescents' sense of feeling connected.

Adolescent development in the family context. Research has demonstrated that family structure and family context are important in adolescent development. Studies suggest that adolescents from single-parent homes tend to have higher rates of problem behaviors. Recent family disruptions also tend to create proximate stress and anxiety within adolescents (Hoffman, 2006). However, Langenkamp and Frisco (2008) found that it is not necessarily the transition or disruption itself that can affect emotional well-being. According to the researchers, it is the context of the family during the transitions that affects adolescent emotional distress. Certain specific contextual factors, such as increased parental supervision and close bonds between parent and child can mediate as protective factors against emotional distress in times of family conflict or family disruption (Cookston, 1999; Langenkamp & Frisco, 2008).

Adolescents and family conflict, divorce, and loss. Conflict within the family unit can inhibit an adolescent's ability to develop appropriate coping skills (Michael, Torres, & Seemann, 2007). Roustit, Chaix, and Chauvin (2007) found that changes in family structure are associated with an increase in poor psychosocial adjustment in adolescents. Roustit et al. (2007) further posit that parents' divorce in adolescence can be very harmful, as opposed to divorces occurring at earlier stages. This may be because of an adolescent's need for his parents to assist in his identity development. However, Michael, Torres, and Seemann (2007) found that family

conflict, not divorce itself, leads to marked psychological impairment. In their study, they found that participants who came from high-conflict families engaged in less adaptive health habits, used more avoidance coping, and had a poorer self-concept than individuals from low-conflict families. Those from low-conflict families had a more problem-focused style of coping and had improved physiological responses. For adolescents lacking coping skills, problem-focused music therapy would likely be beneficial because music is typically widely accepted in this age group.

Hilliard (2001) studied music therapy and bereavement in children and adolescents. Since divorce also represents a type of significant loss, one can hypothesize that his findings may be relevant to children and adolescents from divorced families as well. According to Hilliard (2001), the treatment for grieving children must include symbolic and nonverbal means of expressing emotion due to their difficulties vocalizing their emotions. In the study, child participants were divided into an experimental group that was exposed to music therapy and a control group that was not. The experimental group used singing, songwriting, rap-writing, rhythmic improvisation, structured drumming, lyric analysis, and music listening to identify and express emotions, and to understand grief. Results indicated a significant reduction in grief symptoms, including emotions, thoughts, physical complaints, and behavior. This suggests that music may provide some children with some relief in the bereavement process. Further research is needed to test the application of music therapy in the context of the adolescent loss by way of parental divorce.

Some research has shown that the effects of parental divorce on adolescents are long-term. Huurre, Junkkari, and Aro (2006) conducted a follow-up study to assess whether 32-year old adults who had experienced parental divorce before the age of 16 differed in psychosocial well-being from adults from non-divorced families. Results indicated that females from divorced

families reported more psychological problems and difficulties in their interpersonal relationships. Both males and females from divorced families tended to have less education, more unemployment, divorce, negative life effects, and more risky health behaviors. Since the negative psychosocial effects of experiencing parental divorce can and often do persist through adulthood, it is important for adolescents to seek treatment in order to reduce the likelihood of experiencing such difficulties later in life.

Music therapy and the family. The effectiveness of music therapy has been addressed in individual and group settings. However, it also has benefits when used in conjunction with family therapy. In a study conducted by McIntyre (2009), it was found that music therapy, when used with family therapy, allows all members of the family to bond through the shared experience of creating music together by using instruments. Creating music together in an interactive music therapy session is often the first time the family spends a significant amount of time together focused on completing one activity. Much like it does with the individual, music also reduces the overall level of stress within the family. The family's creation of music can expose thoughts and emotions surrounding unspoken family dynamics and processes. As they play their instruments, the family reveals certain information about their level of communication and cooperation with one another. This is captured on a recording, and the family is given a CD to take home with them as a transitional object so that they may listen to their creation. According to McIntyre (2009), families tend to understand more about their own dynamics after receiving this type of interactive music therapy.

Music therapy can also be used to promote positive parenting and healthy child development (Nicholson, Berthelsen, Abad, Williams, & Bradley, 2008). Since music can make it easier for a parent to communicate with the child, there is more opportunity for parent-child

bonding. Nicholson et al. (2008) studied parent-child pairs for 8 weeks using a program called *Sing & Grow*. Participants sang songs to greet and bid farewell to each other by name, which aimed to encourage social skills. Action and movement songs were used to practice motor skills. Playing instruments was also used to practice motor skills and to encourage children to follow directions. Quiet music was used to foster parent-child bonding and physical closeness. When necessary, parents were also provided with parenting skills training. Pre and post treatment analyses showed improvements in various parenting behaviors, child behavioral, social, and communication skills outcomes, and parent mental health. Parent satisfaction rates with this type of program and compliance with strategies in the home were also assessed. Both rates were high, which may indicate that music therapy is both easy and enjoyable to implement. Again, follow up after the program would lend increased validity to the study.

Music therapy on its own has various benefits. When used simultaneously with family therapy, it can affect the family as a whole in a positive way. Thus, it can be argued that adolescents who come from high-conflict families or are experiencing parental divorce would likely benefit from family music therapy. Especially with divorce, engaging in this type of treatment may help adolescents understand the new family dynamics, bond with each parent, and cope with the transition.

Rationale for use of music interventions with adolescents. One of the major reasons to use music interventions with adolescents is music's popularity. According to North, Hargreaves, and O'Neill (2000), adolescent males believed that music allows them to portray a certain impression toward others, while females believed that music helps regulate their moods. North et al. (2000) further found that 17.8% of adolescents played music and 50% had previously played but given up a musical instrument. Only 2.9% of all 2465 adolescents reported that they did not

listen to music very often. By contrast, 39.6% reported listening to music as often as possible. The mean time respondents reportedly spent actually listening to music was 2.45 hours daily. Since involvement with music appears to be important in adolescence, it is possible that adolescents may be more receptive to therapeutic techniques using music than to more traditional therapeutic interventions. They can identify readily with music, making music therapy a valid area to be taken into consideration when treating adolescents.

Adolescents identify listening to music as their most frequently used strategy for coping with stressful life events (Kurdek, 1987). According to Miranda and Claes (2009), coping is achieved in one of three ways. First, music can provide an adaptive distraction from unwanted negative moods. Second, music may provide a sense of validation for their concerns, which can combat feelings of isolation. Third, music can have a cathartic effect, providing a release from negative emotions. Since music appears to have such beneficial effects against daily stressors in this population, music therapy can serve to reinforce coping skills that adolescents already seem to be utilizing.

In addition to coping, music is particularly effective in encouraging emotional expression in reluctant clients, especially children and adolescents. Many clients within this age group have never been provided with opportunities for self-expression in a non-threatening environment (McClary, 2007). Children and adults alike are typically responsive to music, and music can be especially appealing to children and adolescents who find no interest in toys and other forms of play therapy. In these cases, music can serve as alternative option to more traditional forms of talk therapy. What is gained through music therapy can be generalized to the outside world, and clients can learn to use music to their benefit outside of the sessions (Carmichael & Atchinson,

1997). Furthermore, clients do not have to be particularly talented in order to enjoy these benefits.

Music interventions have also demonstrated an increase in communication skills. According to Mark (1988), adolescents can accept and communicate their feelings through lyrics. Music helps them label their emotions and explain their own circumstances, desires, and fears. Music is especially useful for material that may be too intimidating or hurtful to explore more directly. Instead, the adolescent can discuss the general message or theme evoked by a particular set of song lyrics. It can be argued that divorce is one area that may be incredibly difficult for an adolescent to discuss. Therefore, songs with lyrics about grieving and loss may help the adolescent begin to communicate such feelings indirectly.

Synthesis and implications. Studies have shown that adolescence is associated with increased rates of psychological distress, including depression, suicide, eating disorders, and delinquency (Larson, 1995). Family conflict and parental divorce are also highly correlated with negative psychological outcomes (Huure et al., 2006). According to the research, music-based interventions with adolescents can be particularly effective as a means for coping, to mediate emotional regulation and expression, and to improve communication skills (Kurdek, 1987; Miranda & Claes, 2009; McClary, 2007; Mark, 1988). Using music therapy techniques with families can also promote familial bonding, mutual understanding, and positive parenting (McIntyre, 2009; Nicholson et al., 2008). While much of the literature identifies the benefits that can be gained from music therapy with families, especially with adolescents, there are a limited number of resources available to help guide mental health professionals in the use of music-based interventions with adolescents (McFerran, 2010). More specifically, there appears to be a lack of resources available for adolescents particularly coping with family conflict or parental

divorce. Future research should aim to expand on existing research about music therapy techniques used with families in transition, especially with adolescents, and should aim to create a standard of practice for using music-based interventions with this specific population.

Definition of key terms.

Music Therapist: “A specially trained individual whose intervention is based on a thorough knowledge of all facets of music (historical, theoretic and practical), the behavioural sciences, treatment and educational models, and accepted therapeutic approaches” (Munro & Mount, 1978, p. 1029).

Music Therapy: “Music therapy is the use of sounds and music within an evolving relationship between client and therapist to support and encourage physical, mental, social, and emotional well-being” (Bunt, 1994, p. 8).

Active Music Therapy: The performance, improvisation, or composition of music using either musical instruments or one’s voice in order to express, explore, and work through conflicts (Bruscia, 1998; Choi, Lee, & Lim, 2008).

Passive Music Therapy: Listening to music (Montello & Coons, 1998).

Family Conflict: “Incompatibilities that can be expressed by people related through biological, legal, or equivalent ties” (Canary & Canary, 2013, p. 6).

Family Transitions: Changes in the family structure, such as by separation from biological parents or divorce (Langenkamp & Frisco, 2008).

Chapter 2: Methodology

I use music constantly. Music is every emotion.

– Johnny Depp (as cited in Edwards, 2008)

The central goal of this project was to develop a resource manual for clinicians, who are not trained music therapists, to use in order to help them apply music therapy techniques in their work with adolescents coping with family conflict or parental divorce. This chapter will focus on describing the methodology used in the development of the resource manual. The first phase included an extensive review of the existing literature and research studies to inform the content of the resource manual. The second phase involved obtaining information from registered music therapists about current applications of music therapy techniques in order to further identify material for inclusion in the manual. The next phase included the integration of data and the development of the manual. Lastly, a panel of non-music therapist clinicians (the target audience for the manual) critiqued the manual in order to evaluate the usefulness, efficacy, and relevance of its content. All participants received a \$25 gift card to one of three companies, depending on participant preference, as compensation for their participation. Companies included iTunes, Amazon, or Target, and were sent to participants directly from the company of their choice, via email, upon completion of their participation.

Manual Development

Review of the literature and existing resources. Sources of data that were considered during the review of literature to inform the content of the resource manual included databases such as PsycINFO, Academic Search Elite, PsycARTICLES, Research Library, Education Full Text (Wilson), ERIC, EBSCOHOST, ProQuest, books in prints, and internet resources.

Information from local and national organizations was also considered, including the American

Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT). The review of literature focused mostly on music therapy and its indications for adolescents coping with family conflict or parental divorce. More specifically, keyword searches included various combinations of the following terms: adolescents, music, music therapy, applications, techniques, family, conflict, divorce, transition, loss, grief, and coping.

The search process began with current information about the benefits of music, family conflict, and transition. Results of this search were included in the literature review section of the manual. Specifically, an overview of music therapy was provided in order to give comprehensive information about its history, healing functions, and applications. Then, descriptive information about adolescents' challenges and development within the family context was provided, with more detailed information provided regarding effects on adolescents struggling with high family conflict, loss, or parental divorce. Finally, the focus shifted to rationale and treatment recommendations for the use of music therapy techniques to be used with adolescents coping with such difficulties in order to better inform criteria for inclusion in the resource manual. Upon completion of the review of the literature and existing resources, this author recruited participants via an initial phone contact (see Appendix A).

Input from music therapists. Three music therapists who work with adolescents and families were selected at random using a random number generator through an on-line search of the American Music Therapy Association directory. The criteria for music therapists selected for this study indicated that they must work in psychiatric hospitals, rehabilitative facilities, hospitals, outpatient clinics, day treatment centers, community mental health centers, drug and alcohol programs, correctional facilities, halfway houses, schools, and/or in private practice. This

author called potential participants and provided the purpose of the study, eligibility criteria, and an overview of the procedures involved in the participation in the project (see Appendix A).

A music therapist was defined as an individual who has completed an approved college music curricula, gained internship experience, and is certified by the Certification Board of Music Therapists. Criteria for inclusion in the study consisted of the following: a) must currently use active and/or passive music therapy techniques regularly; b) must currently work with adolescents and/or families; c) must practice in the United States; and d) must have been certified with the CBMT for a minimum of 3 years.

Music Therapist Input Questionnaire/Interview

A brief telephone interview was developed by this author specifically for use in this project. Once a music therapist met the eligibility criteria as assessed by a 5-item questionnaire (see Appendix B) and agreed to participate in the project, an informed consent form was mailed to the participant with a pre-paid return envelope, or was sent via e-mail, depending on the participant's preference. The consent form (see Appendix C) described the nature and purpose of the study, this author's affiliation, potential risks and benefits of participating in the study, and privacy and confidentiality concerns. It also explained that participation is voluntary.

Upon receipt of the signed consent form either by postal mail or via e-mail as an attachment, a brief telephone call was scheduled during which this author reviewed the contents of the informed consent form and proceeded with the brief interview, including both demographic information and open-ended questions (see Appendix D). More specifically, the interview included questions about general background information of typical clients (i.e., age, gender, clinical diagnoses), types of music therapy techniques used, the effectiveness of such techniques, concerns about general psychotherapists using music in their work with adolescents

experiencing family conflict, and considerations for referrals. Sample items included: “Please list and describe the types of music therapy techniques you currently use;” “Are there ways of using music with adolescents that you would recommend for general psychotherapists?;” and, “What criteria should general psychotherapists use in determining the need for referral to a certified music therapist?”

Music therapists who preferred to complete the questionnaire in writing rather than via phone interview were either mailed the questionnaire with a pre-addressed postage-paid return envelope, or were sent the questionnaire via e-mail. No identifying information about clients was requested. Therapist names were not associated with a specific questionnaire or interview. Questionnaire responses and notes on therapist phone interviews will remain securely locked in a cabinet, separate from the consent forms, and maintained by this author. All information obtained from music therapists will be kept anonymous.

Recruitment strategies and procedures. The recruitment process included initial telephone calls to certified music therapists, located through the American Music Therapy Association. This author provided the music therapists with information related to this author’s affiliation, nature of the telephone call, and purpose of recruiting music therapists for brief telephone interviews. This author also provided an overview of the procedures involved in developing the manual and explained the desire to include input from current music therapists. This author conducted all telephone interviews and recorded responses on a questionnaire. Telephone interviews were not scheduled until an informed consent was received. This process continued until three certified music therapists were interviewed.

Integration of data and resource manual content. The content of the resource manual, *Using Music-Based Interventions with Adolescents Coping with Family Conflict or Parental*

Divorce: A Resource Manual (hereafter referred to as the “Music-Based Interventions for Adolescents (MBIA) Manual”) was informed by multiple sources. Some of the interventions suggested in the resource manual were selected following a comprehensive review of the literature. More specifically, the literature described music-based interventions and provided case studies that demonstrated their use. The MBIA was also informed by a questionnaire completed by music therapists who work with adolescents and/or families. Through the questionnaire, the music therapists identified both passive and active music-based interventions, and described how to implement them. Once the comprehensive search of the literature, as well as the music therapist questionnaires were completed, the data was reviewed by this author. This author’s own clinical experiences demonstrating the use of music-based interventions were then integrated via case studies. The information was synthesized and organized into categories to inform the specific content of the MBIA.

Evaluation of Resource Manual

The purpose of the evaluation phase of the project was to obtain feedback on the content and usefulness of the resource manual from three mental health providers (i.e., evaluators) who work with adolescents and are not certified music therapists, and who were recruited via phone calls (see Appendix E). Participating evaluators met the following criteria, outlined by the Evaluator Qualification Form (see Appendix F): a) be a licensed MFT, LCSW, or psychologist, b) have at least 5 years’ experience working with adolescents, c) have a general understanding of stressors associated with family conflict, transition, or divorce, d) currently practice in the United States, and e) be able to read and speak English.

Once an evaluator agreed to participate, he or she received several items, including: a cover letter detailing the nature and purpose of the study, as well as instructions for completion

(see Appendix G); an informed consent form detailing the nature and purpose of the study, the researcher's affiliation, potential risks and benefits of participating in the study, privacy and confidentiality concerns, and voluntary status of all participants (see Appendix H); the MBIA Manual (see Appendix I); an evaluation form (see Appendix J); and a postage-paid pre-addressed return envelope for the consent form, manual, and the evaluation. All materials were sent by postal mail, unless an evaluator requested electronic forms. In this case, pdf format documents were attached to an email and the evaluator was asked to scan the completed documents and send them back to this author electronically.

Once the evaluators received the MBIA Manual and other materials, they were asked to read all included materials and complete the evaluation form in order to assess the organization, design, content, and usefulness of the manual (see Appendix J). Specific questions were asked in a questionnaire format utilizing a combination of Likert scale and open-ended questions. Scale items were used to measure opinions, beliefs, and attitudes of the evaluators regarding the MBIA Manual. The items were presented as one of the following: inquiries allowing respondents a level of agreement after the question with five possible responses ranging from "not useful" to "very useful," or from "strongly disagree" to "strongly agree;" or open-ended questions allowing evaluators to write their own responses. Sample items included: "How useful do you find this manual for non-CBMT certified clinicians intending to integrate music into work with adolescents and families?;" "What did you find particularly useful about this manual as it pertains to non-certified clinicians using music therapy techniques in their work with adolescents struggling to cope with family conflict and/or parental divorce?;" and "What could have been added to the manual to make it more useful for utilizing music therapy techniques in your work with adolescents struggling to cope with family conflict and/or parental divorce?"

The evaluation form was available as a hard copy, and electronically if requested. The evaluators had the opportunity to write any additional comments, recommendations, or suggestions for this author. The data collected from the evaluation process was then reviewed. Strengths and limitations of the MBIA Manual are addressed in the discussion section of the final report.

Recruitment strategies and procedures. Evaluators in the United States were identified using the American Psychological Association (APA) “Find a Psychologist” search function. Terms for inclusion included “adolescents” and “family dysfunction,” as listed in the drop-down menus of the search function. Evaluators were randomly selected using a random number generator and counting down the list of therapists to that number. When three participants were not secured within two weeks, the search was expanded to include the member directory of Psychology Today, and the same search and selection guidelines were used. When all three participants were not secured within two months, the search was expanded to include eligible participants known by this author. An identified potential participant was initially contacted by telephone to explain the nature and purpose of the MBIA Manual and to inquire whether the individual would be willing to evaluate the MBIA Manual for its accuracy, relevance, and usefulness for its intended population. Individuals who agreed to participate were sent an informed consent form (see Appendix H), which detailed the nature and purpose of the study, the author’s affiliation, potential risks and benefits of participating in the study, and privacy and confidentiality concerns. The MBIA Manual and evaluation form were included, as well as a postage-paid pre-addressed return envelope for the consent and the evaluation. Evaluation materials were sent by postal mail unless an evaluator specifically requested electronic forms. In

this case, pdf format documents were attached to an email and the evaluator was asked to scan the completed documents and send them back to the researcher electronically.

Overview of Evaluators' Feedback

Three evaluators for the MBIA Manual were recruited between October 2014 and January 2015. The purpose of the evaluation was to assess the MBIA Manual in terms of usefulness, efficacy, and relevance of its content for the intended population. All evaluators met the eligibility criteria of being a licensed psychologist, LMFT, or LCSW, having a minimum of five years of experience working with adolescents, having a general understanding of stressors associated with family conflict, transition, or divorce, currently practicing in the United States, and being able to read and speak English. The evaluators included a 44-year old Caucasian female LMFT who has worked with adolescents for 10 years, a 49-year old Caucasian female LCSW who has worked with adolescents for 15 years, and a 53-year old Caucasian male LMFT who has worked with adolescents for 13 years. Evaluators were provided with an informed consent form (see Appendix H), the MBIA Manual (see Appendix I), and the Evaluation Form (see Appendix J). The informed consent form was reviewed, signed, and returned by all evaluators prior to their evaluation of the manual.

The evaluators completed the Evaluation Form and provided additional feedback on open-ended items. Following the evaluators' completion of the Evaluation Form, it was returned to this author for review and consideration. The evaluators' feedback on the Evaluation Form was reviewed. Limitations, areas for improvement, and strengths of the MBIA Manual were then identified and addressed in the discussion section of the final report.

Chapter 3: Results

Music can help reveal what a person may be going through by drawing out the emotions that are already within.

– Catherine David, music producer (personal communication, June 15, 2015)

This chapter will provide an overview of the development and content of the resource manual and a summary of the evaluation process. First, a brief overview of the process of collecting data via a review of past and current literature will be presented. Next, the structure and content of the resource manual (see Appendix I) will be discussed. Finally, feedback on the resource manual from three evaluators will be reviewed and examined.

Brief Overview of the Development of the Resource Manual

The initial phase of the study involved a comprehensive review of literature pertaining to music therapy techniques and their efficacy, family conflict and transition during adolescence, and the therapeutic use of music with adolescents. The purpose of this phase was to develop a better understanding of adolescent development and the therapeutic needs of adolescents struggling with family conflict, and to understand how the application of music-based interventions may be beneficial for this population. The second phase involved recruiting three currently practicing music therapists, who then completed a Music Therapist Input Questionnaire (see Appendix D). The purpose of the questionnaire was to identify specific music-based interventions for inclusion in the MBIA Manual. Information derived from the literature review and the Music Therapist Questionnaire was integrated with this author's own clinical experiences for the development of the MBIA Manual.

The MBIA Manual was created for clinicians who currently work with adolescents who are struggling with family conflict and/or parental divorce, and who are interested in

implementing or learning more about music-based interventions as a supplemental form of treatment. However, it should be noted that the MBIA Manual is not intended to replace music therapy, nor should it be used as the primary treatment model. Clinicians should also use the MBIA Manual to help them identify when a referral to a certified music therapist would be more appropriate, and should make such referrals as warranted.

The MBIA Manual is 38 pages in length. It begins with a brief review of the literature regarding music therapy, adolescent developmental issues and challenges, and family conflict, transition, and divorce. It also suggests why music-based interventions may be appropriate and effective for adolescents struggling with family conflict and/or divorce. Next, the MBIA Manual provides specific interventions and techniques that may be used with this population and brief case studies to help understand their application, followed by a discussion regarding when to use music-based interventions and how to select appropriate music. Finally, a list of relevant resources (i.e., music therapy organizations, websites, and books), as well as lists of suggested songs from a variety of musical genres, is provided.

Summary of the Results

Following the data collection phase of this project, seven interventions were identified by the music therapists and included in the MBIA Manual (Table 1), which was then reviewed by the evaluators. Overall, on a Likert-scale of one to five, one being “Not Useful” and five being “Very Useful”, the average of the evaluators’ responses to all items on the Evaluation Form regarding the usefulness of the Resource Manual (items one, two, four, and five) was 4.8. The average of the responses for Evaluators 1 and 3 was 5, while Evaluator 2’s average was 4.5.

Table 1

Overview of techniques for using music in interventions with adolescents

Technique	Brief Description
Music Journaling	The client writes down what music he or she is listening to over the course of several days to weeks. This provides insight into the client's musical preference(s), as well as to any potentially important themes or patterns in the client's life.
Music Listening	The client selects a song that has lyrical significance and the clinician and/or family listens to the lyrics in order to gain an understanding of the client's inner experience. Another variation includes selecting and listening to soothing and/or empowering songs for relaxation or motivation, respectively.
Lyric Analysis	Print and listen to song lyrics with clients. Discuss the general theme, the client's thoughts and feelings in response to the content, and how the lyrics relate to the client's life.
Songwriting	Clients write songs in order to express and/or communicate their thoughts and emotions. They may write their own original lyrics and melodies (original compositions), or re-write pre-existing songs (lyric substitution, piggyback songwriting).
Active Music Engagement	Clients physically interact with music via playing instruments, dancing, or using movement with live or recorded music.
Therapeutic Singing	Clients sing pre-existing songs, or songs they have written. They may sing alone as an adaptive alternative to expressing emotions, or with others in order to practice cooperative work and play.
Music Assisted Relaxation	Traditional relaxation techniques, such as guided imagery or progressive muscle relaxation, are paired with soothing, calming music in order to enhance the relaxation experience for clients.

Figure 1 presents the ratings for each of the evaluators on the four Likert-scale items. In general, the three evaluators were in agreement in their assessment of the MBIA Manual with item number 1 (“How useful do you find this manual for non-certified clinicians intending to integrate music into work with adolescents and families?”) and number 4 (“How useful do you find this manual in educating non-certified clinicians about current music therapy techniques?”). Evaluator 1 and 3, both LMFT’s, rated items 2 and 5 (“How useful do you find this manual in

working with adolescents struggling to cope with family conflict and/or parental divorce?;” “How useful do you find this manual in addressing the application of music therapy techniques to family conflict and/or divorce?”) 1 point higher than Evaluator 2, an LCSW. The average of the evaluators’ responses to item one was 5. For item two, the average of the evaluators’ responses was 4.7. The average of the evaluators’ responses for items four and five were again 5 and 4.7, respectively.

Items twelve, thirteen, and fourteen were also rated by the evaluators on a Likert-scale ranging from one to five, with one being “Strongly Disagree” and five being “Strongly Agree.” The average rating for the items was 5, as each of these items (“This manual provides clinicians with an adjunctive resource for working with adolescents struggling to cope with family conflict and/or parental divorce;” “I would recommend this manual to clinicians seeking to integrate music into their work with adolescent clients experiencing family conflict;” “This manual is user-friendly and easy to understand”) were rated as a 5 by all three evaluators.

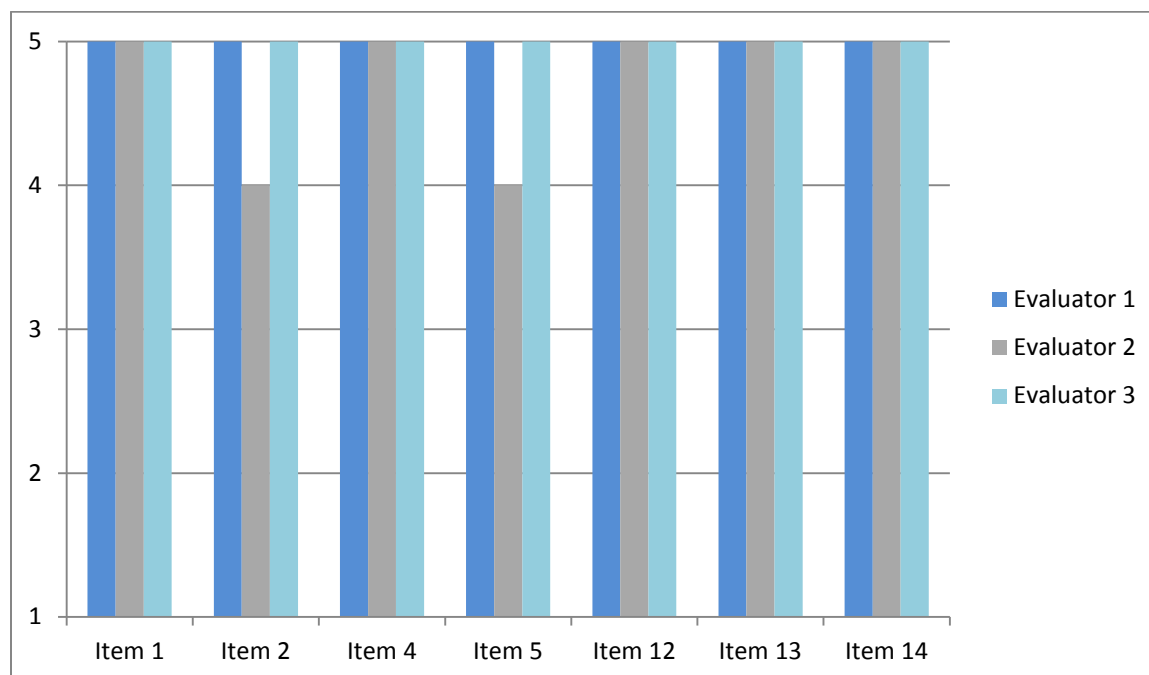


Figure 1. Evaluators’ responses to seven Likert-scale items

Items three, and six through eleven, consisted of open-ended questions in which evaluators were asked to provide more elaborate feedback about the MBIA Manual. Items three and seven, specifically, asked about usefulness and strengths of the MBIA Manual. Some of the strengths identified by the evaluators included the manual’s specific suggested interventions, its user-friendliness, and its practicality. Suggestions to improve the manual included providing more case study examples and exploring particular topics (including but not limited to: separation anxiety, isolation, externalizing/oppositional behaviors) in more depth.

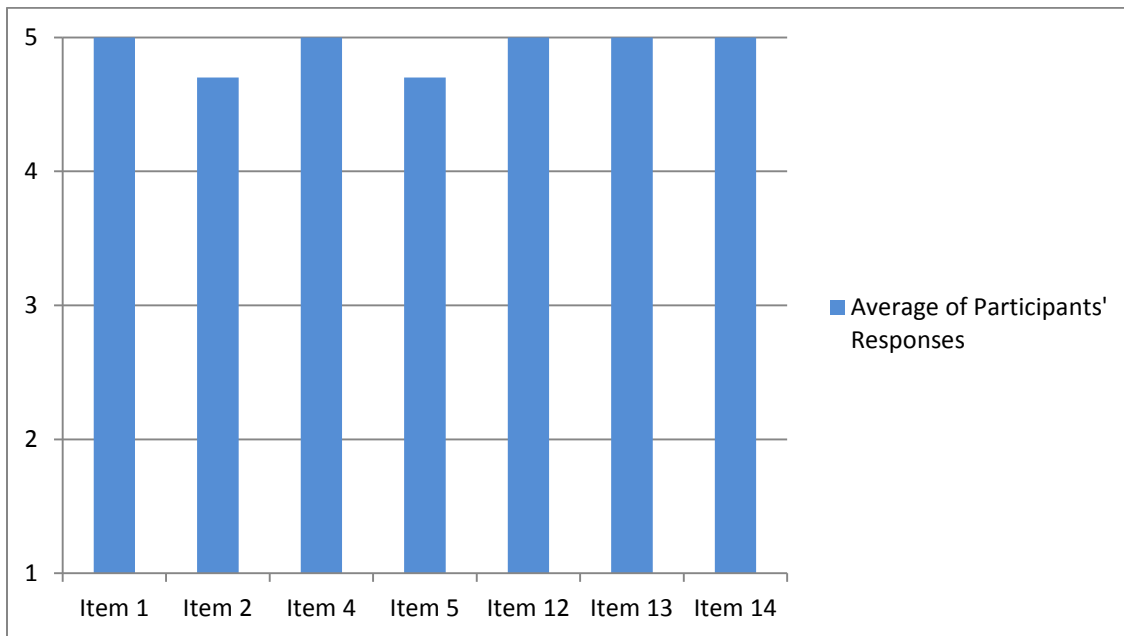


Figure 2. Average of evaluators’ responses to seven Likert-scale items

Written feedback regarding the strengths of the MBIA Manual provided by Evaluator 1 included “powerful exercises” that could be used with adolescents and their families, as well as the list of suggested songs. Additionally, Evaluator 1 described the MBIA Manual’s format as “very easy to comprehend.” Evaluator 2 stated “specific interventions providing an overview” as the MBIA Manual’s strength. Evaluator 3 described the MBIA Manual as “user-friendly,

practical, easy to grasp and understand,” “insightful,” and “worldly.” Evaluator 3 also identified the MBIA Manual’s ability “to cut across all ethnicities, ages, sex” as a particular strength.

Feedback regarding the weaknesses of the MBIA Manual was provided by all evaluators in the form of suggested revisions. Evaluator 1 expressed a preference for the suggested songs list in the MBIA Manual to preclude the references section. Evaluator 2 suggested exploring specific topics in more depth and providing more empirical support. Specifically, the evaluator identified examining “typical responses to divorce and build[ing] a stronger bridge to those diagnostic responses and the interventions using research,” examining grief, and providing strategies to improve co-parenting. Evaluator 3 suggested illustrating more case studies and “examples of its efficacy, in greater detail.”

Although several open-ended questions were included in the Evaluation Form, Evaluator 2 chose to leave most of her responses to each individual question brief or blank, and instead elected to provide the majority of her written feedback on a separate page. Tables 2 through 8 present the evaluators’ responses to the open-ended questions, and Table 7 specifically contains the bulk of the second evaluator’s responses.

Table 2

Responses to first open-ended question (Item 3)

What did you find particularly useful about this manual as it pertains to non-certified clinicians using music therapy techniques in their work with adolescents struggling to cope with family conflict and/or parental divorce?	
Evaluator	Response
1	It provides powerful exercises that can be utilized and worked through with clients and families. The resource of suggested songs is very helpful.
2	Specific interventions providing an overview.
3	The manual is user-friendly, practical, easy to grasp and understand.

Table 3

Responses to second open-ended question (Item 6)

What aspects of this manual did you find not particularly relevant for its intended purposes?	
Evaluator	Response
1	I found every aspect relevant.
2	(Blank)
3	I <u>did not find</u> any irrelevant aspects of this manual.

Table 4

Responses to third open-ended question (Item 7)

What do you consider to be the strengths of the manual?	
Evaluator	Response
1	The manual is laid out in a very easy to comprehend format. It provides information from the what, when, how and why framework which allowed the flow to be well received.
2	Specific interventions
3	Insightful, worldly – It cuts across all ethnicities, ages, sex – Music is a universal language – Human contact the same – Good combo –

Table 5

Responses to fourth open-ended question (Item 8)

What do you consider to be the weaknesses of the manual?	
Evaluator	Response
1	My preference would be for the song suggestions to preclude the reference section – it turned out to be a nice surprise however may have been overlooked.
2	See comments inside
3	I would have liked the manual to illustrate more case studies – Examples of its efficacy in greater detail.

Table 6

Responses to fifth open-ended question (Item 9)

What could have been added to the manual to make it more useful for utilizing music therapy techniques in your work with adolescents struggling to cope with family conflict and/or parental divorce?	
Evaluator	Response
1	I believe all data was included.
2	<i>(Blank)</i>
3	More case studies.

Table 7

Responses to sixth open-ended question (Item 10)

Are there any parts of the manual that you would omit, change, or revise? Please explain.	
Evaluator	Response
1	Suggest song suggestions before the references.
2	<i>(Blank)</i>
3	N/A

Table 8

Responses to seventh open-ended question (Item 11)

Additional comments and/or suggestions:	
Evaluator	Response
1	Beautifully done. I am blessed to have had this opportunity.
2	<p>Lori <u>I love it</u>. To make it better/more relevant examine typical responses to divorce and build a stronger bridge to those diagnostic responses and the interventions using research. IE ___% of kids experience depressive sx's as a result of parental divorce. Which of the interventions provided is best suited to address depression based upon the research? Do the same for</p> <ul style="list-style-type: none"> - Separation anxiety - Isolation - General anxiety sx's - Externalizing/oppositional bx's <p>Keep in mind that it becomes very hard to work with families once the decision to divorce has been made. Perhaps examine how the strategies can be used to improve co-parenting once the decision has been made? Or to focus only on the adolescent + participating parent? Examine messages + feelings that come up for the teens specifically. Also examine research related to grief + music therapy. Ultimately divorce is a grieving experience. Making this connection will further strengthen your arguments. You have done a great amount of work here and created a very useful manual.</p> <p>(Re: Appendix B, Suggested Motivational Songs) If you chose, you could examine some positive psychology concepts + use them to tie in with this piece.</p>
3	Excellent read – Practical manual

Chapter 4: Discussion

People take whatever message they want from music. Whether positive or negative, the message people hear is what they want to hear. If they want it to be healing, it will be.

– Benji Madden, Good Charlotte (personal communication, November 30, 2011)

This dissertation project involved the creation of a resource manual designed to help clinicians who are not trained music therapists learn how to implement music-based interventions in their work with adolescents coping with family conflict or parental divorce. The development of the MBIA Manual was informed by a review of the literature about music therapy, questionnaires completed by three certified music therapists, and this author's own clinical experiences. The manual was then evaluated by three clinicians (i.e., not credentialed as music therapists) who met all eligibility criteria. Feedback for the manual was collected via an Evaluation Form regarding strengths, weaknesses, and suggestions for improvement.

Identified Strengths of The MBIA Manual

Three evaluators reviewed the MBIA Manual and provided responses to items on the Evaluation Form identifying its strengths and weaknesses. One identified strength was the specific interventions and exercises provided. Other strengths included the MBIA Manual's user-friendliness, ease of comprehensibility, practicality, and relevance. Additionally, based on their Likert-scale responses, all evaluators were in agreement that the manual is useful and educational for clinicians intending to integrate music into their work with adolescents and families, and that it provides clinicians with an adjunctive resource for working with adolescents struggling to cope with family conflict and/or parental divorce.

The MBIA Manual may also be useful because it addresses family issues and the context within which the adolescent is living. Furthermore, integrating music-based interventions may be

particularly attractive for diverse adolescents, not merely because of age, but because their culture may discourage traditional talk therapy. Music may provide more culturally congruent coping methods for such adolescents.

Identified Weaknesses of the MBIA Manual

Three evaluators provided a variety of suggestions that may help strengthen the MBIA Manual. Two of the three evaluators suggested providing more information and/or empirical research. Specifically, one evaluator expressed a preference for the inclusion of additional case studies, while another evaluator recommended integrating research related to positive psychology, as well as exploring various topics in more depth. Such topics included, but were not limited to separation anxiety, externalizing behaviors, and grief. The inclusion of research related to music therapy and bereavement may particularly be useful, as divorce often represents a significant loss for adolescents and symbolic and nonverbal means of emotional expression may ease an adolescent's difficulties vocalizing his or her emotions (Hilliard, 2001).

Limitations and Recommendations for Future Research

Although this dissertation project aimed to provide comprehensive evidence in support of the use of music-based interventions with adolescents struggling with family conflict and/or parental divorce, the research aimed at this target population is limited in comparison to other, more traditional treatment approaches. The development of this manual was largely informed by three music therapists, and although they met all qualification criteria, the manual's content and efficacy may have benefitted from a larger number of participants. Future studies should aim toward a larger collection of data. Similarly, the number of evaluators was limited to three participants, which consisted of two LMFTs and one LCSW. Future studies should not only include a larger sample size, but should also seek to validate the usefulness and efficacy of

music-based interventions from a variety of mental health professionals, including psychologists. Finally, although participants included both males and females, it should be noted that all participants were Caucasian. Future studies should aim to recruit a more diverse sample in order to increase the MBIA Manual's applicability across cultures.

Aside from the weaknesses of the MBIA Manual specifically identified by the evaluators, there are additional limitations which may impact the practicality and applicability of interventions. First, not all adolescents struggling with family conflict and/or parental divorce would benefit from the use of music-based interventions. Although the literature suggests that adolescents typically identify music as a primary activity (Larson, 1995), those who are hard of hearing or otherwise have auditory deficits may not receive the maximum benefits of music-based interventions. Additionally, the MBIA Manual was intended for use with adolescents and includes some interventions that may be used with their families. However, utility may be limited if the family includes members who are too young to fully engage in more active techniques, or if certain members of the family refuse to cooperate with treatment. Furthermore, if the family members have vastly differing musical preferences, negative responses may be evoked when using music that does not fall within an individual's preference of musical genre.

Another limitation of the study is that it does not take into account that clinicians may not have access to the tools and resources necessary to engage in some of the listed music-based interventions. It may be beneficial for future research to include suggestions regarding the modification of specific strategies, such as those that involve instruments, as needed. For instance, suggestions may include using a variety of office supplies (e.g., books, pens, tabletops) as makeshift "drums", when instruments are not available. Finally, the study does not include the administration of standardized measures to assess the efficacy of these interventions. Including

outcome measures such as the Beck Depression Inventory (BDI)-II or the Youth Self-Report Scale (YSR) may help provide evidence for the effectiveness of engaging in music-based interventions.

Evaluation results suggest that the following modifications to the next version of the MBIA Manual would strengthen its usefulness:

- 1) A larger and culturally diverse sample size of music therapist participants to help inform the manual.
- 2) A larger, more diverse sample size of mental health professionals to evaluate the usefulness and efficacy of the manual across cultures.
- 3) Suggested modifications to specific interventions for clinicians who lack access to the tools and/or resources necessary for implementation.
- 4) The inclusion of standardized measures, such as the BDI-II or the YSR, to assess whether utilizing music-based interventions may lead to improvements in an adolescent's mood and/or functioning.

Future steps for the MBIA Manual include making modifications suggested by the evaluators in this study, as well as any additional modifications based on this author's reflections and feedback from the dissertation committee. A revised MBIA Manual could be strengthened in terms of its content, efficacy, and applicability. The MBIA Manual could then be used in a pilot study with adolescents and/or their families. Additional feedback may then be collected from the clinicians, as well as from the clients. Such a pilot study could then identify additional strengths, weaknesses, and areas for improvement.

Conclusion and Implications of this Study

The MBIA Manual was developed as an adjunctive treatment guide for mental health clinicians working with adolescents who are struggling to cope with family conflict and/or parental divorce. The MBIA Manual was developed via a comprehensive review of the existing literature about music therapy, adolescents, and family conflict, as well as feedback from three music therapists and this author's own clinical experiences. The MBIA Manual was evaluated by three mental health professionals who currently work with adolescents and who have received no training in music therapy. It is hoped that this study will contribute to addressing the relative neglect of music therapy techniques by mainstream psychology. Finally, given the significance of music in the lives of adolescents, it is also hoped that development of the MBIA Manual will increase awareness and knowledge regarding the use of music-based interventions with adolescents experiencing family conflict or divorce.

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APPENDIX A:

Telephone Script for Recruitment of Music Therapists

Telephone Script for Music Therapists

Hello, may I please speak to (name of potential music therapist)?

If unavailable, leave name, number, and end call.

If available, continue.

Hello, my name is Lori Meono, and I am a psychology doctoral student at Pepperdine University Graduate School. I received your contact information from the American Music Therapy Association, as a music therapist who currently works with adolescents or families. I am contacting you to see if you would be willing to help inform a resource manual I am developing for therapists working with adolescents struggling to cope with family conflict or parental divorce. This study is part of my dissertation research. Do you have a moment for me to describe the nature and purpose of my study?

If not, thank individual for their time and end call.

If so, continue.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop a resource manual for use by therapists in their work with adolescents struggling to cope with family conflict or parental divorce. At this particular stage in the project, I am gathering information about specific music therapy techniques that can be used with this specific population. Should you choose to participate, I will send you a consent form for your participation. Once the consent form is received, we will arrange a brief phone interview. During the interview, I will ask you for demographic information about your typical clients, such as their age, gender, ethnicity, and diagnoses. I will also ask a series of open-ended questions about the specific music therapy techniques you use during your sessions, as well as your own evaluation of their effectiveness. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. Is this something that you would be willing to do?

If not, thank individual for their time and end call.

If so, continue.

Do I have your permission to ask a few background questions, followed by some questions related to your experience with using music therapy techniques with adolescents? Please note that you may refuse to answer any question at any time during the interview.

If not, thank individual for their time and end the call.

If so, continue on and refer to the Music Therapist Qualification Form (Appendix B).

After reviewing the Music Therapist Qualification Form (Appendix B):

If music therapist does not meet the requirements: Thank you for your willingness to participate. However, you do not meet the qualifications to participate in this study.

If music therapist does meet the requirements: May I please have your mailing and email addresses to send you the necessary materials? Within a week, you will receive two consent forms, one for you to keep and the other to be returned.

Thank you very much for your time. If you should have any questions or concerns regarding the study, please feel free to contact me or Dr. Shelly Harrell. Thank you again for volunteering to participate. I appreciate your time and assistance.

End call.

APPENDIX B:

Music Therapist Qualification Form

Music Therapist Qualification Form

Participant Number _____

Have you obtained certification from the Certification Board of Music Therapists?

Yes No

Do you currently practice in the United States?

Yes No

Do you currently work with adolescents?

Yes No

If so, for how many years? _____

How familiar are you with the stressors associated with family conflict, transition, or divorce?

Not at all familiar Somewhat familiar Very Familiar

Can you provide some examples?

APPENDIX C:

Consent Form for Music Therapist Participation

Music Therapist Consent Form

Thank you for volunteering to participate in a research study conducted by Lori Meono, a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D. entitled “Using Music-Based Interventions with Adolescents Coping with Family Conflict or Parental Divorce: A Resource Manual.”

You have been selected to participate in this study based on your commitment to the advancement of music therapy. Upon signing and returning this form to the researcher, you understand that you are consenting to be contacted via telephone by the researcher for a brief 15-minute interview. You also understand that your participation in this study is entirely voluntary, and you may withdraw your participation at any time.

By signing this form, you also understand that all information obtained in this study will be kept confidential. The consent forms will be stored in a file separate from all other study materials. All research materials will remain in a locked file cabinet for five years, at which time the data will be destroyed. Your responses will be kept anonymous and will be identified only by a participant number assigned to you, and not by your name. You understand that any comments submitted may be published or presented to a professional audience and that no personal identifying information will be released.

You understand that if you have any questions regarding the study procedures, you may contact Lori Meono, M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, to obtain answers to any of your questions. Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms.

Name (printed)

Signature

Date

APPENDIX D:

Music Therapist Input Questionnaire

Music Therapist Input Questionnaire

Please provide demographic information for your typical clients:

Age range (check one):

- Infants through Elementary School Age (0-10)
- Adolescents (Middle School through High School, 11-17)
- Adults (age 18-64)
- Older Adults (65+)

Gender (check one):

- Only Males/Primarily Males
- Males and Females
- Only Females/Primarily Females

Please provide the races and/or ethnicities of clients you typically work with (may be more than one):

Please list any clinical diagnoses you typically work with:

Do you typically use passive music therapy techniques, active music therapy techniques, or both (check one)?

- Passive Active Both

Please list and describe the types of music therapy techniques you currently use:

Please speak to the effectiveness of the techniques listed above. More specifically, how effective do you find each technique to be? Is there one that you find to be more effective than others?

Please share anything else you think is important to understand about how music therapy can be used to help adolescents cope with family conflict or parental divorce.

Thank you!

APPENDIX E:

Telephone Script for Evaluators

Telephone Script for Evaluators

Hello, may I please speak to (name of potential evaluator)?

If unavailable, leave name, number, and end call.

If available, continue.

Hello, my name is Lori Meono, and I am a psychology doctoral student at Pepperdine University Graduate School. I am currently recruiting licensed therapists who identify themselves as specializing in working with adolescents. I am contacting you to see if you would be willing to help inform a resource manual I am developing for therapists working with adolescents struggling to cope with family conflict or parental divorce. This study is part of my dissertation research. Do you have a moment for me to describe the nature and purpose of my study?

If not, thank individual for their time and end call.

If so, continue.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop a resource manual for use by therapists in their work with adolescents struggling to cope with family conflict or parental divorce. At this particular stage in the project, I have completed the resource manual and am looking for licensed therapists willing to read and evaluate the manual. Should you choose to participate, I will send you a consent form for your participation. Once the consent form is received, I will mail you a packet with the manual itself, as well as a brief evaluation form for you to fill out and return to me in a pre-addressed postage-paid envelope. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. Is this something that you would be willing to do?

If not, thank individual for their time and end call.

If so, continue.

Do I have your permission to ask a few background questions about yourself and your work? Please note that you may refuse to answer any question at any time during the interview.

If not, thank individual for their time and end the call.

If so, continue on and refer to the Evaluator Qualification Form (Appendix H).

After reviewing the Evaluator Qualification Form (Appendix H):

If evaluator does not meet the requirements: Thank you for your willingness to participate. However, you do not meet the qualifications to participate in this study.

If evaluator does meet the requirements: May I please have your mailing and email addresses to send you the necessary materials? Within a week, you will receive two consent forms, one for you to keep and the other to be returned. Once you return the consent form, I will send you the study packet for your evaluation.

Thank you very much for your time. If you should have any questions or concerns regarding the study, please feel free to contact the research investigator or Dr. Shelly Harrell. Thank you again for volunteering to participate. I appreciate your time and assistance.

End call.

APPENDIX F:

Qualification Form for Evaluators

Qualification Form for Evaluators

Participant Number _____

Are you currently licensed by the Board of Psychology or the Board of Behavioral Sciences?

Yes No

If so, by which Board? _____

Do you speak and read English fluently?

Yes No

Do you currently practice in the Los Angeles area?

Yes No

Do you currently work with adolescents?

Yes No

If so, for how many years? _____

How familiar are you with the stressors associated with family conflict, transition, or divorce?

Not at all familiar Somewhat familiar Very Familiar

Can you provide some examples?

APPENDIX G:

Evaluation Packet Cover Letter

Dear (Name of Evaluator),

Thank you for volunteering to serve as an evaluator in my dissertation research study entitled “Using Music-Based Interventions with Adolescents Coping with Family Conflict or Parental Divorce: A Resource Manual.” Enclosed is a manual geared toward clinicians who intend to use music in their work with adolescents, two informed consent forms (one is yours to keep), and a manual evaluation form. The evaluation form is provided to facilitate your process in evaluating the manual. If it is easier for you to answer questions by placing comments throughout the document, please feel free to do so. It is recommended that the evaluation process be completed at a time that is most convenient to you, taking breaks as needed.

Please remember to review and complete the consent form. Once you have completed your evaluation of the manual, please return the signed consent form, the manual, and the completed manual evaluation form in the postage-paid, pre-addressed envelope provided in this packet.

Although your input is greatly appreciated, please remember that you are under no obligation to complete the study at any time. Should you wish to discontinue participation in this study for any reason, please return all materials in the enclosed postage-paid, pre-addressed envelope. Thank you very much for your time and contribution to my research project.

Respectfully,

Lori Meono, M.A.
c/o Pepperdine University
Graduate School of Education and Psychology, Psy.D. Program
6100 Center Drive
Los Angeles, CA 90045

APPENDIX H:

Evaluator Informed Consent Form

Evaluator Consent Form

I authorize Lori Meono, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include me in the research project entitled “Using Music-Based Interventions with Adolescents Coping with Family Conflict or Parental Divorce: A Resource Manual.” I understand that my participation in this study is strictly voluntary.

I have been asked to participate in this study that will include the development of a resource manual for clinicians using music therapy techniques in their work with adolescents struggling to cope with family conflict or divorce. I have been asked to volunteer to participate in this study based on my expertise in providing therapy for adolescents and/or families. My participation in this study will consist of approximately 1 ½ hours of my time, in which I will review a manual for clinicians, developed by Lori Meono, M.A., followed by the completion of an evaluation form related to the usefulness, accuracy, and effectiveness of the manual.

I understand that all information obtained in this study will be kept confidential. The Informed Consent Forms will be stored in a file separate from all other study materials. All research materials will remain in a locked file cabinet for five years, at which time the data will be destroyed. I understand that any comments submitted may be published or presented to a professional audience and that no personal identifying information will be released.

I understand that possible risks for participating in the study are minimal but may include mild levels of boredom or fatigue in response to reading the manual and completing the series of rating and open-ended questions on the evaluation form. In consideration of such factors, I understand that I have the option of writing the answers to questions listed on the evaluation form directly in the margins of the manual itself. I have also been advised to read the manual and complete the evaluation at a time that is most convenient to me, taking breaks as necessary.

In addition, I understand that I have the right not to answer any particular question listed on the evaluation form and may withdraw from the study at any time.

I understand that if I have any questions regarding the study procedures, I can contact Lori Meono, M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045.

Signature

Date

Name (printed)

APPENDIX I:
MBIA Resource Manual

USING MUSIC-BASED INTERVENTIONS WITH ADOLESCENTS
COPING WITH FAMILY CONFLICT OR PARENTAL DIVORCE:
A RESOURCE MANUAL

Developed by: Lori Meono, M.A.

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Introduction

“Music gives a soul to the universe, wings to the mind, flight to the imagination, and life to everything.” - Plato

Music has long been a significant presence in the lives of human beings. Benefits derived from listening to or performing music include: positive emotional experience, relief of tension, reduction of feelings of loneliness and worries, identification and validation of life experiences, social acceptance and belonging, and feeling understood and comforted (Bruscia, 1998; Carmichael & Atchinson, 1997; Mark, 1988; Miranda & Claes, 2009; North, Hargreaves, & O’Neill, 2000; Saarikallio & Erkkila, 2007). Studies have found that music can have positive physiological and healing effects, and its positive influence on physical and psychological health can be observed across a variety of cultures (Aluede, 2006; Dufrene & Coleman, 1994; Nelson & Weathers, 1998; Stuckey & Nobel, 2010). Access to diverse musical expressions also has become more easily available and music’s popularity continues to grow. For example, revenues from music streaming services exceeded \$1 billion for the first time in 2012, and streaming services saw a 39% increase from 2012 to 2013 (Recording Industry Association of America, 2014).

Adolescents typically identify music listening as a primary activity, while adults rarely identify it as a primary activity (Larson, 1995; Larson & Richards, 1994). Teens are among the most active consumers of music, and research suggests that music plays an important role during the developmental phase of adolescence (McFerran, 2010; North, Hargreaves & O’Neill 2000). For instance, music allows adolescents to engage in a process of self-exploration and to create a sense of independence and separation between themselves and their parents (Larson, 1995). It

can also provide a sense of stability that may serve as a substitute for the lost sense of preadolescent stability previously provided by parents (Larson, 1995).

The family context also plays a significant role in adolescent development (Larson, 1995). Although adolescents spend less time with their families than their preadolescent counterparts, research suggests that adolescents experience greater emotional variability than preadolescents and that spending time with the family is a mediating factor for such emotionality (Larson, 1995; Larson, Csikszentmihalyi, & Graef, 1980; Larson & Richards, 1991).

Furthermore, family transitions such as divorce have become increasingly common experiences for children and adolescents, with the number of single-parent households increasing worldwide (Amato, 2000; DeLucia-Waack & Gellman, 2007; Huure, Junkkari, & Aro, 2006). Family transitions may have a significant effect on an adolescent's emotional well-being, and these effects can last well into adulthood (Amato, 2000; Huure et al., 2006; Roustit, Chaix, & Chauvin, 2007). For example, studies have found that women who experienced parental divorce during adolescence also experienced higher rates of depression and minor psychiatric disturbances, as well as lower satisfaction with their social network, than women from non-divorced families (Huure et al., 2006). Adults whose parents divorced during their adolescence also tend to have lower education levels, and higher rates of unemployment, divorce or separation, hazardous alcohol consumption, smoking, interpersonal problems, and negative life events (Amato, 2000; Huure et al., 2006).

Music therapy as a clinical intervention has a rather recent history (Bruscia, 1998; Bunt, 1994; Stuckey & Nobel, 2010). Despite its novelty in the field of psychology, studies indicate that individuals who have received music therapy as a form of treatment show marked improvements in several areas of their lives (Bruscia, 1998; Gold, Voracek & Wigram, 2004;

Keith, Russel, & Weaver, 2009). Research further suggests that music therapy techniques can be applied to children and adolescents struggling with various psychological difficulties, including family conflict, divorce, and loss (DeLucia-Waack & Gellman, 2007; Hilliard, 2001; McIntyre, 2009; Montello & Coons, 1998).

Despite the demonstrable benefits achieved through the application of musical interventions, the therapeutic utilization of music appears to be largely neglected by professional psychology. The limited studies that do exist regarding adolescents experiencing family conflict, parental divorce, or loss have found several benefits in engaging in music therapy, whether individually, in groups, or with the family (Carmichael & Atchinson, 1997; McIntyre, 2009; Nelson & Weathers, 1998). However, few resources exist to assist psychotherapists in the application of music-based interventions (McFerran, 2010). Thus, this manual is intended to provide clinicians with suggestions for integrating music into their work with adolescents who are struggling with family conflict or parental divorce.

Section 1: Music Therapy

*“Music produces a kind of pleasure
which human nature cannot do without.”
- Confucius*

Overview

One of the greatest strengths of music therapy is that it can be effectively applied to diverse populations, and across various settings (AMTA, 1998; Bruscia, 1998). Children, adolescents, adults, and the elderly can all benefit from music therapy (Bruscia, 1998). Music has consistently been found to be effective for mood enhancement and improving family relationships (Arnett, 1995; Bakagiannis & Tarrant, 2006; Choi et al., 2008; Gantz, Gartenberg, Pearson, & Shiller, 1978).

Another benefit of music therapy is that it can be used with clients who have difficulties with verbal expression. Verbal communication is only one way in which individuals express themselves, and some individuals lack the verbal, intellectual, or affective abilities to communicate using their words. Studies suggest that children often communicate symbolically through the use of singing, song writing, or playing instruments (Lefevre, 2004). Therapists may facilitate and encourage this type of symbolic communication in order to allow children and adolescents to engage in a process of self-exploration, expression, and growth. Using musical instruments also provides for the development of social skills, such as using cooperative and creative play symbolically to interact with the therapist (Lefevre, 2004; Moreno, 1985).

History

The use of music as a healing practice can be traced back thousands of years. Ancient African cultures often relied on herbalists, medicine men, and faith healers, all of which used music and natural remedies such as plants, herbs, and animal bones to treat both physical and psychological ailments (Aluede, 2006). In the Western world, the ancient Greeks also valued the

healing powers of music, and Aristotle wrote about the importance of music in emotional release (Munro & Mount, 1978). Shamans in ancient Aboriginal cultures often incorporated art into their healing practices, and music continues to be widely used as a healing mechanism in Native American cultures (Dufrene & Coleman, 1994).

In the 20th century, the development of music therapy as a healthcare profession in the United States began to mobilize after World War II (Bunt, 1994). Musicians began playing for injured and traumatized veterans in hospitals around the country, who then began to exhibit positive physical and emotional changes in response to the musicians (AMTA, 1998). The world's first music therapy degree program was established shortly afterward in 1944 at Michigan State University (Bunt, 1994).

Around the same time that the demand for musicians grew for war veterans, music also began to gain recognition in its effectiveness with children. Music was identified as a valuable technique that could be used in conjunction with traditional play therapies (Bender & Woltmann, 1941). Play is often described as a natural medium of expression for children, similar to the way adults use spoken language to communicate. It was believed that children should have the ability to use musical instruments in order to help them play their feelings, much like they would use toys to play their feelings in traditional play therapy (Moreno, 1985).

Healing Functions and Applications

Indeed, music has long had an appeal as a universal form of language (Carmichael & Atchinson, 1997). Music therapy has been described as an effective form of treatment for clients who have difficulties with self-awareness and/or self-expression (McClary, 2007). It can provide clients with a safe environment to express what they had previously been unable to express. By creating music, clients are first able to symbolically represent their symptoms, and then use the

music to alleviate those symptoms. Clients gain new insights about their ailments and are then able to incorporate that knowledge into a new self-awareness through this process. For example, when adolescent clients can become aware of the different parts of their selves and their psyche, they may then be able to integrate those parts into a whole, and thus, individuate (McClary, 2007).

The techniques used by music therapists can be passive or active. Passive music therapy, which involves listening to music, is frequently used as a relaxation technique. As the client rests, the therapist plays soothing music. The client is then instructed to imagine peaceful images to induce relaxation (AMTA, 1998). In active music therapy, the client and/or therapist create music using either musical instruments or his/her voice. The client may also write songs and discuss songs with the therapist or with a music therapy group (Choi, Lee, & Lim, 2008). Research suggests that active music therapy is particularly effective for improving self-esteem, peer relationships, and group cohesiveness (Montello & Coons, 1998). The therapist must take caution to tailor the approach of the session for each individual client.

Section 2: Applications to Adolescence

*“Adolescence is such a confusing time.
During this time when nothing else makes sense, music is everything.”
- Adrian Young, No Doubt*

Developmental Issues and Challenges

Adolescence is a time of growth, identity development, and increasing separation from parents (Larson, 1995) that can often include the experience of internal conflict (McFerran, 2010; Morgan & Roberts, 2010). Research suggests that adolescents often have a tendency to minimize their concerns, and that they find value in feeling connected to their peers (Lew, 2002). Music is incredibly valuable during this stage because it assists adolescents in the identity development process (North, Hargreaves & O’Neill, 2000). Music can provide adolescents with a sense of catharsis and can help them feel more connected to the outside world (Mark, 1998). More specifically, listening to music allows adolescents to infiltrate social groups based on musical subcultures, thereby creating a sense of belonging during this phase of transition (Bakagiannis & Tarrant, 2006; Miranda & Claes, 2009). Music therapy can also enhance the adolescent’s expression of feelings, positive associations, and socialization (Gladding, 1999; McFerran, Roberts, & O’Grady, 2010).

Adolescents and Depression

Music is a behavior that helps regulate mood (Saarikallio & Erkkila, 2007), and studies suggest that music therapy may be effective in treating adolescent depression (Field et al., 1998; Hendricks & Bradley, 2005). Listening to music is associated with certain physiological responses, such as a decrease in stress hormones (i.e., cortisol) and a shift toward left frontal EEG activation in the brain, which is associated with positive affect (Field et al., 1998; Saarikallio & Erkkila, 2007). Saarikallio and Erkkila (2007) specifically studied adolescent use

of music in mood regulation. They suggested that all types of musical engagement, including listening to music and songwriting, are used to reach mood-related goals and that adolescents tend to choose different music for different types of activities. More specifically, when attempting to regulate their moods, adolescents tend to choose what they believe to be mood-congruent music and to engross themselves in the feelings conveyed by the music. Doing so can provide them with a greater sense of understanding of their own emotions (Saarikallio & Erkkila, 2007), as well as the sense that someone else understands what they are feeling.

Adolescent Development in the Family Context

Family structure and family context are very important in adolescent development. Studies suggest that adolescents from single-parent homes tend to have higher rates of problem behaviors (Roustit et al., 2007; Huurre et al., 2006). Recent family disruptions also tend to create proximate stress and anxiety within adolescents (Hoffman, 2006). However, other studies have found that it is not necessarily the transition or disruption itself that can affect emotional well-being, but rather the context of the family during the transitions that affects adolescent emotional distress (Langenkamp & Frisco, 2008). Furthermore, certain specific contextual factors, such as increased parental supervision and close bonds between parent and child can mediate as protective factors against emotional distress in times of family conflict or family disruption (Cookston, 1999; Langenkamp & Frisco, 2008).

Adolescents and Family Conflict, Divorce, and Transitions

Conflict within the family unit can inhibit an adolescent's ability to develop appropriate coping skills, and changes in family structure are associated with an increase in poor psychosocial adjustment in adolescents (Michael, Torres, & Seemann, 2007; Roustit et al., 2007). Studies suggest that parents' divorce in adolescence can be very harmful, as opposed to

divorces occurring at earlier stages (Roustit et al., 2007). This may be because of adolescents' need for their parents to assist in their identity development. Other studies have found that family conflict leads to marked psychological impairment, and that adolescents who came from high-conflict families engaged in less adaptive health habits, used more avoidance coping, and had a poorer self-concept than those from low-conflict families (Michael et al., 2007). Furthermore, individuals from low-conflict families typically have a more problem-focused style of coping and have improved physiological responses.

Some research has shown that the effects of parental divorce on adolescents are long-term. One study in particular compared adults who had experienced parental divorce before the age of 16 to adults from non-divorced families (Huurre et al., 2006). This study indicated that females from divorced families reported more psychological problems and difficulties in their interpersonal relationships. Both males and females from divorced families tended to have less education, more unemployment, divorce, negative life effects, and more risky health behaviors. Since the negative psychosocial effects of experiencing parental divorce can and often do persist through adulthood, it is important for adolescents to seek treatment in order to reduce the likelihood of experiencing such difficulties later in life.

Music Therapy and the Family

The effectiveness of music therapy has been addressed in individual and group settings. However, it also has benefits when used in conjunction with family therapy. When used with family therapy, music therapy techniques allow all members of the family to bond through the shared experience of creating music together by using instruments (McIntyre, 2009). Creating music together in an interactive music-based session is often the first time the family spends a significant amount of time together focused on completing one activity. Much like it does with

the individual, music also reduces the overall level of stress within the family. The family's creation of music can expose thoughts and emotions surrounding unspoken family dynamics and processes. As they play their instruments, the family reveals certain information about their level of communication and cooperation with one another. This may be captured on a recording, and given to the family on a CD to take home with them so that they may listen to their creation. Families tend to understand more about their own dynamics after receiving this type of interactive music intervention (McIntyre, 2009).

Music therapy techniques can also be used to promote positive parenting and healthy child development (Nicholson, Berthelsen, Abad, Williams, & Bradley, 2008). Music can facilitate positive parent-child communication and provide an opportunity for bonding. It can also encourage social skills and motor skills via action and movement songs, and/or by playing instruments (Nicholson et al., 2008). Quiet music can be used to facilitate physical and emotional closeness. Using such techniques may lead to improvements in various parenting behaviors, child behavioral, social, and communication skills outcomes, and parent mental health.

Music interventions on their own have various benefits. When used simultaneously with family therapy, they can affect the family as a whole in a positive way. Thus, adolescents from high-conflict families or who are experiencing parental divorce may benefit from family music-based therapy. Especially with divorce, engaging in this type of treatment may help adolescents understand the new family dynamics, bond with each parent, and cope with transition.

Key Terms

Music Therapist: "A specially trained individual whose intervention is based on a thorough knowledge of all facets of music (historical, theoretic and practical), the

behavioural sciences, treatment and educational models, and accepted therapeutic approaches” (Munro & Mount, 1978, p. 1029).

Music Therapy: “Music therapy is the use of sounds and music within an evolving relationship between client and therapist to support and encourage physical, mental, social, and emotional well-being” (Bunt, 1994, p. 8).

Active Music Therapy: The performance, improvisation, or composition of music using either musical instruments or one’s voice in order to express, explore, and work through conflicts (Bruscia, 1998; Choi, Lee, & Lim, 2008).

Passive Music Therapy: Listening to music (Montello & Coons, 1998).

Family Conflict: “Incompatibilities that can be expressed by people related through biological, legal, or equivalent ties” (Canary & Canary, 2013, p. 6).

Family Transitions: Changes in the family structure, such as by separation from biological parents or divorce (Langenkamp & Frisco, 2008).

Section 3: Music Therapy Interventions and Techniques

*“Music is the universal language of mankind.”
– Henry Wadsworth Longfellow*

Music is an important feature in the lives of most adolescents and can be used to reduce the stress created by family conflict, transition, or divorce. It can also be used to help adolescents cope in a positive manner. This section includes suggested music therapy interventions and techniques that a clinician may use in his or her work with adolescents. Given that music plays important identity-related functions during adolescence, it is important to use and support adolescents in their musical preferences. Furthermore, interventions will likely be more successful if an adolescent’s preferred music is used. Although this manual is intended to assist diverse mental health clinicians in treatment planning and implementation of the listed techniques, it is strongly recommended that clinicians seek continuing education, training, and/or consultation from a music therapist that has been certified by the Certification Board for Music Therapists, or refer clients to a music therapist as needed.

Interventions and Techniques

Music Journaling

Music journaling is often the first step in providing music-based interventions. This can be used when a client indicates that he or she has an interest in music and identifies music as a frequent hobby or coping strategy. In order to gain a better understanding of an adolescent’s musical interests and/or preferences, clinicians may ask clients to write down what they are listening to over the course of several days or weeks. It may also be helpful to look for potential patterns and themes in the songs selected by the adolescents, and to discuss such themes as needed. For example, this author encouraged a client in her late adolescence to keep a music journal, as the client had already identified music listening as one of her primary coping

strategies. At the time, she was struggling with stress related to frequent arguments between her parents, and she stated that in previous times of distress, she had always felt better after listening to music. As her father's medical health began to decline, the client stated that she could not understand why listening to music was no longer providing her with any sense of relief. This author, upon reviewing the client's music journal, realized that the client was solely listening to songs with themes of loss and sadness. This author was also able to identify the client's apparent preference for pop and soft rock music, and was able to suggest specific songs within these genres that had more upbeat and motivational lyrics. The client agreed to listen to the songs at home, and during the following session, she disclosed that although the conflict between her parents was still present, she noticed a reduction in the severity of her depressed mood after listening to the recommended songs, and that she felt more capable of coping with the stress at home. The client also began exploring other songs with similar, more positive messages, and discovered an appreciation for songs and recording artists she had never been exposed to before.

Music Listening

Hendricks and Bradley (2005) suggest having one or more family members select a song that has some personal significance to them. The family can then listen to the song(s) together during the session, after which they may discuss each person's responses that were evoked by the song(s). Hendricks and Bradley (2005) described how this technique was used with a family that sought treatment for the 17-year old son's depression. In this case study, the clinician asked the son to bring a song that had some personal relevance, and the family listened to the song "Paradise City" by Guns N' Roses during the following session. The parents, initially dismissive of the heavy metal song, were encouraged to listen to the message of the song. Using music listening, followed by lyric analysis (see below), the adolescent's parents were able to develop a

better understanding of the adolescent's sense of grief and desperation in his current environment.

Another suggestion is to encourage clients to identify helpful songs that they can listen to during moments of distress at home. For example, this author worked with a 19-year old client with passive suicidal ideation related to her parents' impending divorce, as well as her brother's struggles with alcoholism. The client, who expressed both a preference for punk rock music and an openness to explore new songs, described her suicidal thoughts as "fleeting" and stated that she occasionally simply needed a "reminder to snap out of it" because she recognized she had no control over her family's difficulties. This author played the song "Hold On" by Good Charlotte, a song that contains the lyrics, "hold on if you feel like letting go." The client stated that she would download the song and keep it on her phone and on her iPod in order to have it readily accessible when her suicidal thoughts emerged.

Lyric Analysis

According to Mark (1998), music is especially useful for material that may be too intimidating or hurtful to explore more directly. Lyric analysis can be used for mood support, processing of emotions or experiences, and/or developing insight. For this technique, the therapist can print and listen to song lyrics with a client, and then facilitate a discussion about the general message or theme evoked by a particular set of song lyrics. Benji Madden, guitarist and vocalist for the bands Good Charlotte and The Madden Brothers, has suggested that people tend to interpret songs' meanings for themselves (B. Madden, personal communication, November 30, 2011). Allowing clients to discuss lyrical content may help clinicians have a more accurate understanding of the clients' interpretations. Clinicians may then enhance the depth of such a discussion by asking the client how the lyrics relate to his or her life and/or family situation.

Furthermore, clinicians may also inquire about how specific sets of song lyrics are either similar or different to the client's real or desired experience at home. For adolescents who struggle with verbal communication, it may feel safer to discuss song lyrics, rather than their own experiences within the family context.

Lyric analysis may also be used to help clients adopt new motivational messages. For instance, this author once worked with an older adolescent who had been sexually abused by a relative. After years of abuse, she disclosed her experience to the rest of her family members. She stated that although her family was surprisingly supportive, she eventually became "tired of being treated like a victim." This author encouraged the client to change her perspective and view herself as a "survivor" rather than a victim. The client responded well and stated that the term "survivor" reminded her of a song of the same name by the R&B group, Destiny's Child. This author played the song in session and inquired about the similarities the client saw between the song lyrics and her own life. The client stated that she could relate to the overall message of the song. More specifically, she stated that she "survived" the abuse, plans to move forward successfully in her life, and that she will not allow a man to "hold [her] back." At termination, the client stated that she had adopted the song lyrics, "I'm a survivor, I'm not gon' give up" (lyrics from the song), as her personal mantra.

Songwriting

Many clinicians are familiar with the use of therapeutic journaling. Songwriting is a similar intervention in the sense that there is no correct or incorrect way to write a song, and its aim is for the client to write about his or her own thoughts and feelings. It can be used in session, given that sufficient time is dedicated to this task, or it may be given as an activity to complete at

home. Some music therapists recommend using lyric analysis (above) prior to using songwriting techniques, although it is not necessary.

This technique works well for clients who are musically and/or poetically inclined, or who appreciate creative and artistic outlets of expression. It may be used to facilitate emotional expression, to process stressors, or to communicate with others. When writing a song, clients can explore and express their feelings and thoughts about themselves or events, and there is a product (i.e., the song) that can be recorded or sung. This is effective in individual settings, as well as with groups and families. However, it should be noted that some families discourage such direct expression, or may not provide the safety for the client to share his or her own songwriting. In this case, it is suggested that songwriting be utilized as a means of personal emotional exploration, expression, and catharsis, rather than as a method of communication. Additionally, there are a few variations of songwriting that can be used to achieve these goals, described below:

Original compositions. Clients can be encouraged to write their own songs with original lyrics and melodies, and may include lyrics describing their experiences or about what they would like others (i.e. the clinician and family members) to know about them. Some clients may choose to sing their compositions, while others may prefer to share their songs in writing, or by reading them aloud. Another variation is to have the client share the lyrics as “spoken word” poetry with an instrumental music background of their choosing. The process of selecting an instrumental background can also be an opportunity to process the relationship between music and mood. It is essential to take into account the client’s comfort level when asking them to share their compositions. Original compositions are helpful within the context of the family because the song(s) created by the client provides a direct account of the conflict from the client’s

perspective, and it can be shared with family members in order to strengthen the family's understanding of the client. Original compositions can also give clients a greater sense of control, which is often lacking in the midst of family conflict and/or transition.

Lyric substitution. This technique can be used with adolescents who want to experiment with songwriting, but either struggle with, or are insecure about, their ability to create original compositions. In order to use this technique, the clinician and client must first select an existing song with original lyrics that are related to the client's issue or struggle. It may be helpful to listen to or sing through the song once with the client. Then, have the client re-write the song in a way that is meaningful to him or her. He or she may keep some lines of the original song, tailoring the parts that need modification in order to better fit the client's current experience. For example, this author worked with a 17-year old client who struggled with resentment toward her father following her parents' separation. According to the client, she was unable to express her emotions about her perceived abandonment by her father because she wanted to be "strong" for her mother. In order to help the client explore her underlying emotions, this writer encouraged the client to substitute lyrics to a song about paternal abandonment, written from a son's perspective. The following is an excerpt of the original lyrics to the song, "Sincerely Yours," by AJ McLean:

Now I'm a man, out on my own

I am not ashamed

You broke my heart, you stole my pride

All you left me was my name

I know you wanna be in my shoes

So how does it feel?

Although the original lyrics had some relevance to the client's current situation, she was unable to relate to the parts of the song about the father's desire for fame. Thus, she substituted some of the lyrics in order to express her feelings more accurately. The following is an excerpt of the client's substituted lyrics:

Now I'm a girl that feels alone

And you're the one to blame

You broke my heart, I cried and cried

Nothing will ever be the same

I know you wanna forget about us

So how should I feel?

Following this exercise, the client was able to take ownership of her hurt and anger surrounding her parents' separation. She also found a new, safe outlet that allowed her to express and process her emotions without overly relying on her mother for emotional support.

Piggyback songwriting. This technique shares qualities of both lyric substitution and original composition. It can be used when a client likes the particular melody or tune of a song, but the lyrics do not represent what the client is experiencing. The melody and feeling of the music is more important than the existing lyrics because the lyrics will be changed by the client. In order to use this technique, it is important to select a song of the client's preference, and to then ask the client to write new lyrics to the song's pre-existing melody. Unlike the original composition technique, the client does not need to create an entirely new melody. While the lyric substitution technique involves modification of existing lyrics, the piggyback songwriting technique provides an opportunity for the client to write original lyrics that reflect their experience.

Active Music Engagement

Active music engagement can address social and emotional needs. This technique includes physical interaction with music and may be used for goals pertaining to coping or normalization of new environments. It may include playing instruments, or using dance or movement with live or recorded music.

Instrument play/improvisation/exploration. This is a non-verbal intervention in which an adolescent can use musical instruments or sounds to create music. Some adolescents may find the non-verbal approach to be less threatening. Through improvisation, they can emote without necessarily knowing or having to label their feelings with a verbal description. This may also be a cathartic experience for clients.

A case study conducted by Moreno (1985) illustrated the benefits of using music symbolically. Moreno used music therapy with a 17-year old boy who struggled with mental retardation, hyperactivity, and isolation in order to help him increase his communication and socialization skills, as well as decrease his hyperactive and destructive behaviors. The boy was initially resistant to music therapy, and he often ran around the investigator's room and struck the keys of a piano aggressively in an effort to communicate his opposition to the therapeutic process. According to Moreno (1985), the boy was allowed to make his own choices about whether he would play with any of the instruments, how, and when. After several weeks of behavioral outbursts and resistance, the boy eventually sat next to the investigator and the two began to play together. The boy became increasingly open to learning new melodies, and his tendency to socially isolate and become destructive decreased. New skills translated into the boy's classroom environment, as he became more attentive to the teacher and refrained from running around and destroying the classroom.

If instrument play is used with the adolescent and his or her family, it can become a cooperative group experience for the family members. Some music therapists recommend having individuals and/or family members “play out their feelings,” which can help clients express any inner-turmoil physically and safely. Families can also use instrument play to learn how to work cooperatively with each other and possibly understand new family roles. The clinician may record the music produced by the family and provide a CD for them to take home as a reminder that positivity can occur when the family works together and respects each other’s roles.

Therapeutic Singing

Singing is another activity that can provide a variety of benefits to clients. Studies have shown that singing may improve mood, distract from negative thoughts, and create opportunities for socialization, emotional expression, and cognitive stimulation (Unwin, Kenny, & Davis, 2002; Clift et al., 2010). In order to use this in session, clients can sing pre-existing songs, or songs they have written. This author suggests that this intervention may be particularly helpful for clients who have a tendency to raise their voices or yell during times of frustration, as singing is often considered to be more adaptive and/or acceptable than yelling. It may sometimes be quite powerful for the clinician and client to sing a song together. This may facilitate the development of the therapeutic relationship, as well as provide a connecting experience for the client more generally. Furthermore, much like instrument play, therapeutic singing can be used with the family in order to practice communication and cooperative work and play, as family members must practice singing together to create a product (i.e., the song).

Music Assisted Relaxation

Adolescents living with tension in their family environment may be empowered to manage their own stress and anxiety using music. Many clinicians are already familiar with

various relaxation exercises, including but not limited to: deep breathing exercises, guided imagery, and progressive muscle relaxation; however, using music along with such exercises does not appear to be commonly used in the therapy room. McKinney et al. (1997) found that participants exposed to guided imagery and music therapy for 13 weeks showed decreased levels of the stress hormone cortisol. Thus, it appears that pairing appropriate, calming music with such exercises may help mask auditory distractions and deepen the relaxation response.

In another study, Scheufele (2000) conducted an experiment in which participants were asked to complete a number cancellation task and then were exposed to a minimally stressful situation that was followed by a 15-minute break. Participants were divided into 4 groups. The first group engaged in a progressive relaxation activity during the break, the second listened to classical music, the third was required to complete another focused attention task, and the fourth group sat in silence for the duration of the break. Following the break, participants again completed the number cancellation task. Results of the experiment indicated that the participants exposed to the progressive muscle relaxation condition or to the music listening condition had lower heart rates, increased attention, and lower reported rates of stress following the experimental condition than the participants exposed to the task completing condition or the condition of silence.

Since both traditional relaxation exercises and listening to calming music appear to have positive outcomes, this author suggests selecting calming music to play softly in the background while guiding a client through a relaxation exercise.

Final Thoughts

“Where words fail, music speaks.” – Hans Christian Andersen

The techniques presented above for utilizing music interventions in therapy with adolescents represent an integration of existing literature, case studies, and information obtained from interviews with music therapists. Table 1 provides an overview of the techniques. The music therapists interviewed for this manual shared some additional core recommendations, including the importance of using music that is preferred by the adolescent, and caution regarding a tendency to make assumptions about what an adolescent’s music preferences means. Different clients have different musical interests and preferences, and there is no set genre or style that will work for everyone (see Appendix A for a list of suggested songs about conflict and transition within a few different musical genres). Validating the client’s song preferences is important because preferences are often closely tied to identity, and doing so may also provide clients with a sense of empowerment. Furthermore, providing opportunities for clients to share musical preferences or meaningful songs may provide insight into the client’s feelings and behaviors for the clinician, and possibly for the family as well.

Although Saarikallio and Erkkila (2007) found that across adolescent participants, self-selected music generally resulted in mood changes toward a positive direction, it should also be noted that not all music preferences are positive. According to the study, when music was used to reflect on negative feelings, adolescents temporarily reported feeling worse. This may raise ethical concerns for clinicians working with adolescents. Clinicians must use sound clinical judgment and be able to provide justification for focusing on negative feelings that result in the adolescent clients’ negatively altered mood state. It may be argued that proceeding with music interventions that focus on negative feelings eventually helps the adolescents shed their negative

emotions in favor of more positive feelings, thus allowing them to discharge and/or resolve their conflicts over time (Saarikallio & Erkkila, 2007). Should the music selected by the client

Table 1

Overview of techniques for using music in interventions with adolescents

Technique	Brief Description
Music Journaling	The client writes down what music he or she is listening to over the course of several days to weeks. This provides insight into the client's musical preference(s), as well as to any potentially important themes or patterns in the client's life.
Music Listening	The client selects a song that has lyrical significance, and the clinician and/or family listens to the lyrics in order to gain an understanding of the client's inner experience. Another variation includes selecting and listening to soothing and/or empowering songs for relaxation or motivation, respectively.
Lyric Analysis	Print and listen to song lyrics with clients. Discuss the general theme, the client's thoughts and feelings in response to the content, and how the lyrics relate to the client's life.
Songwriting	Clients write songs in order to express and/or communicate their thoughts and emotions. They may write their own original lyrics and melodies (original compositions), or re-write pre-existing songs (lyric substitution, piggyback songwriting).
Active Music Engagement	Clients physically interact with music via playing instruments, dancing, or using movement with live or recorded music.
Therapeutic Singing	Clients sing pre-existing songs, or songs they have written. They may sing alone as an adaptive alternative to expressing emotions, or with others in order to practice cooperative work and play.
Music Assisted Relaxation	Traditional relaxation techniques, such as guided imagery or progressive muscle relaxation, are paired with soothing, calming music in order to enhance the relaxation experience for clients.

contain strong messages surrounding suicide, violence, or other dangerous behaviors, it is crucial for the clinician to conduct a thorough risk assessment, consult, and intervene and create a safety plan as needed.

Another important factor to consider is the intended purpose of the music intervention(s). Using and/or creating music with lyrics can be beneficial for the purposes of emotional exploration, communication, catharsis, and social bonding. Using instrumental music (i.e., without lyrical content) can help induce or enhance relaxation. Playing instruments can help develop communication and cooperation between family members.

Although adhering to the clients' musical preferences is generally recommended, some adolescents may also be open to exploring new songs and/or genres. Thus, they can work collaboratively with the clinician to discover new music that may represent a transition. However, exploring new music is only recommended for clinicians who love music themselves and who are familiar with a wide array of different songs and genres. Additionally, clinicians must also be careful about the interventions they implement. If recorded music is used, clinicians should know how the musical elements of a song might affect one's emotional and/or arousal state. Music therapists are particularly sensitive to this, and they put quite a bit of thought into the recorded music they use with clients. If live music is used, it's important that the clinician has significant skill on the instrument(s) in order to support the client and the musical relationship in a client-centered manner. This might mean rapidly transposing songs, playing songs at different tempos, or adjusting lyrical content or other elements of the composition.

Ultimately, should clinicians choose to use music-based interventions, it is strongly recommended that they consult with music therapists as needed. A clinician must first recognize his or her own scope of competence. Passive strategies (e.g., music listening and lyric analysis) may require less training than active strategies (e.g., playing instruments or singing), and there are various situations in which a referral to a music therapist is warranted.

One situation that may warrant a referral would be when clients are having difficulties with coping, might benefit from non-verbal opportunities for expression, and the clinician is unable to provide this opportunity. More specifically, if a clinician has already unsuccessfully attempted to utilize traditional talk therapies, then the approach must be shifted, potentially toward more creative outlets. An example of this may include working with a client who struggles with a disorder that impedes his or her ability to communicate verbally, or when expressive and receptive learning style behaviors and preferences call for movement and tactile experiences (i.e., kinesthetic learner or expressive needs). Another example may include a client who identifies music as the preferred method of expression and refuses to “talk.” In either case, a consultation with a music therapist would be recommended at minimum. However, if the clinician either has no interest in music or has not received some education and/or training on how to facilitate such interventions, then a referral is most appropriate.

Another instance that would warrant a referral includes when the clinician feels that live music requirements are beyond his or her musical capabilities. For example, if a family expresses an interest in active music engagement, and the clinician does not have sufficient resources (e.g., accessible instruments in the therapy room), then a referral is recommended. Furthermore, facilitating an active engagement activity requires a certain level of musical knowledge, skill, and attention that may be lacking in someone who has never been musically trained. In this case, consultation with a music therapist would be insufficient and a referral is strongly encouraged.

If the clinician determines that the development of group or social behaviors are needed and the client could benefit from group therapy instead of, or in addition to, family therapy, then a referral to a music therapist is also encouraged. Groups can provide adolescents with a sense of normalization, understanding, and social bonding by allowing them to interact with peers who

are struggling with similar issues. A music therapist who facilitates a music therapy group can provide adolescents with the opportunity to develop and strengthen group or social behaviors through their participation in an ensemble or small group.

A referral to a music therapist is also recommended when the client displays strong auditory processing and/or there has been a traumatic experience that was primarily auditory. For example, if the client talks about what he or she hears while discussing a traumatic event, rather than what he or she sees or feels, then that may be evidence for strong auditory processing. Unless a clinician has received training or continuing education specifically in this area, then this may be outside of the clinician's scope of competence and a referral would be warranted.

While this manual is intended for clinicians to have an adjunctive form of treatment via musical interventions, it is not meant to replace music therapy. The central goal of this resource is to provide clinicians who are not trained music therapists with more knowledge about the field of music therapy, and how specific music interventions can be used to help adolescents struggling with family conflict and/or parental divorce. This may be particularly helpful for adolescents who do not respond well to traditional talk therapies and for whom a more creative approach may be beneficial. Various case examples were included to help demonstrate when and how to use specific music therapy interventions, and suggestions for songs across different genres were also included (see Appendixes A and B). Recommendations for when to refer a client to a music therapist were also listed. Should a clinician choose to refer a client, he or she can consult with local music therapy organizations or search the American Music Therapy Association on-line directory. Relevant organizations, websites, and books have been included (see Section IV: Resources) for further reading. Finally, though this manual includes a review of the literature and various current techniques, it is limited to a very specific population. Future

research should focus on expanding toward clients across the lifespan, and struggling with a variety of presenting problems.

Section 4: Resources

Organizations

American Music Therapy Association

American Psychological Association

Certification Board for Music Therapists

Websites

American Music Therapy Association, www.musictherapy.org

American Psychological Association, www.apa.org

Certification Board for Music Therapists, www.CBMT.org

Journal of Music Therapy, www.jmt.oxfordjournals.org/

Books

Bunt, L., & Stige, B. (2014). *Music therapy: An art beyond words* (2nd ed). New York, NY: Routledge.

Hadley, S., & Yancy, G. (Eds.). (2012). *Therapeutic uses of rap and hip hop*. New York, NY: Taylor & Francis Group, LLC.

McFerran, K. (2010). *Adolescents, music, and music therapy: Methods and techniques for clinicians, educators, and students*. Philadelphia, PA: Jessica Knightley Publishers.

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APPENDIX A

SUGGESTED SONGS ABOUT CONFLICT/TRANSITION

Punk/Rock/Alternative

- “Daddy’s Gone,” *Glasvegas*
- “Mother Mother,” *Tracy Bonham*
- “Crawling in the Dark,” *Hoobastank*

Country

- “If Nobody Believed in You,” *Joe Nichols*
- “Little Toy Guns,” *Carrie Underwood*
- “Every Other Weekend,” *Reba McEntyre and Kenny Chesney*

Pop/Adult Contemporary

- “Sincerely Yours,” *AJ McLean*
- “Because of You,” *Kelly Clarkson*
- “Confessions of a Broken Heart,” *Lindsay Lohan*

Hip-Hop/Rap

- “Dear Mama,” *2pac*
- “Cleaning Out My Closet,” *Eminem*
- “Runaway Love,” *Ludacris featuring Mary J. Blige*

APPENDIX B

SUGGESTED MOTIVATIONAL SONGS

Punk/Rock/Alternative

- “Alive,” *P.O.D.*
- “Hold On,” *Good Charlotte*
- “Don’t Stop Believin’,” *Eagles*

Country

- “I Won’t Let Go,” *Rascal Flatts*
- “My Wish,” *Rascal Flatts*
- “If You’re Going Through Hell,” *Rodney Adkins*

Pop/Adult Contemporary

- “Keep Holding On,” *Avril Lavigne*
- “Show ‘Em (What You’re Made Of),” *Backstreet Boys*
- “Jumper,” *Third Eye Blind*

Hip-Hop/Rap

- “The Show Goes On,” *Lupe Fiasco*
- “Live Your Life,” *T.I featuring Rihanna*
- “Hope,” *Twista featuring Faith Evans*

APPENDIX J:
Program Evaluation Form

Evaluation Form

Please note that all information provided on the evaluation form will remain strictly confidential.

DEMOGRAPHICS

What is your age? _____ years old

What is your gender? Male Female

What is your ethnicity? African-American Asian/Pacific Islander Caucasian

Latino(a) Native-American Multiethnic Other _____

What is your profession/job title?

What best describes your work setting? Private Practice Hospital
 Community Agency Other: _____

What age group do you typically work with?

- Infants through Elementary School (ages 0-10)
- Middle School through High School (ages 11-17)
- Adults (ages 18-64)
- Older Adults (65+)

Please select the ethnicities of the adolescents that you have worked with? (Check all that apply)

- African-American Asian/Pacific Islander Caucasian Latino(a)
- Native-American Multiethnic Other _____

PROGRAM EVALUATION

Note: The term "certified" refers to certification by the American Music Therapist Association

1. How useful do you find this manual for non-certified clinicians intending to integrate music into work with adolescents and families? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful
2. How useful do you find this manual in working with adolescents struggling to cope with family conflict and/or parental divorce? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

3. What did you find particularly useful about this manual as it pertains to non-certified clinicians using music therapy techniques in their work with adolescents struggling to cope with family conflict and/or parental divorce?

4. How useful do you find this manual in educating non-certified clinicians about current music therapy techniques? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

5. How useful do you find this manual in addressing the application of music therapy techniques to family conflict and/or divorce? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

6. What aspects of this manual did you find **not** particularly relevant for its intended purposes?

7. What do you consider to be the strengths of the manual?

8. What do you consider to be the weaknesses of the manual?

9. What could have been added to the manual to make it more useful for utilizing music therapy techniques in your work with adolescents struggling to cope with family conflict and/or parental divorce?

10. Are there any parts of the manual that you would omit, change, or revise? Please explain.

11. Additional comments and/or suggestions:

In regards to the overall manual, please rate the following statements using the scale below:

(1) Strongly Disagree (2) Somewhat Disagree (3) Neutral (4) Somewhat Agree (5) Strongly Agree

This manual provides clinicians with an adjunctive resource for working with adolescents struggling to cope with family conflict and/or parental divorce.

Rating: _____

I would recommend this manual to clinicians seeking to integrate music into their work with adolescent clients experiencing family conflict.

Rating: _____

This manual is user-friendly and easy to understand.

Rating: _____

Thank you for your time!

APPENDIX K:
Literature Table

Authors	Year	Abbreviated Title	Type	Topic areas/ Variables	Methodology	Sample - size and age	Sample- gender	Sample- ethnicity	Measures/ Data Collection	Summary of Results/Key Points
Aluede, C. O.	2006	Music therapy in traditional African societies	Qualitative	Music therapy, African cultures	Ethnography	n/a	n/a	African	Literature search	Music has been used as a method of healing physical ailments and psychological disorders in African societies for thousands of years. Herbalists, witch doctors, and faith healers all use music to provide healing.
Amato, P. R.	2000	Consequence of divorce for adults and children	Meta-analysis	Divorce, stress, adjustment, offspring	Meta-analysis	Children through adults	Males and females	Black, White, Latino(a), Asian	Literature search	Adults and children from divorced families score lower on indicators of well-being. Divorce disrupts parent-child relationships, contributes to continued discord between former spouses, and is associated with difficulties with emotional support, finances, and negative life events.
Bakagiannis, S. & Tarrant, M.	2006	Effects of shared music preference in adolescence	Quantitative	Music preference, social identity, intergroup attitudes	Empirical	Sample size = 97 students (year 10); mean age = 14.79	Males and females	Not defined; participants from the UK	Questionnaires about thinking style and group ratings	Adolescents' beliefs in similar musical preferences between groups can improve intergroup relations; improvements also noted when common ingroup identity was absent.
Bender, L. & Wolmann, A.	1941	Play and psychotherapy	Qualitative	Children, play therapy	Grounded Theory	n/a	Males and females	Not defined	Literature search	Play therapy can facilitate emotional expression in children.
Bruscia, K. E.	1998	Defining music therapy	Qualitative	Music therapy	Empirical	n/a	n/a	Not defined	Literature search	Defining music therapy is difficult because there are multiple factors that must be considered before establishing an appropriate definition.
Bunt, L.	1994	Music therapy: art beyond words	Qualitative	Music therapy, coping	Empirical	n/a	n/a	Not defined	Literature search, case studies	Music can be used to alleviate illness and distress.

Carmichael, K. D. & Atchinson, D. H.	1997	Music in play therapy: playing feelings	Meta-analysis	Non-directive play therapy and music play therapy	Meta-analysis	Children	Males and females	Not defined	Literature search, case studies	Music can provide children with a safe outlet for emotional expression; prosocial changes are often a secondary gain.
Choi, A., Lee, M. S., & Lim, H.	2008	Group music interventions, depression, anxiety, and relationships	Quantitative	Group music therapy, anxiety, depression, and relationships	Empirical	Sample size = 26; mean age = 37.4	Males and females	Not defined; participants from South Korea	Beck Depression Inventory, State and Trait Anxiety Inventory, Relationship Change Scale	Patients in music therapy group showed greater improvements in severity of psychiatric symptoms than patients assigned to the non-music control group. Use of music appeared to increase self-confidence and self-worth.
Cookston, J. T.	1999	Parental supervision and family structure	Quantitative	Family structure, adolescents, parental supervision, substance use	Empirical, longitudinal	Sample size = 105,000 students; ages 11-19	Males and females	Caucasian, African-American, American-Indian, Asian American, and unclassified	Questionnaire and at-home interview about emotional distress, suicidality, violence, substance use, sexual behaviors, family and school context, and individual characteristics	Parental supervision appears to have a positive effect on deterring rates of adolescent problem behavior acquisition. Highest rates of problem behavior and lowest levels of parental supervision observed in single-father homes. Adolescents from single-father families had higher levels of problems behaviors than those from single-mother families.
Delucia-Waack, J., & Gellman, R. A.	2007	Music's impact on kids of divorce groups	Quantitative	Music therapy, anxiety, depression, and irrational beliefs about divorce	Empirical	Sample size = 134; ages 5-10	Males and females	Not defined	Children's Beliefs about Parental Divorce Scale, Revised Children's Manifest Anxiety Scale, Children's Depression Inventory	Music therapy and more traditional psychoeducational treatment are effective in reducing symptoms of depression and anxiety following divorce. Irrational beliefs about divorce are a mediator for depression.
Dufrene, P. M. & Coleman, V. D.	1994	Art & healing for Native Americans	Qualitative	Art therapy, healing, Native Americans	Ethnography	n/a	n/a	Native Americans	Literature search	Art plays a significant role in the healing process of traditional societies, though is often suppressed by the Western world. Counselors should aim

Field, T., Martinez, A., Nawrocki, T., Pickens, J., Fox, N.A., & Schanberg, S.	1998	Music shifts frontal EEG in depressed adolescents	Quantitative	Music, depression, physiology, female adolescents	Experimental	Sample Size = 28; ages 14-19	Females	African-American, Hispanic	Beck Depression Inventory, Diagnostic Interview Schedule, Behavior Observation Schedule, Depression Adjective Checklist, salivary cortisol samples, EEG recording, EEG analysis	to incorporate art into their therapy with these cultures. Experimental (music) group's cortisol levels decreased significantly from pre- to posttest and frontal alpha laterality ratios moved significantly closer to symmetry during and after the music session; BOS and DAQL yielded no changes during or following the music sessions.
Gladding, S.	1999	Group work	Qualitative	Group therapy	Empirical	n/a	n/a	Not defined	Literature search	Group therapy helps group members cope with psychological distress.
Gold, C., Voracek, M., & Wigram, T.	2004	Music therapy and kids/adolescents with psychopathology	Meta-analysis	Music therapy and psychopathology	Meta-analysis	11 studies, 188 subjects, children/adolescents	Males and females	Not defined; participants from USA and Europe	Literature search; 11 studies included	Music therapy has a medium to large positive effect on clinically relevant outcomes. Effects greater for behavioral and developmental d/o than for emotional d/o; greater for eclectic, psychodynamic, and humanistic approaches than for behavioral models; and greater for behavioral and developmental outcomes than for social skills and self-concept.
Hanser, S. B. & Thompson, L. W.	1994	Music therapy effects on depressed older adults	Quantitative	Music listening and symptoms of depression	Experimental	Sample size = 31; ages 61-86	Predominantly female	Not defined	Geriatric Depression Scale, BSI, Self-Esteem Inventory, Profile of Mood States - Bipolar Form, and BDI	Participants in the music conditions performed significantly better posttreatment than the no-music control group on standard measures of depression, distress, self-esteem, and mood. Improvements were maintained over a 9-month follow up period.

Hendricks, C.B. & Bradley, L.I.	2005	Interpersonal theory and music techniques case study	Qualitative	Depression, music therapy, interpersonal therapy, adolescents	Case study	1 case study, age 15	Male	Not defined	Case study	Integration of interpersonal therapy and music therapy techniques appears to have improved family dynamics; adolescent responded well to music as an intervention.
Hilliard, R. E.	2001	Music therapy-based bereavement groups and grieving kids	Quantitative	Music therapy and grief symptoms	Experimental	Sample size = 18; ages 6-11	Males and females	Black and White	BRIC (at home and at school), DSRS, BP	Participation in music therapy based bereavement groups reduced grief symptoms among the participants in the home.
Hoffman, J.P.	2006	Family structure, community, and adolescent problem behaviors	Qualitative	Family structure, adolescent problem behaviors	Empirical	Sample size = 10,286; 10th grade adolescents	Males and females	Not defined	Questionnaires about family, problem behaviors	Singer mother/families are more likely to reside in impoverished areas with higher rates of unemployment. Adolescents from single-parent households had the highest rates of problem behaviors.
Huure, T., Junkkari, H., & Aro, H.	2006	Psychosocial effects of parental divorce	Quantitative	Divorce, longterm effects of divorce	Empirical, follow-up, longitudinal	Sample size = 1471; ages 16-32	Males and females	Not defined	Psychosomatic Symptoms score, BDI, AUDIT, General Health Questionnaire	Females from divorced families reported more psychological problems and more problems in their interpersonal relationships. These problems were not found in men. Study found that childhood stress from parental divorce has effects that last into adulthood, especially in females.
Keith, D. R., Russell, K., & Weaver, B.S.	2009	Music listening and inconsolable premature infants	Quantitative	Music intervention, episodes of inconsolable crying, physiological differences	Repeated measures design	Sample size = 24; infants 32-40 weeks	Males and females	Not defined	Physiological responses were measured; time at which the infants ceased crying was recorded	Significant reduction in frequency and duration of inconsolable crying and improved physiological measures after music intervention.
Kurdek, L.	1987	Gender differences in adolescent symptoms and coping strategies	Quantitative	Adolescents, coping, symptoms, gender	Empirical	Sample size = 298; 7th and 9th grade adolescents	Males and females	Not defined	SCL-90 (revised), Adolescent Coping Orientation for Problem Experiencing Scale	Participants identified listening to music and watching TV as their most frequently used coping strategies

Lagenkamp, A.G. & Frisco, M.L.	2008	Family transitions and adolescent emotional distress	Quantitative	Adolescents, family content and structure, binge drinking	Empirical	Sample size = 10,969; 7th through 12th grade adolescents	Males and females	Not defined	Questionnaire based on the 15 Center for Epidemiologic Studies Depression Scale, survey about drinking behaviors, survey about household/family context	Context of family transitions shapes the consequences on adolescent emotional distress. Maternal emotional-distance also correlates with increased internalized and externalized emotional distress. Female adolescents are more likely than males to report acute depressive symptoms.
Larson, R.	1995	Bedroom secrets: adolescents' private use of media	Meta-analysis	Adolescents, media, identity	Meta-analysis	Studies of adolescents	Males and females	Western, primarily European-American	Literature search	Adolescents use private media for personal and age-appropriate needs; they use television to disengage from feelings and music to engage with issues of identity.
Larson, R., Csikszentmihalyi, M., & Graef, R.	1980	Adolescent mood variability and psychosocial adjustment	Quantitative	Adolescents, psychosocial adjustment, mood states	Empirical	Sample size = 182; adolescents	Males and females	Not defined	Self-report measures	Adolescents experience wider and quicker mood swings; results do not confirm that mood variability is related to stress, lack of personal control, or maladjustment; suggests that emotional variability is a natural part of adolescents' lifestyle.
Larson, R. & Richards, M.H.	1991	Companionship in late childhood and early adolescence	Quantitative	Children, adolescents, family and peer relations, satisfaction	Empirical	Sample size = 483; ages 9-15	Males and females	Not defined	Self-report measures and interviews	Adolescents spend less time with family as they get older; no significant difference found in quality of family time across age groups; interactions with friends appear to be more rewarding as adolescents get older; no significant difference in time spent with friends; alone time also appears to increase as adolescents get older.
Larson, R. & Richards, M.H.	1994	Emotional lives of mothers, fathers, and adolescents	Quantitative	Parents, adolescents, emotions	Empirical	Sample size = 55 families	Males and females	European-American	Self-report measures and interviews	Troubled families tend to maintain separate realities. Healthy families should aim toward convergence.

Lefevre, M.	2004	Playing with sound	Qualitative	Music therapy, communication	Empirical	Children	Males and females	Not defined	Literature search, case studies	Children often communicate symbolically. Social workers can use music instruments/techniques to facilitate communication, but research re: using music is limited.
Mark, A.	1998	Metaphoric lyrics and the adolescent's world	Qualitative	Lyrics, social belonging, and communication	Empirical	Adolescents	Males	Not defined	Group participation/discussion	Music lyrics help adolescents communicate and develop a sense of their role in society.
McClary, R.	2007	Healing through music, myth, and ritual	Qualitative	Music therapy, symbolization	Empirical	Not defined	Not defined	Not defined	Literature search	Symptoms are the result of the psyche's self-regulation process. Music therapy also serves as a symbol for conceptualizing symptoms into sounds. The psyche can be healed by using music.
McFerran, K.	2010	Adolescents, music, and music therapy	Qualitative	Adolescents, music therapy, techniques	Empirical	Adolescents	Males and females	Not defined	Literature search, case studies	Music therapy can provide adolescents with powerful opportunities for emotional expression and release.
McFerran, K., Roberts, M., & O'Grady, L.	2010	Music therapy with bereaved teenagers	Quantitative	Adolescents, bereavement, music therapy	Empirical	Sample size = 16; ages 12-16	Males and females	Not defined	Group participation/discussion, Harter Self Perception Profile, Adolescent Coping Scale, group interview	Group participation increases feelings of connectedness to family and peers. Having fun appears to serve as a spring-board for grief.
McIntyre, J.	2009	Interactive family music therapy	Qualitative	Benefits of music therapy for families	Case studies	2 case studies (families); ages 10+	Males and females	Not defined	Case studies	Group Music Therapy can facilitate the process of emotional self-expression; families can participate and create music together.
Michael, K. C., Torres, A., & Seemann, E. A.	2007	Adolescents and interparental conflict	Quantitative	Family conflict, and adolescent health habits, coping styles, and self-concept	Empirical	Sample size = 530; ages 17-19	Males and females	Caucasian, Black, Asian and Hispanic	Perceptions of Interparental Conflict Intensity/Frequency scale, Multidimensional Self-Concept Scale, Coping Responses	High family conflict had a negative impact on a variety of health habits, compromised well-being, fostered avoidant coping styles, and resulted in lower adolescent self-concept scores.

Miranda, D. & Claes, M.	2009	Adolescent music listening, coping, peer affiliation and depression	Quantitative	Music listening, peer affiliation, coping, and depression	Empirical	Sample size = 418; ages 15-19	Males and females	French-Canadian	Inventory, Lifestyle Inventory, Health Habits Survey	BDI: measure assessing music style preference	Music preferences and depression levels of participants are related to those of their peers.												
Montello, L.M., & Coons, E.E.	1998	Active vs. passive group music therapy on preadolescents	Quantitative	Preadolescents, music therapy, psychological disorders	Empirical	Sample Size = 16; ages 11-14	Predominantly male	White, African-American, and Hispanic	Achenbach's (1991a) Teacher's Report Form	Music therapy techniques appear to have positive effects on preadolescents; passive techniques appear to be less threatening for those who are struggling with more severe psychological difficulties and require safety and security first.													
Moreno, J.J.	1985	Music play therapy	Qualitative	Music therapy, play therapy, developmental disorders	Case study	1 case study, age 17	Male	Not defined	Case study	Music therapy techniques appeared to help subject increase acceptance of and communication with the therapist, which then appeared to translate into his classroom.													
Morgan, J.P. & Roberts, J.E.	2010	Bereaved children and adolescents	Meta-analysis	Bereavement, children, adolescents, group therapy	Literature review, case studies	Children through adolescents	Males and females	Not defined	Case studies	Allowing group members to grieve their losses helps them learn to cope.													
Munro, S. & Mount, B.	1978	Music therapy in palliative care	Qualitative	Music therapy, terminally ill patients	Case studies	6 case studies; adults	Males and females	Not defined	Case studies	Music has positive effects (i.e., comfort, expression of feelings) on the terminally ill and is typically well-received by patients and their families in hospital settings.													
Nelson, D. & Weathers, R.	1998	Music and healing in psychotherapy	Qualitative	Music therapy, healing	Case studies	4 case studies; adolescent through adults	Males and females	Not defined	Case studies	Music may lead to increased awareness, understanding, and communication.													
Nicholson, J. M., Berntsen, D., Abad, V., Williams, K., & Bradley, J.	2008	Music therapy, positive parenting, and child development	Quantitative	Music therapy, parenting, parent-child relationships, child development	Empirical	Sample size = 358 parents and children (ages 0-5)	Males and females	Not defined	Child Rearing Questionnaire, Parental Perceptions and Behaviors Scale, Early Childhood Longitudinal Study—Birth Cohort, Kessler	Significant improvements found for therapist-observed parent and child behaviors, and parent-reported irritable parenting, educational activities in the home, parent mental health													

North, A. C., Hargreaves, D. J., & O'Neill, S. A.	2000	The importance of music to adolescents	Quantitative	Involvement in musical activity and teen identity	Empirical	Sample size = 2465; ages 13-14	Males and females	Not defined; participants from England	K6 screening scale, subscale of the NEELS Scales of Developmental Competency	and child communication and social play skills.
Rosner, R., Kruse, J., & Hagl, M.	2007	Interventions for bereaved kids and adolescents	Meta-analysis	Bereavement, children, adolescents,	Meta-analysis, literature review	91 studies; 1,073 children and adolescents	Males and females	Not defined	Literature search	Older children tend to benefit from treatment for grief than younger children; studies describing music therapy interventions were the most successful.
Roustic, C., Chaik, B., & Chauvin, P.	2007	Family breakups and adolescent maladjustment	Quantitative	Family breakup, adolescent psychosocial maladjustment	Empirical	Sample size = 2346; ages 13-16	Males and females	Not defined; participants from Canada	Social and Health Survey of Children and Adolescents, Psychological Distress Index, Parental Psychological Distress Index, Conflict Tactics Scale	Maladjustment, as defined by internalizing disorders, externalizing disorders, substance abuse, and alcohol consumption, was significantly associated with family breakup. The effect of family breakups was weaker on internalizing disorders than on externalizing problems and addictions.
Saarikallio, S. & Erkkila, J.	2007	Role of music in adolescents' mood regulation	Qualitative	Music and adolescent mood regulation	Empirical	Sample size = 8; ages 14 and 17.	Males and females	Finish	Group interviews and follow-up forms	Theoretical model of mood regulation by music was created. Study found that music promotes emotional self-regulation through various music-related activities.
Schwartz, K.D. & Fouts, G.T.	2003	Adolescent music preferences, personality, and development	Quantitative	Adolescents, preferences, personality, music	Empirical	Sample size = 164 adolescents	Males and females	Not defined	Personality measure and measure of music listening preference	Participants who prefer either light qualities or hard qualities of music had at least moderate difficulty in negotiating distinct domains of personality and/or development. Those who had eclectic music preferences did not appear to have the same difficulties.

APPENDIX L:
IRB APPROVAL NOTICE

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

June 16, 2014

Lori Meono

Protocol #: P0414D01

Project Title: Using Music Based Interventions Coping with Family Conflict or Parental Divorce: A Resource Manual

Dear Ms. Meono:

Thank you for submitting your application, *Using Music Based Interventions Coping with Family Conflict or Parental Divorce: A Resource Manual*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Harrell, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Full Approval**. The IRB approval begins today, **June 16, 2014**, and terminates on **June 16, 2015**.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. One copy of the consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent that have been stamped with the GPS IRB expiration date to obtain consent from your participants.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For **any** proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **[DATE]**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

A handwritten signature in cursive script that reads "Thema Bryant-Davis".

Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Compliance Attorney
Dr. Shelly Harrell, Faculty Advisor

