An Examination of Therapeutic Approaches Employed by Music Therapists Servicing Children and Teens with Behavior Disorders

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AN EXAMINATION OF THERAPEUTIC APPROACHES EMPLOYED BY
MUSIC THERAPISTS SERVICING CHILDREN AND TEENS WITH
BEHAVIOR DISORDERS

By

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A Thesis submitted to the
College of Music
in partial fulfillment of the
requirements for the degree of
Master of Music

Degree Awarded:
Summer Semester, 2010
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ACKNOWLEDGEMENTS

There are several people I would like to thank for assisting me in the process of writing my thesis. First of all, I would like to thank my thesis advisor, Dr. Alice-Ann Darrow, for her suggestions, support, and guidance throughout this research process. Special thanks go to Dr. Jayne Standley and Professor Gregory for serving on my thesis committee. I would also like to thank my parents, colleagues, and friends who offered their advice and encouragement throughout this process. Lastly, a giant thank you goes to my fiancé, Todd Fowler, for being an amazing partner and best friend who encourages me every step of the way.
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ABSTRACT

The purpose of this study was to examine the therapeutic approaches employed by music therapists servicing children and teens with behavior disorders. The therapeutic approaches were examined in relation to: (a) the frequency of approaches (behavioral, analytical, Nordoff-Robbins, etc.) employed by music therapists, (b) the degree to which interventions employed by music therapists followed the research literature on evidence-based practice with children and teens who have behavior disorders, (c) the degree to which therapists’ approaches were influenced by their academic training (approach stressed by their university program) and by their professional identity (behaviorist, Nordoff-Robbins practitioner, etc.), and (d) the degree to which therapists’ approaches influenced the goals they addressed, and (e) the degree to which therapists’ approaches influenced the interventions they used with children and teens who have behavior disorders. Board-certified music therapists from the 2009 American Music Therapy Association Sourcebook who worked with children and teens with behavior disorders served as participants (N=114). Participants completed a 28-item questionnaire that addressed the five research questions and included items related to participants’ demographic information, their education, therapeutic approaches, music therapy experiences, behavior disorder caseloads, music interventions, and non-music techniques. Results indicated that (1) the most frequently utilized approach was behavioral, followed closely by eclectic, (2) 79.40% of music therapists continued to follow the approach stressed by their university programs, (3) participants’ professional approaches did not influence the social goals the music therapists addressed, though approaches may have influenced the other goals they addressed with children and teens who have behavior disorders, (4) participants in the present study employed therapeutic interventions that followed the research literature on effective practices with children and teens who have behavior disorders, and they also employed interventions that have yet to be studied by researchers, and (5) participants’ therapeutic approaches influenced the interventions they employed with children and teens who have behavior disorders. These findings highlight the relationship between participants’ education, their professional identity, and their approaches to servicing children and teens with behavior disorders. Additionally, results from this study identify interventions used by music therapists that follow the research literature on effective practices with children and teens who have behavior disorders; also identified are interventions
that have yet to be examined by researchers.
Three hundred sixty-seven music therapists are working with clients who are classified as having a behavior disorder, or related disabilities such as attention deficit hyperactivity disorder, conduct disorder, oppositional defiant disorder, and disruptive behavior disorder (AMTA Sourcebook, 2009). These music therapists have had professional and academic training at one of the American Music Therapy Association’s (AMTA) accredited institutions, and many have completed internships at one of AMTA’s accredited clinical sites. Many colleges and universities identify with a specific therapeutic approach (behavioral, humanist, analytical, etc.) that may affect the way music therapists approach working with the behavior disorder population.

Children and teens with behavior disorders present significant challenges to teachers, peers, and families. It is advisable for music therapists to understand their therapeutic approach in working with this population, particularly in relationship to the related evidenced-based research.

**Behavior Disorders**

The literature has identified a number of negative outcomes for children and teens with behavior disorders. These outcomes include dropping out of school, poor peer relationships, lack of employment, and trouble with the law. Students with behavior disorders generally exhibit externalizing behaviors or internalizing behaviors. Externalizing behaviors are overt negative behaviors such as acting out in class, aggressive acts toward others, attention-seeking behaviors, destruction of property, and deceitfulness or theft. Internalizing behaviors are generally covert and do not generally interfere with the well-being of others. Examples of internalizing behaviors are anxiety, worry, crying, and depression (Adamek & Darrow, 2005; McConaughy & Skiba, 1993). It is also common for behavior disorders to be comorbid with other disorders, such as learning disabilities, anxiety, and depression (August, Realmuto, MacDonald, Nugent, & Crosby, 1996; Smith & Adams, 2006; Wingenfield, 2002).

Statistics from the past decade have shed light on the prevalence of behavior disorders. The U.S. Department of Education (2009) estimated the prevalence of behavior disorders ranging from 8% to 20%, with boys outnumbering girls 5:1. The text revision to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, (DSM-IV-TR; American Psychiatric Association, 2000) categorizes behavior disorders as those that are usually first
diagnosed in infancy, childhood, or adolescence. Attention-deficit and disruptive behavior disorders (conduct disorder, oppositional defiant disorder, and disruptive behavior disorder not otherwise specified [NOS]) are included in the behavior disorder classification (American Psychiatric Association, 2000).

**Intervention Approaches for Behavior Disorders**

Behavior disorders can affect every area of a child’s development: intellectually, educationally, and socially. Adamek and Darrow (2005) outlined several classifications of behavior disorders, all resulting in various client needs: conduct disorder, oppositional defiant, anxiety-withdrawal, attention problems, immaturity, socialized aggression, psychotic behavior, and motor excesses. In response to these needs, teachers, parents, and therapists have developed various techniques and approaches to working with children and teens with behavior disorders.

Two of the more widely used approaches are applied behavioral analysis (ABA) and positive behavioral support (PBS) (Adamek & Darrow, 2005). Sulzer-Azaroff & Mayer (1977) defined applied behavioral analysis as a “systematic, performance based, self-evaluative method of changing behavior…used in the prevention and amelioration of behavioral problems and programs for learning” (p. 6). It has been effective in increasing behavior through reinforcements, reducing behavior, and teaching new behavior through such as techniques as reinforcement, punishment, extinction, contingencies, token economies, and stimulus control (Madsen & Madsen, 2000; Standley et al., 2008). Positive behavioral support is a form of school-based programming that focuses on improving the student and support provider’s daily life across all settings through strategies such as functional behavioral assessments and the implementation of necessary alterations, self-monitoring, skill training, and contingency contracting (Adamek & Darrow, 2002; Webber & Plotts, 2008).

Children and teens with behavior disorders have been shown to respond well to classroom structure, therapy, contingency management systems, multidisciplinary approaches, and psychopharmacology (AACAP, 1997; de l’Etoile, 2005; Presti, 1984; Tcheremissine, 2006). Treatment for behavior disorders varies depending on the diagnosis. Children and teens with ADHD may require less restrictive therapies such as school-based therapies, while more severe behavior disorders such as conduct disorder may require residential treatment. Information on evidence-based practice is essential to providing optimal service delivery and treatment for children and teens with behavior disorders.
Creative Arts Therapies and Behavior Disorders

According to the National Coalition of Creative Arts Therapies Associations (2010), art therapy, dance/movement therapy, drama therapy, music therapy, poetry therapy, and psychodrama all employ arts modalities and creative processes in the context of therapeutic intervention. These forms of expressive and creative therapies are often used with children and teens with behavior disorders. They are effective in addressing many of the needs of the behavior disorder population, including increases in self-expression, self-esteem, attention to task, and communication skills, and decreases in inattention, hyperactivity, and impulsivity. Art, poetry, and music therapists have developed techniques for children and teens with behavior disorders. These techniques have included poetry and lyric analysis, creative expression, counseling, and movement (Gillispie, 2005; Jackson, Muro, & Parker, 2008; Rickson, 2006).

Music Therapy and Behavior Disorders

In the United States, research pertaining to the use of music therapy for behavior disorders dates back to the 1960s (Madsen & Madsen, 1968). Since this time, a number of articles regarding music therapy and behavior disorders have been published in music therapy journals, including the Journal of Music Therapy, Music Therapy, and Music Therapy Perspectives. Music has shown to be an effective intervention in students with attention deficit hyperactivity disorder (ADHD) (Jackson, 2003). Using techniques such as music and movement, instrument playing, individual lessons, ensemble performance, group singing, songwriting, and lyric analysis, music therapists have been successful in managing behavior and inducing mood change and relaxation (Frisch, 1990; Jackson, 2003; Kivland, 1986; Rickson, 2006). Other strategies include the purposeful use of music as a competing behavior, as a contingency, to modify inappropriate behavior, to modulate mood, to modulate physical activity, and the use of lyric analysis to counsel (Adamek & Darrow, 2005).

Purpose of the Study

The purpose of this study was to examine the therapeutic approaches employed by music therapists servicing children and teens with behavior disorders. Therapeutic approaches were examined in relation to: (a) the frequency of approaches (behavioral, analytical, Nordoff-Robbins, etc.) employed by music therapists, (b) the degree to which interventions employed by music therapists followed the research literature on evidence-based practice with children and teens who have behavior disorders, (c) the degree to which therapists’ approaches were
influenced by their academic training (approach stressed by their university program) and by their professional identity (behaviorist, Nordoff-Robbins practitioner, etc.), and (d) the degree to which therapists’ approaches influenced the goals they addressed, and (e) the degree to which therapists’ approaches influenced the interventions they used with children and teens who have behavior disorders.
CHAPTER 2
REVIEW OF LITERATURE

Children and teens with behavior disorders often require therapeutic interventions and treatment in order to function appropriately in school and daily life. Three hundred sixty-seven members of the American Music Therapy Association worked with these children and teens in 2009. In an examination of music therapists’ theoretical awareness of their practices, and the factors that influence music therapists’ specific theoretical orientations and models, Choi (2008) found that many therapists base their current practice on their previous schooling, areas of practice, age, and academic degrees. It is not yet known how academic preparation and theoretical orientation affect the way music therapists approach their clinical work clients who have behavior disorders.

The following review of literature will define behavior disorders and the consequences of behavior disorder diagnoses on children and teens. Commonly used interventions and treatments for the behavior disorder population will be identified. In addition, evidence-based music therapy practices will be discussed in relation to common therapeutic goals for the population of students with behavior disorders. Lastly, theoretical approaches employed by music therapists working with clients who have behavior disorders will be identified and discussed.

**Defining Behavior Disorders**

Behavior disorders are difficult to define because behavior is a social construct that has varying levels of acceptance based on cultural and personal conventions. Children and teens are considered to have a behavior disorder when their behavior falls outside the norm. Children and teens with a behavior diagnosis must exhibit a pattern of hostile, aggressive, or disruptive behaviors for more than six months (APA, 2000). Behavior disorders are often related to mental health and learning problems that lead to emotional and social difficulties. Adamek and Darrow (2002) described three criteria that the behavior must meet in order for it to be considered disordered: it must be chronic — persistent and long-lasting, it must be severe — intense and extreme, and it must be pervasive — widespread, across settings.

Behavior disorders are grouped into two broad categories: externalizing and internalizing. Externalizing behaviors include acting out, aggression, interfering, attention seeking, and conduct problems. Children and teens who exhibit externalizing behaviors directly challenge
authority, cause problems in schools, and demand our attention; specifically, they affect the teachers’ ability to instruct, disrupt classroom routines, and affect classmates adversely. Internalizing behaviors are more inner-directed and include anxiety, worry, and depression (McConaughy & Skiba, 1993; Webber & Plotts, 2008). The text revision to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV-TR; American Psychiatric Association, 2000) categorizes behavior disorders as those that are usually first diagnosed in infancy, childhood, or adolescence. Attention-deficit and disruptive behavior disorders (conduct disorder, oppositional defiant disorder, and disruptive behavior disorders not otherwise specified [NOS]) are included in the behavior disorder classification (American Psychiatric Association [APA], 2000).

Defining Attention Deficit Hyperactivity Disorder. Attention-Deficit Hyperactivity Disorder (ADHD or ADH) is a neurobehavioral developmental disorder. It is characterized by symptoms that include hyperactivity and difficulty staying focused, paying attention, and controlling behavior. In order to be diagnosed with ADHD, symptoms must be observed in two different settings for six months or more, and to a degree that is greater than other children of the same age (APA, 2000). It is one of the most common childhood disorders, affecting about 3-5% of children globally. As it is a chronic disorder, many individuals diagnosed in childhood continue to have symptoms into adulthood. ADHD is diagnosed two to four times as frequently in boys as in girls. A specific cause of ADHD is not known. There are, however, a number of factors that may contribute to ADHD. They include genetics, diet and social and physical environments (National Institute of Mental Health, 2008).

There are three subtypes of ADHD — predominantly hyperactive-impulsive type, predominantly inattentive type, or combined type if criteria for both subtypes are met. These subtypes are characterized as follows:

(1) Predominantly hyperactive-impulsive: Symptoms may include children fidgeting and squirming in their seats; talking nonstop; dashing around; touching or playing with anything and everything in sight; having trouble sitting still during dinner, school, and story time; being constantly in motion; and difficulty doing quiet tasks or activities;

(2) Predominantly inattentive: Symptoms may include being children being easily distracted, missing details, forgetting things, and frequently switching from one activity to another; difficulty focusing on one thing; becoming bored with a task after only a few minutes,
unless they are doing something enjoyable; difficulty focusing attention on organizing and completing a task or learning something new; trouble completing or turning in homework assignments and often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities; not seeming to listen when spoken to, daydreaming, becoming easily confused, and moving slowly; difficulty processing information as quickly and accurately as others; and struggling to follow instructions; and

(3) Combined hyperactive-impulsive and inattentive: Symptoms may include a combination of both aforementioned subtype symptoms (APA, 2000)

Defining Conduct Disorder. Conduct disorder (CD) is seen as a more severe form of oppositional defiant disorder (ODD) and is known as the childhood equivalent of an antisocial personality disorder. According to the DSM-IV-TR, conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate societal norms or rules are violated. Conduct disorder is diagnosed according to the presence of three or more of the listed criteria within the past year, with at least one being present in the past six months. The DSM-IV-TR criteria for conduct disorder includes aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules. The aggression to people and animals criteria for a diagnosis of conduct disorder includes one who frequently bullies, threatens, or intimidates others, initiates physical fights, has used a weapon that can cause serious harm to others (e.g., a bat, brick, broken bottle, knife, or gun), has been physically cruel to people and/or animals, has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, or armed robbery), and/or has forced someone into sexual activity. Other criteria includes the destruction of property such as deliberate engagement in fire setting with the intention of causing serious damage, or the deliberate destruction of others’ property (other than by setting fire). The criteria for deceitfulness and theft include breaking into someone else’s house, building, or car, frequently lying to obtain goods or favors or to avoid obligations (i.e., “cons” others), and/or stealing items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery). The criteria for serious violations of rules include staying out at night despite parental prohibitions (beginning before age 13), running away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period), and frequent truancy from school (beginning before age 13).
A person diagnosed with conduct disorder may exhibit behavioral disturbances that cause clinically significant impairment in social, academic, or occupational functioning, and if the individual is age 18 years or older, the criteria are not met for antisocial personality disorder. Conduct disorder is generally seen as the childhood version of the aforementioned antisocial personality disorder. As of October 1, 1996, a new code required at least one of the criteria to be present before the age of 10 in order for conduct disorder to be typified as child-onset (APA, 2000).

The etiology of conduct disorder involves an interaction of many genetic, familial, and social factors. Children may inherit a decreased baseline autonomic nervous system, making it harder to achieve stimulation, which may account for the high prevalence of sensation-seeking behaviors. Common factors contributing to conduct disorder include brain damage, school failure, and inconsistent parental availability. Other factors that have been known to lead to the development of conduct include parental substance abuse and/or mental illness, family violence, child abuse, and neglect. Additionally, while conduct disorder is present in all socioeconomic levels, it is higher in lower socioeconomic groups, which may further complicate the situation (Searight, Rottnek, & Abby, 2001).

**Comorbid Disorders with Behavior Disorders.** Many children and adolescents with behavior disorders meet diagnostic criteria for more than one disorder, including anxiety, depression, learning disabilities, and oppositional defiant disorder (August, Realmuto, MacDonald, Nugent, & Crosby, 1996; Smith & Adams, 2006; Wingenfield, 2002). ADHD is commonly comorbid with other disorders, with the most common disorders being oppositional defiant disorder (ODD) and conduct disorder. Such combinations can greatly complicate diagnosis and treatment. August et al. (1996) found that up to 67% of children with ADHD meet the criteria for oppositional defiant disorder while 20-56% meet criteria for conduct disorder.

ADHD may also accompany other disorders such as anxiety, depression, and learning disabilities (Smith & Adams, 2006). Wingenfeld (2002) noted the importance of recognizing that internalizing behaviors may often be overlooked because they are not as disruptive to the classroom or home as externalizing behaviors. Additionally, children who have depression or anxiety may appear inattentive. It is also common for children with ADHD to have a learning disability (LD). Smith and Adams (2006) reported discrepancies in prevalence rates of comorbid ADHD with learning disabilities, with the ranges varying from 10-92%. They examined the
prevalence of comorbid ADHD with learning disabilities in children from the 2001 National Household Education Survey (NEHS). Of the total number of children surveyed (n =9,583), 358 (3.7%) had comorbid ADHD and learning disabilities.

The Consequences of Behavior Disorders on Children and Teens

Behavior disorders are social disabilities that affect children and teens in areas that require interpersonal interactions. As most academic and social activities require interpersonal interactions, behavior disorders affect children and teens intellectually, educationally, and socially (Adamek & Darrow, 2005). When behavior disorders are coupled with learning disabilities, increased problems exist. A large percentage of students with learning disabilities experience short- or long-term memory difficulties (Gfeller, 1983). They may fail at initiating memory aids and strategies such as spontaneous verbal rehearsal techniques, thus affecting academic productivity. Though not all children with behavior disorders exhibit academic deficits, those that do are more likely to disrupt the classroom or refuse to comply with the teachers’ demands, which can lead to negative interactions with teachers, increased association with delinquent peers, and increased removal from the classroom (Bowen, Jenson, & Clark, 2004).

Consequences of ADHD. The difficulty that children and teens with ADHD face in the classroom is well documented (Adamek & Darrow, 2005; Hallahan & Kauffman, 2003; Smith & Adams, 2006; Webber & Plotts, 2008). Children and teens with ADHD have social problems that interfere with the learning process and affect academic performance (Hanser, 1999). ADHD also affects an individual’s daily functioning, social relationships, behavior, health, and sleep patterns. Cognitive problems, such as poor concentration, tend to persist into adolescence. Additionally, expulsion and early withdrawal from school are common in children and teens with ADHD (Alloy, Riskind, & Manos, 2005).

Comorbidity presents additional problems for children and teens with behavior disorders. Smith and Adams (2006) found that children and teens with comorbid ADHD and learning disabilities experienced difficulty in academic performance and achievement. They found that parents were more likely to be contacted than parents of children with ADHD due to their significantly lower grades. Some children and teens with ADHD may also be at greater risk for substance abuse at an early age (Hallahan & Kauffman, 2003), and for acquiring a conduct disorder (Alloy, Riskind, & Manos, 2005).
Consequences of Conduct Disorder. As noted earlier, children with conduct disorder have serious behavioral and emotional issues often leading to lying, stealing, and physical and emotional abuse of others. Children and teens with conduct disorder often bully, threaten, and intimidate others, pick fights, use dangerous weapons, and are physically cruel to people. Alloy, Riskind, and Manor (2005) stated that children who develop conduct disorder before age 10 tend to be more aggressive, have very few friends, and are more likely to have antisocial personality disorder as adults. They are generally defiant to authority and act without considering or caring about the consequences of their actions, frequently causing harm to others whether physical or otherwise. School violence is prevalent among these children, often creating problems for the children and those in contact with them in both family and school settings. Peers and adults may view children with conduct disorder as “bad” and put them in the juvenile justice system (APA, 2000; Searight, Rottnek, & Abby, 2001).

Without proper treatment many children and teens with conduct disorders are unable to adapt to the demands and responsibilities of adulthood, and may experience relationship and work related difficulties. Conduct disorders and other behavior disorders are sources of stress for children and their families, schools, and communities. The importance of proper identification and assessment of behavior disorders is important to receive the proper intervention and treatment. Several treatment options are available for children and teens with behavior disorders.

Interventions and Treatments for Children and Teens with Behavior Disorders

Treatments and interventions for behavior disorders vary and have been widely studied. Research has demonstrated the effectiveness of behavior management (Broden, Bruce, Mitchell, Carter, & Hall, 1970; Presti, 1984; Webber & Plotts, 2008), cognitive-behavioral techniques, parent management training (PMT) and problem solving skills training (PSST) (Miller & Prinz, 1990; Serketich & Dumas, 1996), multidisciplinary approaches (AACAP, 1997; Webber & Plotts, 2008), and medication therapy (AACAP, 1997; Webber & Plotts, 2008). Approaches such as applied behavioral analysis (ABA) and positive behavioral support (PBS) are commonly used in schools to deal with problem behaviors (Adamek & Darrow, 2005; Madsen & Madsen, 2000; Webber & Plotts, 2008). Music therapy interventions that focus on generating socially appropriate behavior that is incompatible with inappropriate behavior have been successful with these children and teens (Hanser, 1999).

Treating Children and Teens with ADHD
Children and teens with ADHD have shown improvement in behaviors, attention, impulsivity, and activity level through behavior management and cognitive-behavioral techniques. Strategies and procedures with children and teens who have ADHD have been effective in improving maladaptive behaviors (Broden, Bruce, Mitchell, Carter, & Hall, 1970; Presti, 1984), increasing focus of attention (de l’Etoile, 2005), and teaching problem-solving skills (Sue & Sue, 2008; Webber & Plotts, 2008). Contingency management systems have included behavioral contracts and token economy systems to change targeted behaviors of children (Presti, 1984). Additionally, medication therapy has shown many beneficial short-term effects among children and teens with ADHD (Julien, 1998).

**Behavior Management.** Behavioral strategies such as positive reinforcement, behavior reduction procedures to reduce or eliminate negative behaviors, and the use of structure and routine have been successful in improving children’s behaviors associated with ADHD (Broden, et al., 2008). Behavior reduction procedures such as operant conditioning have been effective in increasing learning procedures and reducing behaviors that interfere with learning. Broden et al. (1970) found that contingent teacher attention increased the attending behaviors of children described as extremely disruptive. Presti (1984) examined the use of a contingency management system to change targeted behaviors of children attending a rehabilitation center. The researcher incorporated a hierarchical levels system in which children experienced different behavioral expectations, reinforcements, and consequences when they progressed to the next level. The researcher also used behavioral contracts to outline specific behaviors as well as token economy systems to reward the children for meeting behavioral goals.

Children and teens with ADHD have been shown to respond well to structure and routine (Adamek & Darrow, 2005; Webber & Plotts, 2008). A clear and orderly environment minimizes distractions so that students can focus on instruction and function more effectively. Suggestions for setting up a structured learning environment include keeping the room arrangement consistent, using assigned seating and placing children with ADHD away from distractions and close to the teacher, following a consistent routine in each class, setting clear expectations for desired behavior, minimizing downtime, and structuring transitions with countdowns and reminders (de l’Etoile, 2005).

**Cognitive-Behavioral Techniques.** Cognitive-behavioral techniques for children and teens with ADHD have included increasing attention and decreasing impulsivity. Cognitive-behavioral
Techniques are aimed at teaching children to practice and learn a set of self-statements and/or problem-solving sequences so that they are able to monitor and reinforce their own behavior. After learning how to monitor and reinforce their behavior, children are taught to evaluate their success through frequent check-ins with themselves. Examples of cognitive-behavioral techniques have included self-talk, self-monitoring, and problem solving (Sue & Sue, 2008; Webber & Plotts, 2008).

Medication Therapy. Medications to treat ADHD and symptoms of conduct disorder are controversial and have been widely studied. Sue and Sue (2008) reported that psychostimulant medications are the most commonly used and studied medications to treat individuals with ADHD. Webber and Plotts (2008) reported that physicians most commonly prescribe methylphenidate (Ritalin). Other drugs to treat symptoms of ADHD have included Dexedrine, Cylert, Straterra, Adderall, and Concerta. Short-term effects may be seen in children when taking stimulant medication, such as sustained attention, activity level, and improved classroom behavior. Medications and doses must be individualized in order to meet the needs of the child.

Controversy over the prescription and use of stimulant medications has been widespread due to their adverse side effects, a nationwide tendency for doctors to overprescribe, or doctors’ inappropriate recommendation of stimulant therapy. Side effects of stimulants may include headaches, stomachaches, insomnia, loss of appetite, irritability, mood swings, tics, and growth inhibition. Julien (1998) found that approximately 10-30% of children with ADHD do not respond to psychostimulant medication. Stimulants have the potential for clients’ illicit use, abuse, and dependence; thus, making them a Schedule II medication (controlled substance) (Sue & Sue, 2008). Children and teens receiving stimulant medication must be closely monitored to ensure appropriate use and dosage levels (Webber & Plotts, 2008).

Treating Children and Teens with Conduct Disorder

Searight, Rotnnek, and Abby (2001) warned that adolescents and younger children will often continue to have behavioral problems throughout their life if they and their families do not receive early and comprehensive treatment for their conduct disorders. Treating conduct disorders can be an extremely challenging task due to the range of maladaptive behaviors and the dysfunction frequently seen between parents and child (Webber & Plotts, 2008). In developing a comprehensive treatment plan for a child with a behavior disorder, treatment must involve all the people who routinely interact with the child: parents, teachers, and peers. Successful treatments
have included multidisciplinary approaches, parent management training, and problem-solving skills training.

**Parent Management Training and Problem Solving Skills Training.** Among youth with conduct disorders, parental involvement in the treatment process is equally important as their child’s involvement. Parent management training (PMT) involves interventions targeted at decreasing unsuccessful parenting habits and breaking the cycle of negative interactions between parent and child. Parents must learn new skills in order to support prosocial behaviors, including “establishing clear rules for behavior, using positive reinforcement, negotiating compromises, and using only mild forms of punishment” (Webster & Plotts, 2008, p. 305). Parent management training is not effective when parents are unavailable, unwilling, or unable to make commitments to treatment.

Lix, Zennaro, and Mazzeschi (2001) stated that parent management training is a cognitive-behavioral intervention that allows the therapist to work with the parents in the home, while problem solving skills training (PSST) is targeted at the way children think about and deal with social situations in order to develop interpersonal problem-solving skills. The emphasis of problem-solving skills training is on how children approach situations. They are taught step-by-step approaches to solve various interpersonal situations. Prosocial behaviors are selected as solutions to the problems and are taught through modeling and direct reinforcement. Children’s treatment often involves structured tasks such as games, academic activities, and stories. Therapists model the cognitive process, provide cues to use the skills, and provide feedback and praise in order to help children and families reach treatment goals (Kazdin, 2007).

**Multidisciplinary Approach.** The American Academy of Children and Adolescent Psychiatry (1997) developed the *Outline for Practice Parameters for the Assessment and Treatment of Children and Adolescents with Conduct Disorder.* It included five aspects of treatment: family interventions (parent guidance, training, and family therapy), individual and group psychotherapy, psychosocial skills building training, psychopharmacology, and additional psychosocial interventions including peer intervention, school intervention, juvenile justice system intervention, the Big Brother/Big Sister program, job and independent living skills training. Behavioral and psychotherapy have been shown to help children appropriately express and control their anger. Functional family therapy assumes that the problem behavior of the child
serves a function in the family. Goals include changing negative day-to-day interactions into more positive and adaptive ways of communicating.

School-based programming has included the use of functional behavioral assessments and positive behavioral interventions and supports (PBS). It is important to remember that parents may need professional assistance in the creation and implementation of special management and educational programs (Webber & Plotts, 2008). Bowen, Jenson, and Clark (2004) outlined several school-wide interventions that have been effective in reducing maladaptive behaviors. They have included school-wide bully prevention and social skills training, bus and cafeteria interventions, and structured recess. Positive behavioral support (PBS) has gained increasing acceptance as a form of school-based programming (Webster & Plotts, 2008). Adamek and Darrow (2002) defined the goal of positive behavioral support as improving the student and support provider’s daily life across all settings. Multiple strategies may be incorporated in order to match the needs of the student. Common positive behavioral support strategies have included:

- Functional behavioral assessments
- Alteration of home, school, classroom, and teacher variables based on assessment results
- Clear expectations and routines
- Skill training for alternative and replacement behaviors
- Contingency contracting (an “if…then” contract)
- Punishment only as necessary
- Self-monitoring
- Class-wide or cross-age peer tutoring
- Strategies for involving parents and community in schools (Adamek & Darrow, 2002; Webber & Plotts, 2008).

**Music Therapy and Behavior Disorders**

According to the American Music Therapy Association, music therapy is an established healthcare profession using music to address emotional, social, and cognitive needs for people of all ages (2009). Music is effective in capturing a child’s attention, allowing the child to have a sense of control in the environment, to create a safe space, to create a routine, and to provide opportunities for success (Brunk, 2004). Gaston (1968) suggested that rhythm activities facilitate internal organization through the structured use of the body. Additionally, music therapy engages
children in positive creative efforts that enhance self-awareness, self-expression, and self-esteem (Hanser, 1999).

Hanser (1999) noted that children with behavior disorders were the second most frequent population treated by music therapists. Cripe (1986) discussed the benefits of using music therapy as an alternative to traditional treatment among children with ADHD, which included its noninvasiveness, its ability to target one child with the use of a headset, and the ease at which it can be administered with regards to cost and music selection. Music therapy can be particularly effective for children and teens with behavior disorders in that music is a highly desirable activity that can be used as a competing behavior, as a contingency, or to modify inappropriate behavior, to modulate mood and/or physical activity, and to counsel (Adamek & Darrow, 2005).

Music therapy techniques may vary based on the behavior disorder diagnosis. Children and teens with ADHD may need music therapy to aid in behavioral, psychosocial, and cognitive goals (Jackson, 2003; Rickson, 2006), while children and teens with conduct disorder, oppositional defiant disorder, and disruptive behavior disorders may respond better to interventions focusing on social and psychosocial goals (Ficken, 1976; Kivland, 1986). Jackson (2003) surveyed board-certified music therapists to examine what music therapy methods were being used for children with an ADHD diagnosis, how effective the treatment was perceived to be, and the role that music therapy played in relation to other forms of treatment. Of the 500 questionnaires sent to music therapists who indicated that they worked with elementary-aged children, 268 responded to the questionnaire. Of these responses, 98 indicated that they currently worked with children with a diagnosis of ADHD. Upon examination of the questionnaires, Jones found that music therapists employed a variety of music therapy methods when working with children with ADHD. Music and movement was the method that most respondents used, followed by instrumental improvisation, musical play, and group singing. Regarding goals, respondents reported that behavioral goals were addressed most frequently, followed by psychosocial goals and cognitive goals.

Using techniques such as music making through ensemble performance, individual lessons, and instrument playing, songwriting, and lyric analysis, music therapists are able to focus attention and modify behavior in order to address therapeutic goals (Hanser, 1999). Music therapists have often used music making and performance techniques to motivate youth with behavior disorders. Research has shown music making mediums such as individual piano lessons
(Kivland, 1986), ukulele lessons (Michel & Martin, 1970), hip-hop therapy (Tyson, 2002), and instrumental improvisation (Rickson, 2006) can have a positive impact on the behavior and psychosocial health of children and teens with behavior disorders.

A review of the literature revealed seven therapeutic goals for clients with behavior disorders. These seven therapeutic goals include: 

a) increased self-esteem, 
b) increased self-expression, 
c) increased attention to task, 
d) increased socially appropriate behavior and group cohesion, 
e) decreased motor activity and impulsivity, and 
f) decreased aggression and hostility.

To better understand the use of music therapy with children and teens with behavior disorders, each therapeutic goal will be discussed. Additionally, the goals, interventions, and techniques used in research studies will be outlined.

**Increased self-esteem.** Research studies have demonstrated the therapeutic benefits of music on self-esteem. Ficken (1976) found that songwriting increased self-esteem in psychiatric patients. The author discussed the validation that the patient received through the songwriting process, resulting in feelings of emotional support and feedback for his/her thoughts and feelings. Kivland (1986) examined the use of individual piano lessons on self-esteem and peer acceptance of a male adolescent diagnosed with conduct disorder. Results showed a decrease in participants’ negative self-statements and an increase in their prompted positive self-statements throughout the course of intervention. Behaviors developed in music therapy reportedly transferred to other areas of the adolescent’s life as well.

**Increased self-expression.** Similar to self-esteem, self-expression can be increased through the therapeutic use of music. Tervo (2001) suggested that rock music provided an opportunity for self-expression and exploration of emotions among adolescents in a psychiatric unit. The author described the use of rock music among adolescents as a tool to “connect with a wide range of emotions including love, longing, anger, sadness, shame, and sexuality” (p. 81). In conjunction with psychotherapy, rock music in therapy aided the adolescents in verbal expression of feelings and getting them “in touch with youth culture” (p. 89).

Songwriting is considered to be a safe, non-threatening medium for self-expression among children and teens. It has been used with adolescents to address self-esteem, self-expression, and other therapeutic goals relating to emotional difficulties. The music therapist generally assists individuals by brainstorming with them, organizing lyrics, and offering choices regarding musical aspects of the song. Ficken (1976) found that songwriting helped clients to express
emotions, to enhance social interaction, and to recover repressed feelings. The author recommended approaching lyric writing through steps of approximation, based on the level of functioning and comfort of the client.

Freed (1976) found that songwriting among patients who were chemically dependent helped facilitate self-disclosure, assess self-concept, and increase self-esteem. Through songwriting techniques such as filling in specific words or completing lead-in sentences of edited popular songs, patients felt more positive about themselves and discovered the motivation to change. Frisch (1990) used songwriting with adolescent psychiatric inpatients to express intense emotions, cope with anxiety and change, and work through difficult issues in a safe and appealing environment. Songwriting was effective in assisting clients to work through self-identification and in building ego strength. Additionally, music was used to facilitate trust between music therapist and client, to help the client learn to relate, trust, and to work through exploration and expression of feelings.

Increased attention and focus. Music therapists have focused on reducing children’s hyperactivity in order to increase their attention and focus, and to aid them in learning tasks. In a 1986 study, Cripe found that rock music significantly reduced hyperactivity in boys with ADHD. Lindsey (1998) found that when preferred background music was used contingently during academic study periods with youth in a residential treatment program, on-task study time significantly increased. When comorbidity occurs between behavior disorders and learning disabilities, interventions should address related needs. In an examination of the use of melodic-rhythmic music as a memory aid to learn academic tasks among children with learning disabilities, Gfeller (1983) found multiple repetitions of music, combined with modeling and cuing, was an effective strategy in producing greater recall.

Increased socially appropriate behavior. Several researchers have used music as positive reinforcement to reduce inappropriate behaviors. Hauck and Martin (1970) used music as a reinforcer and a patient-controlled time-out procedure to eliminate unwanted behavior in an adult with schizophrenia. Ficken (1976) found that songwriting in psychiatric settings aided in participants’ interaction and encouraged socially acceptable behavior in the group process. Hip-hop therapy (HHT) was found to improve self-concept and peer relations in at-risk and delinquent youth (Tyson, 2002). Data also suggested that the participants were more enthusiastic toward treatment due to the hip-hop therapy. The researchers discussed that using popular song
lyrics from rap music was a culturally relevant way to meet the treatment goals of adolescents. Similarly, Horton (2005) found that stepping as a treatment intervention significantly increased group cohesion and the positive oral statements of female adolescents identified as at-risk for dropping out of school, engaging in violent and risky sexual behaviors, and developing a psychological disorder.

Researchers have demonstrated that establishing and maintaining musical contingencies can improve clients’ behaviors (Cook & Freethy, 1973; Reid, Hill, Rawers, & Montegar, 1975; Madsen, Cotter, & Madsen, 1968; Madsen & Madsen, 1976; Wilson, 1976). Cook and Freethy (1973) found that the contingent use of music was helpful in eliminating inappropriate behavior (complaining) in a woman diagnosed with mild mental retardation and schizophrenia. Reid, Hill, Rawers, and Montegar (1975) conducted three experiments with a child who was non-verbal and hyperactive in order to examine the contingent use of music to teach appropriate social skills. The researchers found that the use of contingent music increased the child’s appropriate walking and car riding behaviors and decreased maladaptive baseline behaviors (e.g. rocking, bouncing, climbing, and kicking). Researchers also found that contingent music in combination with Ritalin eliminated all inappropriate car-riding behaviors.

The contingent use of music (guitar lessons) was an effective reward for appropriate behavior and completion of work tasks in an adolescent with aggression and delinquent behavior, as evidenced by his subsequent improvements in work and interpersonal skills and decreases in delinquent activity (Madsen & Madsen, 1976). Additionally, Wilson (1976) used rock music in conjunction with a time-out procedure to decrease inappropriate or disruptive behaviors in children with behavior disorders. If a child exhibited a behavior that was inappropriate or disruptive in the classroom, the music was contingently withdrawn. Lastly, Krout (1988) described the use of electronic resources (computer and software system, digital electronic synthesizer, and digital electronic rhythm composer) to increase socially appropriate behaviors and to teach music to middle school students with behavior disorders.

Decreased motor activity and impulsivity. Studies among the behavior disorder population and additional populations have revealed the benefits of using music to decrease motor activity and impulsivity (Cripe, 1986; Davis, Wieseler, & Hanzel, 1983; Reardon & Bell, 1970; Rickson, 2006; Rieber, 1965;). Cripe (1986) found rock music to be effective in reducing motor activities in children with ADD, though it was not effective in increasing their attention
span. Using percussion ensembles, Rickson (2006) examined the difference between instructional and improvisational music therapy on motor impulsivity in adolescents with ADHD. Results showed no significant difference between the instructional and improvisational approaches on participants’ motor impulsivity. However, Rickson suggested that music therapy may have contributed to a reduction of other participants’ ADHD symptoms in the classroom.

*Decreased aggression and hostility.* Research has demonstrated that active music making has been an effective technique in decreasing aggression and hostility. Populations utilizing such music interventions have included adolescents with diagnoses of ADHD, conduct disorder, and oppositional defiant disorder (Montello & Coons, 1998; Rickson & Watkins, 2003). These interventions included passive music listening, active rhythm-based activities, opportunities to learn about and care for musical instruments, and group songwriting. Goals addressed through instrument playing included increasing attention, motivation, positive peer relationships, and awareness of the existence and feelings of others, while reducing aggression and hostility.

Montello and Coons (1998) examined the effects of active rhythm-based versus passive listening-based group music therapy treatment on the attention, motivation, and hostility of young adolescents with emotional, learning, and behavior disorders. They found that subjects reduced aggression and hostility after receiving either the passive or active listening intervention. Similarly, Rickson and Watkins (2003) examined the effects of active music making versus listening activities in reducing aggressive behaviors among adolescent boys with intellectual, social, and emotional deficits. They found that for subjects with less severe attention deficits, the music therapy program increased their awareness of the existence and feelings of others and assisted in their development of positive peer relationships with peers. Among those with the greatest attention problems, the data revealed an increase in classroom disruptive behaviors after each active music therapy session. The authors suggested that future interventions be employed with more structured approaches in order to avoid overstimulation.

**Theoretical Approaches Employed by Music Therapists**

When E. Thayer Gaston helped establish the music therapy profession in the 1940s, he made theoretical inferences to human behavior from physiological, psychological, and sociological bases (Gaston, 1968). Music therapists began conducting scientific research; however, there was limited conclusive evidence of the effects of music on human behavior. In attempts to rationalize their work, therapists began adopting theories from psychotherapy (Choi,
Early music therapy theorists include Helen Bonny, Charles Eagle, E. Thayer Gaston, Clifford Madsen, Paul Nordoff, Clive Robbins, Mary Priestley, and William Sears (Aigen, 2009). Today, the prominent theoretical approaches to music therapy practice and research are categorized into three major areas: the psychotherapeutic model, the medical model, and approaches adapted from music education (Darrow, 2008).

Many colleges and universities identify with a specific therapeutic approach that may affect the way music therapists approach working with the behavior disorder population. Children and teens that have behavior disorders present significant challenges to teachers, peers, and families. It is advisable for music therapists to understand their therapeutic approach in working with this population, particularly in relationship to the related evidenced-based research. These music therapy approaches are discussed in the following order: behavioral, Nordoff-Robbins, Bonny Method of Guided Imagery and Music, Benenzon, analytical, humanistic, Orff, Neurological Music Therapy, creative, and eclectic.

**Behavioral.** Behavior therapy evolved from B. F. Skinner’s work on behaviorism into a systematic, research-based approach that includes cognitive-behavioral approaches for resolving psychological problems. Applied behavior analysis (ABA) is the basic research component of behaviorism (Standley, Johnson, Robb, Brownell, & Kim, 2008). Sulzer-Azaroff and Mayer (1977) defined applied behavior analysis as a “systematic, performance based, self-evaluative method of changing behavior…used in the prevention and amelioration of behavioral problems and programs for learning” (p. 6). It has many qualities: it is performance-based (focuses on what people do), it identifies behaviors that can be changed and/or modified, it is analytic and can therefore be measured, and it is concerned with improving social behaviors. Applied behavior analysis has been effective in increasing behaviors through reinforcements, reducing negative behaviors, and teaching new behaviors. Music therapists use techniques such as reinforcement, punishment, extinction, contingencies, token economies, and stimulus control to reduce maladaptive behaviors and to increase desired behaviors (Madsen & Madsen, 2000; Standley et al., 2008).

Standley et al. (2008) defined the operant techniques involved in teaching new behaviors as task analysis, prompts, fading, errorless learning, chaining, shaping, successive approximations, and modeling. These techniques are used to “introduce or structure an environmental antecedent event that will encourage an appropriate behavioral response” (p. 110). Additionally, cognitive-
behavioral techniques are used in combination with operant techniques to facilitate therapeutic success by focusing on the three domains of emotional stress – cognitive, behavioral, and physiological. Music therapists have reduced clients’ emotional stress using techniques such as cognitive restructuring, exposure to an undesired stimulus, contingency procedures, psychoeducation, anger management, biofeedback, and relaxation.

Music therapists began incorporating behavioral research designs in the late 50s and early 60s as part of evidenced-based practice (Gregory, 2002). Presti (1984) described a music therapy levels system to shape behaviors in children with severe behavior disorders attending a rehabilitation center. The levels system was a behavioral methodology of contingency management that allowed the music therapist to shape targeted behaviors through a hierarchical structure. The children progressed to a new level when they achieved targeted behaviors. Each level included different behavioral expectations, reinforcements, and consequences. Maultsby (1977) was a behavioral music therapist who encouraged the combination of music therapy with Rational Behavior Therapy (RBT) in order to stimulate and reinforce learning. In an examination of articles published in the Journal of Music Therapy from 1964 through 1999, Gregory (2002) found that 15.8% of the articles included a behavioral research design. Additionally, a survey by Silverman (2007) found that 83.1% of music therapists in psychiatric settings reported using behavioral methodologies.

**Nordoff-Robbins.** The Nordoff-Robbins approach to music therapy was developed in 1959 from the work of Paul Nordoff and Clive Robbins. Nordoff-Robbins music therapists focus on the belief that everyone can respond to music (Kim, 2005). Improvisational and compositional techniques are tailored to fit individual needs using piano and voice to stimulate, support, and develop children’s responses (Nordoff & Robbins, 1977). Nordoff-Robbins music therapists use individual and group therapy to serve diverse populations, including clients with learning disabilities and psychiatric needs, and clients in palliative care. The approach is popular throughout the United States, the United Kingdom, South Africa, Australia, and Germany.

**Bonny Method of Guided Imagery and Music.** Developed in the early 1970s by Dr. Helen Bonny, this approach to music psychotherapy consists of specifically programmed classical music and images created from the imagination. The music therapists’ facilitation of the creative experience involves bringing the relaxed client’s mental images to conscious awareness in order to help integrate new experiences into everyday life. These mental images may include emotions,
sensory images, physical sensations, memories, thoughts, or visual pictures. The relaxation and music involved in this approach bring about an altered state of consciousness that facilitates conflict resolution. The goal of guided imagery and music is to generate growth, healing, and transformation. The approach has been applied with a variety of clients, including people with medical conditions, autism, emotional disturbances, depression, chronic pain, traumatic brain injury, and addiction (Goldberg, 1995).

Benenzon. Benenzon (1981) defined music therapy as the clinical use of the “sound-man complex” – sound being the constant variable before a human’s birth and accompanying it through every moment of its life. Further, “from a scientific point of view, music therapy is a branch of science that deals with the study and investigation of the sound-man complex, whether the sound is musical or not, so as to discover the diagnostic elements and the therapeutic methods inherent in it. From a therapeutic point of view, music therapy is a para-medical discipline that uses sound, music, and movement to produce regressive effects and to open channels of communication that will enable us to start the process of training and recovering the patient for society” (p. 3). In summarizing this approach, Bruscia (1998) wrote “Benenzon believes that sound, music, and movement produce regressive effects that open up channels of communication which stimulate the process of training and recovery” (p. 26).

Analytical. Created by Mary Priestley, analytical music therapy (AMT) was born out of psychoanalysis and consists of guided music experiences between music therapists and clients. Analytical music therapists use musical improvisations to lower clients’ threshold of consciousness, bring forth vivid memories, and reduce emotional denial. Clients are taught to express emotions less painfully and to use aggression and assertiveness in non-threatening ways. Analytical music therapists have served couples in therapy, recidivists, children with emotional and behavior disorders, and clients with depression. Goals of the approach have included enhancing clients’ inner freedom and ability to express difficulties, supporting personal development, and increasing effective coping skills (Mahns, 2002; Priestley, 1994).

Humanistic. Therapists who identify with humanistic psychotherapies view people as unique, self-actualizing, self-aware, and responsible to choose how they will live (Cain, 2002). People are viewed as primarily social beings that need to belong and feel valued. Humanistic therapies are made up of theories (client-centered, existential, and gestalt) that view people holistically, focus on the client-centered relationship, and rely on the human science model (Sue
Humanistic therapists oppose natural science approaches that stress experimental designs, objective measures, and clearly defined goals (Cain, 2002). A study by Norcoss, Hedges, and Castle (2002) found that the number of primarily humanistic psychotherapists decreased from 14% to less than 6% in 2001. In reviewing the literature, there have been no research studies regarding the use of humanistic music therapy with the behavior disorder population.

**Orff-Based Music Therapy.** German musician and composer Carl Orff began developing the Orff Schulwerk approach to music education in the early 1920s. Orff used a variety of instruments to develop his curriculum and to reform music education. The approach focused on rhythm with the use of body sounds, gestures, and improvisation techniques (Orff, 1980). Orff Schulwerk began to be incorporated into music therapy in 1962 when Keller applied the techniques to children with emotional disturbances, intellectual and physical disabilities, Down syndrome, and spastic paralysis. Orff-based music therapists now use techniques such as exploration, imitation, improvisation, and creation to serve a variety of clients. Orff-based music therapists address clients’ goals by allowing music to speak through expression (Colwell, Pehotsky, Gillmeister, & Woolrich, 2008).

**Neurological Music Therapy.** Developed by Dr. Michael Thaut and his colleagues at the Center for Biomedical Research in Music (CBRM) at Colorado State University, Neurological music therapy (NMT) is “the therapeutic application of music to cognitive, sensory and motor dysfunctions due to neurologic disease of the human nervous system (Thaut, 1999, p.1). Neurological music therapy is a scientific, research-based system of standardized clinical techniques that combines neuroanatomy, neurophysiology, brain pathology, medical terminology, and rehabilitation of cognitive and motor functions. The approach is used in sensorimotor training, speech/language training, and neurodevelopmental therapy with clients who need neurologic rehabilitation, neuropediatric therapy, neurogeriatric therapy, and neurodevelopmental therapy. Neurological music therapists serve a variety of clients, including people with Parkinson’s disease, multiple sclerosis, muscular dystrophy, Alzheimer’s disease, Huntington’s disease, cerebral palsy, autism, severe visual impairments, developmental delays, and clients who have had a cerebralvascular accident (CVA) or a traumatic brain injury (TBI) (Standley et al., 2008).
Creative. While creative therapy is not a theoretical approach, many therapists consider themselves to have a creative identity. The National Coalition of Creative Arts Therapies Associations is an organizational network representing over 8,000 members of six creative arts therapies associations (NCCATA, 2010). Poetry, drama, art, dance, and music therapists utilize the arts to facilitate healing and behavioral change with individuals of all ages in various treatment settings and schools (NCCATA, 2010). In discussing the use of creative arts therapies, Bruscia (1989) stressed the importance of the therapist’s special talent and the client’s receptivity to that art form in facilitating the treatment process.

Over the past 40 years researchers have examined the effects of creative arts in therapy. Poetry therapy has been shown to enhance self-expression and group cohesion, strengthen communication skills, and release tension (Gillispie, 2005; Jackson, Muro, and Parker, 2008; Pehrsson & McMillen, 2005). Once group cohesion is established, the poems, stories, etc. can be expanded to fit the needs of the clients. Participants must be at a developmental level in which they are capable of reading, writing, and demonstrating abstract thought (Pehrsson & McMillen, 2005).

Similar to poetry therapists, art therapists address children’s needs by creating an environment in which children can express attachment, overcome difficulties with visual discrimination, problem solve, convey narrative content, increase self-awareness, and growth creatively (Henley, 1998). Henley (1998) described an art therapy program designed to increase socialization of children with ADHD through activities such as free play, group circle, and creative art experiences including impromptu art making and sand therapy. Sand therapy is a tool utilized by art therapists to assist children in introducing characters, struggle with conflict, and then resolve the conflict.

Movement and dance are used creatively in therapy to facilitate expression of strengths and emotions. Gronlund, Renck, and Weibull (2005) discussed the benefits of dance therapy with children who have ADHD. Movement, exercise, and dance increase dopamine in the human brain, which can lead to increased feelings of enjoyment and reinforcement. Bruscia (1989) discussed music’s relationship with other art forms, as they are often intermingled. Dance therapy is often facilitated and structured by music. Music therapists who follow a creative identity may use combined art forms including song-writing, musical story telling, drama, movement to music, musical rituals, and drawing to music.
Eclectic. Goldfried and Norcross (1995) discussed a “dissatisfaction with single-school approaches” and a “concomitant desire to look across theoretical boundaries to see what can be learned from other ways of conducting psychotherapy” (p. 254). Those who use an eclectic approach (also called integrative) attempt to increase therapeutic effectiveness by integrating theories and building on their documented successes. Techniques are chosen based on each client’s problem complexity, motivational distress, resistance level, and coping style. Eclectic music therapists use techniques such as audio/video feedback, problem solving, cognitive-restructuring, self-change techniques, homework assignments, self-control training, imagery, fantasy, social skills training, behavioral contracting, and relaxation. Music therapists have yet to conduct research studies with the behavior disorder population using an eclectic approach.

Rationale and Purpose for the Study

The music therapy literature has provided considerable insight into common goals and objectives used in the treatment of clients with behavior disorders (Adamek & Darrow, 2005; Cripe, 1986; Frisch, 1990; Kivland, 1986; Jackson, 2003; Montello & Coons, 1996; Rickson & Watkins, 2003; Wilson, 1976). However, no studies could be found that examined the influence of academic preparation or professional identity on music therapists’ approach to working with children and teens who have behavior disorders. This examination will contribute to an understanding of the role music therapists’ academic preparation and theoretical orientation play on their approaches to treating children and teens with behavior disorders. Knowledge of the goals and interventions used most frequently with this population will provide information to researchers regarding those practices that warrant investigations of effectiveness.

The purpose of this study was to examine the therapeutic approaches employed by music therapists servicing children and teens with behavior disorders. The therapeutic approaches will be examined in relation to: (a) the frequency of approaches (behavioral, analytical, Nordoff-Robbins, etc.) employed by music therapists, (b) the degree to which interventions employed by music therapists followed the research literature on evidence-based practice with children and teens who have behavior disorders, (c) the degree to which therapists’ approaches were influenced by their academic training (approach stressed by their university program) and by their professional identity (behaviorist, Nordoff-Robbins practitioner, etc.), and (d) the degree to which therapists’ approaches influenced the goals they addressed, and (e) the degree to which therapists’ approaches influenced the interventions they used with children and teens who have
behavior disorders.

Research Questions

1. What are the major approaches employed by music therapists servicing children and teens who have behavior disorders?
2. What is the influence of music therapists’ academic training and their professional identity on the approaches they employ to treat children and teens with behavior disorders?
3. What is the influence of music therapists’ therapeutic approach on the goals they address with children and teens who have behavior disorders?
4. Do the therapeutic interventions used by music therapists follow the research literature on effective practices with children and teens who have behavior disorders?
5. What is the influence of music therapists’ therapeutic approach on the interventions they employ with children and teens who have behavior disorders?
CHAPTER 3
METHOD

This chapter includes information on the participants, development of the questionnaire, and procedures for dissemination of the questionnaire.

Participant Information

In order to identify professional music therapists who work with the behavioral disorder population, the complete 2009 American Music Therapy Association membership roster was examined and a list was compiled of board-certified music therapy professionals currently providing music therapy services to clients with behavior disorders. That list included a total of 367 music therapy professionals. Among these professionals, 338 had email addresses listed in the sourcebook. Seventeen addresses (5%) were not working email addresses and 31 professionals (9.2%) informed the researcher they no longer worked with the behavior disorder population. Among these remaining 290 professionals, 114 responded, resulting in a 39.3% return rate.

Demographic Information. As expected, the majority of participants were female. More participants were in the 31-40 age group than other age groups, and more participants lived in the Great Lakes AMTA region than other regions. More participants had a bachelor’s or master’s degree than a graduate equivalency or doctoral degree. More participants had been practicing music therapy for six to ten years than less than five years and more than 11 years, and more participants had been serving the behavior disorder population for zero to five years than more than six years (Table 1).
Table 1
*A Distribution of Participants’ Demographic Information*

<table>
<thead>
<tr>
<th>Respondents’ Characteristic Categories</th>
<th>Individual Characteristics</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>93.0</td>
</tr>
<tr>
<td>Age</td>
<td>31-40</td>
<td>31.6</td>
</tr>
<tr>
<td></td>
<td>41-50</td>
<td>25.4</td>
</tr>
<tr>
<td></td>
<td>21-30</td>
<td>19.3</td>
</tr>
<tr>
<td></td>
<td>51-60</td>
<td>19.3</td>
</tr>
<tr>
<td></td>
<td>Over 60</td>
<td>4.4</td>
</tr>
<tr>
<td>AMTA region</td>
<td>Great Lakes</td>
<td>20.9</td>
</tr>
<tr>
<td></td>
<td>Mid-Atlantic</td>
<td>17.3</td>
</tr>
<tr>
<td></td>
<td>Southeastern</td>
<td>16.4</td>
</tr>
<tr>
<td></td>
<td>Southwestern</td>
<td>15.5</td>
</tr>
<tr>
<td></td>
<td>Midwestern</td>
<td>10.9</td>
</tr>
<tr>
<td></td>
<td>New England</td>
<td>10.9</td>
</tr>
<tr>
<td></td>
<td>Western</td>
<td>8.2</td>
</tr>
<tr>
<td>Highest academic degree obtained</td>
<td>Bachelor’s degree</td>
<td>44.7</td>
</tr>
<tr>
<td></td>
<td>Master’s degree</td>
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</tr>
<tr>
<td></td>
<td>Graduate equivalency</td>
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<td></td>
<td>Doctoral degree</td>
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</tr>
<tr>
<td>Years practicing music therapy</td>
<td>6-10 years</td>
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</tr>
<tr>
<td></td>
<td>0-5 years</td>
<td>21.1</td>
</tr>
<tr>
<td></td>
<td>11-15 years</td>
<td>18.4</td>
</tr>
<tr>
<td></td>
<td>16-20 years</td>
<td>11.4</td>
</tr>
<tr>
<td></td>
<td>Over 31 years</td>
<td>10.5</td>
</tr>
<tr>
<td></td>
<td>21-25 years</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>26-30 years</td>
<td>7.0</td>
</tr>
<tr>
<td>Years practicing with behavior disorders population</td>
<td>0-5 years</td>
<td>34.5</td>
</tr>
<tr>
<td></td>
<td>6-10 years</td>
<td>21.2</td>
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<tr>
<td></td>
<td>11-15 years</td>
<td>18.6</td>
</tr>
<tr>
<td></td>
<td>16-20 years</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>21-25 years</td>
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<td></td>
<td>26-30 years</td>
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<tr>
<td></td>
<td>Over 31 years</td>
<td>6.2</td>
</tr>
</tbody>
</table>

*Behavior Disorder Caseload and Music Therapy Settings Information.* Participants reported serving children and teens with ADHD most often. Participants who reported other populations specified serving children and teens with behavior disorders and comorbid conditions including depression, bipolar affective disorder, psychotic disorder, anxiety disorder,
Asperger’s, autism spectrum disorder, Tourette’s, cerebral palsy, Pallister Killian Syndrome, Down syndrome, reactive attachment disorder, eating disorders, and teens who are chemically dependent. Children and teens of all ages were seen, with the most frequent age group reported as children 5-7 years old. The setting in which participants reported serving these children and teens most frequently was at school. Other settings in which participants reported serving children and teens with behavior disorders included a community music school, air force base, health department, outreach program, intensive outpatient program, child welfare agency, summer camps through a behavioral health program, and social service agency (Table 2).

Table 2  
**Behavior Disorder Caseload and Music Therapy Settings Information**

<table>
<thead>
<tr>
<th>Options</th>
<th>Percentage of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Populations Served</td>
<td></td>
</tr>
<tr>
<td>Attention deficit hyperactivity disorder</td>
<td>90.1</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>69.4</td>
</tr>
<tr>
<td>Impulsive behavior disorder</td>
<td>59.5</td>
</tr>
<tr>
<td>Abused</td>
<td>56.8</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>55.0</td>
</tr>
<tr>
<td>Disruptive behavioral disorder</td>
<td>53.2</td>
</tr>
<tr>
<td>Cognitive behavioral disorder</td>
<td>45.0</td>
</tr>
<tr>
<td>Juvenile delinquents</td>
<td>35.1</td>
</tr>
<tr>
<td>Other</td>
<td>20.7</td>
</tr>
<tr>
<td>I do not have access to the diagnosis</td>
<td>9.9</td>
</tr>
<tr>
<td>Ages of Children</td>
<td></td>
</tr>
<tr>
<td>5-7 years old</td>
<td>66.4</td>
</tr>
<tr>
<td>8-10 years old</td>
<td>65.4</td>
</tr>
<tr>
<td>11-12 years old</td>
<td>64.5</td>
</tr>
<tr>
<td>17-18 years old</td>
<td>59.8</td>
</tr>
<tr>
<td>13-14 years old</td>
<td>57.0</td>
</tr>
<tr>
<td>15-16 years old</td>
<td>54.2</td>
</tr>
<tr>
<td>Younger than 4</td>
<td>45.8</td>
</tr>
<tr>
<td>Clinical Settings</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>54.1</td>
</tr>
<tr>
<td>Residential placement</td>
<td>21.6</td>
</tr>
<tr>
<td>Private clinic</td>
<td>19.8</td>
</tr>
<tr>
<td>Other</td>
<td>18.0</td>
</tr>
<tr>
<td>Client’s home</td>
<td>15.3</td>
</tr>
<tr>
<td>Psychiatric placement</td>
<td>13.5</td>
</tr>
<tr>
<td>Early childhood center</td>
<td>12.6</td>
</tr>
<tr>
<td>Hospital</td>
<td>9.0</td>
</tr>
<tr>
<td>Group home</td>
<td>4.5</td>
</tr>
<tr>
<td>Rehabilitation center</td>
<td>2.7</td>
</tr>
<tr>
<td>Detention center</td>
<td>2.7</td>
</tr>
</tbody>
</table>
More participants reported utilizing small group sessions. The majority of participants indicated that they used live, commercially-available, popular music more frequently than recorded and/or therapist-client composed music of other genres. Participants who indicated that they used other music genres specified using blues, folk, reggae, Greek music, marches, NMT CDs, world music, culturally-specific music, gospel, instrumental, silly camp songs, Spanish/Latin music, metal, rage, original, and improvised music (Table 3).

Table 3
*Music Therapy Session Information for Children and Teens with Behavior Disorders*

<table>
<thead>
<tr>
<th>Options</th>
<th>Percentage of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Session</strong></td>
<td></td>
</tr>
<tr>
<td>Small group</td>
<td>65.8</td>
</tr>
<tr>
<td>Individual</td>
<td>24.3</td>
</tr>
<tr>
<td>Large group</td>
<td>5.4</td>
</tr>
<tr>
<td>Other</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Method of Music Delivery</strong></td>
<td></td>
</tr>
<tr>
<td>Live</td>
<td>66.4</td>
</tr>
<tr>
<td>Recorded</td>
<td>33.6</td>
</tr>
<tr>
<td><strong>Musical Originality</strong></td>
<td></td>
</tr>
<tr>
<td>Commercially-available</td>
<td>66.7</td>
</tr>
<tr>
<td>Therapist-client composed</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Music Genre</strong></td>
<td></td>
</tr>
<tr>
<td>Popular</td>
<td>80.2</td>
</tr>
<tr>
<td>Children’s songs</td>
<td>56.8</td>
</tr>
<tr>
<td>Rock</td>
<td>50.5</td>
</tr>
<tr>
<td>Hip-hop</td>
<td>45.9</td>
</tr>
<tr>
<td>Country</td>
<td>45.0</td>
</tr>
<tr>
<td>Rap</td>
<td>43.2</td>
</tr>
<tr>
<td>R&amp;B</td>
<td>43.2</td>
</tr>
<tr>
<td>Classic Rock</td>
<td>42.3</td>
</tr>
<tr>
<td>Classical</td>
<td>41.4</td>
</tr>
<tr>
<td>Oldies (50s, 60s, 70s)</td>
<td>35.1</td>
</tr>
<tr>
<td>Other</td>
<td>35.1</td>
</tr>
<tr>
<td>Alternative</td>
<td>29.7</td>
</tr>
<tr>
<td>Broadway/Musicals</td>
<td>22.5</td>
</tr>
<tr>
<td>New Age</td>
<td>21.6</td>
</tr>
<tr>
<td>Jazz</td>
<td>19.8</td>
</tr>
<tr>
<td>Religious</td>
<td>18.0</td>
</tr>
<tr>
<td>Heavy Metal</td>
<td>13.5</td>
</tr>
<tr>
<td>Punk</td>
<td>9.0</td>
</tr>
<tr>
<td>Techno</td>
<td>8.1</td>
</tr>
</tbody>
</table>
Instrument Development

In order to select theoretical approaches and music therapy strategies to be used in the questionnaire, the researcher reviewed articles and books within the music therapy, psychiatric, and psychotherapy literature. Following this review of literature, an initial draft of the questionnaire was developed and reviewed by a panel of practicing music therapists. After integrating the suggested changes into the questionnaire, a cover letter was written, which included an invitation to participate, the purpose of the study, and conditions of informed consent. The questionnaire, cover letter, and other necessary information were then submitted to the Florida State University’s Institutional Review Board (IRB) for approval prior to administration.

Questionnaire

The questionnaire consisted of 28 questions and addressed participants’: a) demographic info (items #1-4), b) education information (items #5-9 and 11), c) music therapy approach (item #10), d) music therapy experience (items #12 and 13), e) behavior disorder caseload (items #14-17), f) music therapy information (items #18-22), g) music information (items #23-24 and 25-26) and h) non-music techniques (item #27). The final statement thanked participants for completing the survey and invited them to share any other information they felt was pertinent to the clinical practice of music therapy with children and teens who have behavior disorders. The questionnaire items addressed the five research questions. Research question one was addressed by item #10, question two was addressed by items #4-10, question three was addressed by items #10 and 18, question four was addressed by item #22, and question five was addressed by items #10 and 22 (See Appendix A).

Procedure

Following the approval of the university IRB, the researcher created the online survey using Survey Monkey. Participants were invited by email to participate in the survey. There was a cover letter (serving as letter of informed consent) and a link in the email to take them to the online survey (Appendix B). Subjects were notified that they had two weeks to complete the survey and that they would receive an email prompt to complete the survey one week prior to the time it would close. The survey was estimated to take between 10-15 minutes to complete. Completion of the survey was viewed as consent. All participation was voluntary and responses were kept confidential to the extent allowed by law. Participants were notified that their name
would not be associated with the research findings. The survey was open and responses were collected for two weeks. The researcher sent follow-up reminders at one week, two weeks, 15 days, and 16 days. After 17 days, the survey was closed and data analysis began.

Data Analysis

Descriptive and comparative analyses, primarily in the form of frequency count data and graphs, were computed and charted for the majority of survey questions. For a majority of the questions, percentages of responses were taken from the data provided by Survey Monkey. Several comparison tables were made using Microsoft Word to examine the trends between specific groups of data, such as the university programs where participants’ music therapy degree(s) were obtained, the university programs’ theoretical approaches, participants’ therapeutic approaches, and the therapeutic interventions participants use in working with clients who have behavior disorders. The results of the survey were analyzed and are presented in the following chapter.
CHAPTER 4
RESULTS

This chapter includes the research questions, presentation of the data used to address the research questions, and a summary response to each question.

Data Analysis for Research Question One

What are the major approaches employed by music therapists servicing children and teens with behavior disorders?

Table 4
A Rank Order of Approaches Used by Music Therapists Working with the Behavior Disorder Population

<table>
<thead>
<tr>
<th>Rank Order of Approach Use</th>
<th>Approach</th>
<th>Percentage of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Behavioral</td>
<td>46.4</td>
</tr>
<tr>
<td>2</td>
<td>Eclectic</td>
<td>44.5</td>
</tr>
<tr>
<td>4</td>
<td>Creative</td>
<td>14.5</td>
</tr>
<tr>
<td>5</td>
<td>NMT</td>
<td>12.7</td>
</tr>
<tr>
<td>6</td>
<td>Nordoff-Robbins</td>
<td>11.8</td>
</tr>
<tr>
<td>7</td>
<td>Psychoanalytical</td>
<td>9.1</td>
</tr>
<tr>
<td>8</td>
<td>Guided imagery and music</td>
<td>7.3</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>7.3</td>
</tr>
<tr>
<td>9</td>
<td>Orff</td>
<td>6.4</td>
</tr>
</tbody>
</table>

Response to Research Question One. Participants’ approaches are rank ordered in Table 2. Results indicated that the most frequently utilized approach was behavioral, followed closely by eclectic. Some of the participants (13.60%) reported that they did not utilize a professional approach. Participants’ responses in the other category included humanistic, client-centered, biomedical, Jungian, trauma informed, Gestalt, and rational emotive.
Data Analysis for Research Question Two

*What is the influence of music therapists’ academic training and their professional identity on the approaches they employ to treat children and teens with behavior disorders?*

**Table 5**

*A Comparison of Matches Between University and Professional Approaches*

<table>
<thead>
<tr>
<th>Participant</th>
<th>University where Music Therapy Degree(s) Obtained</th>
<th>University’s Approach</th>
<th>Professional Approach</th>
<th>Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1. Alverno College 2. Temple University</td>
<td>1. Eclectic 2. Psychoanalytical, other</td>
<td>Eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Alverno College</td>
<td>Eclectic</td>
<td>Biomedical</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>American University</td>
<td>Behavioral, Nordoff-Robbins, creative, eclectic</td>
<td>Eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>1. Arizona State University 2. Temple University</td>
<td>1. Behavioral 2. GIM, other</td>
<td>Behavioral, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Baldwin Wallace College</td>
<td>Behavioral, GIM, psychoanalytical</td>
<td>Behavioral, psychoanalytical</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Berklee College of Music</td>
<td>Behavioral, Nordoff-Robbins, eclectic</td>
<td>Behavioral, Nordoff-Robbins, eclectic, integrative</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Bridgewater State College</td>
<td>Nordoff-Robbins, eclectic</td>
<td>Behavioral, Nordoff-Robbins Eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Cleveland State University</td>
<td>Behavioral</td>
<td>Eclectic</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>College of Saint Teresa</td>
<td>Behavioral, Nordoff-Robbins, behavioral, Orff</td>
<td>Behavioral, Orff</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Colorado State University</td>
<td>NMT</td>
<td>Eclectic</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>Drexel University</td>
<td>Eclectic</td>
<td>Behavioral, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>East Carolina University</td>
<td>Behavioral, eclectic</td>
<td>Creative, humanistic</td>
<td>No</td>
</tr>
<tr>
<td>13</td>
<td>East Carolina University</td>
<td>Behavioral, Orff, creative</td>
<td>Orff, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>De Paul University</td>
<td>Eclectic</td>
<td>Orff</td>
<td>No</td>
</tr>
<tr>
<td>15</td>
<td>Eastern Michigan University</td>
<td>Behavioral</td>
<td>Behavioral</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Table 5 - continued

<table>
<thead>
<tr>
<th>Participant</th>
<th>University where Music Therapy Degree(s) Obtained</th>
<th>University’s Approach</th>
<th>Professional Approach</th>
<th>Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Eastern New Mexico University</td>
<td>Behavioral</td>
<td>Behavioral</td>
<td>Yes</td>
</tr>
<tr>
<td>17</td>
<td>Elizabethtown College</td>
<td>Behavioral</td>
<td>Nordoff-Robbins, creative</td>
<td>No</td>
</tr>
<tr>
<td>18</td>
<td>Elizabethtown College</td>
<td>Behavioral</td>
<td>Eclectic</td>
<td>No</td>
</tr>
<tr>
<td>19</td>
<td>Elizabethtown College</td>
<td>Behavioral</td>
<td>Eclectic</td>
<td>No</td>
</tr>
<tr>
<td>20</td>
<td>Florida State University</td>
<td>Behavioral</td>
<td>Behavioral, creative, Nordoff-Robbins,</td>
<td>Yes</td>
</tr>
<tr>
<td>21</td>
<td>Florida State University</td>
<td>Behavioral</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>22</td>
<td>Florida State University</td>
<td>Behavioral</td>
<td>Behavioral, NMT</td>
<td>Yes</td>
</tr>
<tr>
<td>23</td>
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<td>Behavioral</td>
<td>Behavioral, Orff, Eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>24</td>
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<td>GIM, eclectic, developmental</td>
<td>No</td>
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<td>25</td>
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<td>Behavioral</td>
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<td>Yes</td>
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<td>27</td>
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<td>Eclectic</td>
<td>Creative, eclectic</td>
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<tr>
<td>28</td>
<td>Immaculata University</td>
<td>Nordoff-Robbins, Orff</td>
<td>Behavioral, Nordoff-Robbins, creative</td>
<td>Yes</td>
</tr>
<tr>
<td>29</td>
<td>Immaculata University</td>
<td>Creative</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>30</td>
<td>Immaculata University</td>
<td>Eclectic</td>
<td>GIM, psychoanalytical, eclectic, other</td>
<td>Yes</td>
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<td>31</td>
<td>Lesley University</td>
<td>Other</td>
<td>Eclectic</td>
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<td>32</td>
<td>1. Loyola University 2. University of Iowa</td>
<td>1. Other 2. Eclectic</td>
<td>Behavioral</td>
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<td>33</td>
<td>1. Mansfield University 2. Drexel University</td>
<td>1. Behavioral 2. Psychoanalytical</td>
<td>Humanistic, other</td>
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<td>34</td>
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<td>Behavioral</td>
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<td>No</td>
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<tr>
<td>35</td>
<td>Marywood University</td>
<td>Behavioral, Nordoff-Robbins, creative, psychoanalytical, Orff</td>
<td>Eclectic</td>
<td>No</td>
</tr>
<tr>
<td>Participant</td>
<td>University where Music Therapy Degree(s) Obtained</td>
<td>University’s Approach</td>
<td>Professional Approach</td>
<td>Match</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------</td>
<td>-------</td>
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<tr>
<td>36</td>
<td>Montclair State</td>
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<td>Behavioral Psychoanalytical</td>
<td>Yes</td>
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<tr>
<td>37</td>
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<td>Eclectic</td>
<td>Behavioral, Orff, NMT, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>38</td>
<td>Michigan State University</td>
<td>Behavioral</td>
<td>Behavioral, Nordoff-Robbins</td>
<td>Yes</td>
</tr>
<tr>
<td>39</td>
<td>Michigan State University</td>
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<td>Eclectic</td>
<td>Yes</td>
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<tr>
<td>40</td>
<td>Molloy College</td>
<td>Nordoff-Robbins</td>
<td>Nordoff-Robbins, creative, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>41</td>
<td>Naropa University</td>
<td>Eclectic, other</td>
<td>Behavioral, psychoanalytical, NMT, creative, eclectic, other</td>
<td>Yes</td>
</tr>
<tr>
<td>42</td>
<td>New England Conservatory</td>
<td>Eclectic</td>
<td>Behavioral, GIM, NMT, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>43</td>
<td>New York University</td>
<td>Nordoff-Robbins, GIM, creative</td>
<td>Nordoff-Robbins, creative, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>44</td>
<td>New York University</td>
<td>Nordoff-Robbins, GIM, creative, eclectic, other, psychoanalytical</td>
<td>Eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>45</td>
<td>New York University</td>
<td>Nordoff-Robbins, psychoanalytical</td>
<td>Nordoff-Robbins, psychoanalytical, creative</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| 46          | 1. Ohio University  
2. Eclectic | Eclectic, Nordoff-Robbins, GIM, NMT | Yes   |
| 47          | Radford University                               | Eclectic              | Behavioral            | No    |
| 48          | Saint Mary-of-the-Woods                          | Eclectic              | Eclectic              | Yes   |
| 49          | Sam Houston State University                     | Behavioral, NMT       | Behavioral, NMT       | Yes   |
| 50          | Sam Houston State University                     | Behavioral            | Behavioral            | Yes   |
| 51          | Shenandoah University                            | Eclectic              | Eclectic              | Yes   |
| 52          | 1. SUNY Newpaltz  
2. Marywood University | 1. Behavioral  
2. Behavioral | Behavioral            | Yes   |
<p>| 53          | Temple University                                | GIM, eclectic, other, psychoanalytical | Eclectic | Yes   |
| 54          | Texas Woman’s University                         | Behavioral, eclectic  | Gestalt, humanistic   | No    |</p>
<table>
<thead>
<tr>
<th>Participant</th>
<th>University where Music Therapy Degree(s) Obtained</th>
<th>University’s Approach</th>
<th>Professional Approach</th>
<th>Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>Texas Woman’s University</td>
<td>Behavioral, GIM, psychoanalytical, creative, eclectic, other</td>
<td>Behavioral, psychoanalytical, NMT, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>56</td>
<td>Texas Woman’s University</td>
<td>Eclectic</td>
<td>Eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>57</td>
<td>University of Alabama</td>
<td>Behavioral</td>
<td>Behavioral</td>
<td>Yes</td>
</tr>
<tr>
<td>58</td>
<td>University of Dayton</td>
<td>Behavioral</td>
<td>Behavioral</td>
<td>Yes</td>
</tr>
<tr>
<td>59</td>
<td>University of Dayton</td>
<td>Eclectic</td>
<td>Eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>60</td>
<td>1. University of Georgia 2. Georgia State University</td>
<td>Behavioral</td>
<td>Behavioral</td>
<td>Yes</td>
</tr>
<tr>
<td>61</td>
<td>University of Georgia</td>
<td>Eclectic</td>
<td>Behavioral, other</td>
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<td>62</td>
<td>1. University of Iowa 2. Colorado State University</td>
<td>1. Behavioral, eclectic. 2. NMT</td>
<td>NMT</td>
<td>Yes</td>
</tr>
<tr>
<td>63</td>
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<td>Yes</td>
</tr>
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<td>64</td>
<td>University of Kansas</td>
<td>Behavioral, eclectic</td>
<td>Eclectic, other</td>
<td>Yes</td>
</tr>
<tr>
<td>65</td>
<td>University of Kansas</td>
<td>Behavioral</td>
<td>Behavioral, NMT</td>
<td>Yes</td>
</tr>
<tr>
<td>67</td>
<td>University of Kansas</td>
<td>Eclectic</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>68</td>
<td>University of Miami</td>
<td>NMT, eclectic</td>
<td>NMT</td>
<td>Yes</td>
</tr>
<tr>
<td>69</td>
<td>University of Missouri-Kansas City</td>
<td>Eclectic</td>
<td>Behavioral, psychoanalytical, NMT, creative, eclectic</td>
<td>Yes</td>
</tr>
<tr>
<td>70</td>
<td>University of Wisconsin – Eau Claire</td>
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<td>Eclectic</td>
<td>Yes</td>
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<tr>
<td>71</td>
<td>Virginia</td>
<td>Other</td>
<td>Behavioral, NMT, GIM, eclectic</td>
<td>No</td>
</tr>
<tr>
<td>72</td>
<td>Wartburg College</td>
<td>Eclectic</td>
<td>Creative</td>
<td>No</td>
</tr>
<tr>
<td>73</td>
<td>Wartburg College</td>
<td>Behavioral</td>
<td>Behavioral</td>
<td>Yes</td>
</tr>
<tr>
<td>74</td>
<td>Wartburg College</td>
<td>Behavioral</td>
<td>Behavioral</td>
<td>Yes</td>
</tr>
<tr>
<td>75</td>
<td>Western Michigan University</td>
<td>Behavioral</td>
<td>Eclectic</td>
<td>No</td>
</tr>
<tr>
<td>76</td>
<td>Willamette University</td>
<td>Behavioral, Nordoff-Robbins, GIM, other, psychoanalytical, Orff, creative, eclectic</td>
<td>Eclectic</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Table 5 – continued

<table>
<thead>
<tr>
<th>Participant</th>
<th>University where Music Therapy Degree(s) Obtained</th>
<th>University’s Approach</th>
<th>Professional Approach</th>
<th>Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>Wooster</td>
<td>GIM, eclectic</td>
<td>Behavioral, GIM</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Total Matches: 54; Total Percentage of Matches: 79.4%

Response to Research Question Two. Results indicated that 79.40% of music therapists continued to follow the approach stressed by their university programs (Table 5). Some participants perceived their university program as following a different approach than other participants who attended the same university. For example, the three participants who attended Immaculata University each reported different university approaches. Participant #28 reported that the university followed Nordoff-Robbins and Orff approaches, participant #29 reported that the university followed a creative approach, and participant #30 reported that the university followed an eclectic approach. Other participants from different universities had a consensus on their university’s approach (e.g. participants #20-25 identified Florida State University as following a behavioral approach). Some participants (35.10%) identified with one approach from their university and adopted additional approaches once they began to practice music therapy (e.g. participant #69), while some participants (9.10%) followed only one approach of the many approaches that their university followed (e.g. participant #76). Participants were excluded from the analysis if they did not know the approach of their university, if their university did not stress an approach, and/or if they did not follow a professional approach.
Data Analysis for Research Question Three

What is the influence of music therapists’ therapeutic approach on the goals they address with children and teens who have behavior disorders?

Table 6
A Comparison of Music Therapy Goals with the Behavior Disorders Population, According to Approach

1=Behavioral; 2=Eclectic; 3=NMT; 4=Nordoff-Robbins; 5=Orff; 6=Creative; 7=GIM; 8=Analytical

<table>
<thead>
<tr>
<th>Goal Domains</th>
<th>Percentage of Respondents According to Approach</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td>98.0 93.6 92.9 92.3 100 93.3 100 90</td>
<td>95.0</td>
</tr>
<tr>
<td>Communication</td>
<td>89.8 85.1 85.7 84.6 100 73.3 100 70</td>
<td>86.1</td>
</tr>
<tr>
<td>Behavioral</td>
<td>89.8 83.0 85.7 84.6 100 86.7 75.0 80</td>
<td>85.6</td>
</tr>
<tr>
<td>Emotional</td>
<td>81.6 87.2 92.9 76.9 71.4 80.0 100 90</td>
<td>85.0</td>
</tr>
<tr>
<td>Cognitive</td>
<td>71.4 74.5 85.7 53.8 85.7 60.0 50.0 60</td>
<td>67.6</td>
</tr>
<tr>
<td>Music</td>
<td>55.1 55.3 57.1 46.2 57.1 53.3 37.5 50</td>
<td>51.4</td>
</tr>
<tr>
<td>Sensory</td>
<td>51.0 48.9 57.1 53.8 57.1 46.7 12.5 40</td>
<td>45.9</td>
</tr>
<tr>
<td>Motor</td>
<td>30.6 34.0 35.7 15.4 71.4 33.3 0 20</td>
<td>30.1</td>
</tr>
<tr>
<td>Other</td>
<td>2.0 2.1 0 0 0 0 0 0</td>
<td>0</td>
</tr>
</tbody>
</table>

Response to Research Question Three. All music therapists reported focusing on social goals most often or equally to other goal domains. Behavioral, eclectic, Nordoff-Robbins, and creative music therapists reported focusing on social goals most frequently. Neurological music therapists reported focusing on social and emotional goals equally, while Orff-based music therapists reported focusing on social, communication, and behavioral goals equally. Music therapists who identified with GIM reported focusing on social, communication, and emotional goals equally, and psychoanalytical music therapists reported focusing on social and emotional goals equally. Overall, participants’ professional approaches did not influence the social goals the music therapists addressed, though approaches may have influenced the other goals they addressed with children and teens who have behavior disorders.

Data Analysis for Research Question Four

Do the therapeutic interventions used by music therapists follow the research literature on effective practices with children and teens who have behavior disorders?
Table 7  
*Rank Order of Music Therapy Interventions Found to be Effective in the Research Literature and Interventions Employed by Participants in the Present Study*  

<table>
<thead>
<tr>
<th>Rank Order</th>
<th>Interventions Found to be Effective in the Research Literature</th>
<th>Interventions Employed by Participants in the Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Music listening</td>
<td>Instrumental improvisation</td>
</tr>
<tr>
<td>2</td>
<td>Instrument instruction</td>
<td>Singing/chanting</td>
</tr>
<tr>
<td>3</td>
<td>Other</td>
<td>Music listening</td>
</tr>
<tr>
<td>4</td>
<td>Therapeutic instrument playing</td>
<td>Song writing</td>
</tr>
<tr>
<td>5</td>
<td>Instrument improvisation</td>
<td>Music and movement</td>
</tr>
<tr>
<td>6</td>
<td>Songwriting</td>
<td>Lyric analysis/song discussion</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Therapeutic instrument playing</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Musical games</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Music with another art form</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Music assisted relaxation</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Instrument instruction</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Music audio/video</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Exercise to music</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

*Response to Research Question Four.* Results indicated that participants in the present study employed interventions found to be effective in the research literature, as well as additional interventions. However, the frequency of interventions used by practicing music therapists and those investigated in the music therapy research literature varied. Music listening was the most frequently employed intervention among music therapists in the literature, while it was the third most frequently employed intervention among participants in the present study. While instrumental improvisation was the most frequently employed intervention among participants in the present study, it was the fifth most frequently employed intervention among music therapists in the literature. Generally, participants in the present study employed therapeutic interventions that followed the research literature on effective practices with children and teens who have behavior disorders. They also employed interventions that have yet to be studied by researchers.
Data Analysis for Research Question Five

What is the influence of music therapists’ therapeutic approach on the interventions they employ with children and teens who have behavior disorders?

Table 8
A Comparison of Music Therapy Interventions with the Behavior Disorder Population, According to Approach

1=Behavioral; 2=Eclectic; 3=NMT; 4=Nordoff-Robbins; 5=Orff; 6=Creative; 7=GIM; 8=Analytical

<table>
<thead>
<tr>
<th>Interventions</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental improvisation</td>
<td>75.0</td>
<td>91.5</td>
<td>76.9</td>
<td>76.9</td>
<td>71.4</td>
<td>66.7</td>
<td>100</td>
<td>77.8</td>
<td>79.1</td>
</tr>
<tr>
<td>Singing/chanting</td>
<td>81.3</td>
<td>80.9</td>
<td>61.5</td>
<td>100</td>
<td>100</td>
<td>80.0</td>
<td>87.5</td>
<td>77.8</td>
<td>74.5</td>
</tr>
<tr>
<td>Music listening</td>
<td>75.0</td>
<td>63.8</td>
<td>76.9</td>
<td>76.9</td>
<td>57.1</td>
<td>73.3</td>
<td>87.5</td>
<td>88.9</td>
<td>70.9</td>
</tr>
<tr>
<td>Song writing</td>
<td>68.8</td>
<td>74.5</td>
<td>84.6</td>
<td>69.2</td>
<td>42.9</td>
<td>66.7</td>
<td>87.5</td>
<td>77.8</td>
<td>70.9</td>
</tr>
<tr>
<td>Music and movement</td>
<td>64.6</td>
<td>72.3</td>
<td>53.8</td>
<td>76.9</td>
<td>57.1</td>
<td>80.0</td>
<td>62.5</td>
<td>66.7</td>
<td>67.3</td>
</tr>
<tr>
<td>Lyric analysis/song discussion</td>
<td>62.5</td>
<td>70.2</td>
<td>76.9</td>
<td>69.2</td>
<td>42.9</td>
<td>66.7</td>
<td>100</td>
<td>88.9</td>
<td>65.5</td>
</tr>
<tr>
<td>Therapeutic instrument playing</td>
<td>62.5</td>
<td>70.2</td>
<td>76.9</td>
<td>61.5</td>
<td>57.1</td>
<td>66.7</td>
<td>62.5</td>
<td>55.6</td>
<td>64.5</td>
</tr>
<tr>
<td>Musical games</td>
<td>58.3</td>
<td>55.3</td>
<td>61.5</td>
<td>38.5</td>
<td>71.4</td>
<td>60.0</td>
<td>25.0</td>
<td>66.7</td>
<td>54.5</td>
</tr>
<tr>
<td>Music with another art form</td>
<td>31.3</td>
<td>51.1</td>
<td>38.5</td>
<td>30.8</td>
<td>28.6</td>
<td>40.0</td>
<td>50.0</td>
<td>55.6</td>
<td>42.7</td>
</tr>
<tr>
<td>Music assisted relaxation</td>
<td>35.4</td>
<td>42.6</td>
<td>46.2</td>
<td>30.8</td>
<td>28.6</td>
<td>40.0</td>
<td>50.0</td>
<td>77.8</td>
<td>40.0</td>
</tr>
<tr>
<td>Instrument instruction</td>
<td>41.7</td>
<td>46.8</td>
<td>53.8</td>
<td>38.5</td>
<td>57.1</td>
<td>33.3</td>
<td>25.0</td>
<td>55.6</td>
<td>37.3</td>
</tr>
<tr>
<td>Music audio/video</td>
<td>22.9</td>
<td>34.0</td>
<td>23.1</td>
<td>7.7</td>
<td>14.3</td>
<td>20.0</td>
<td>25.0</td>
<td>22.2</td>
<td>26.4</td>
</tr>
<tr>
<td>Exercise to music</td>
<td>16.7</td>
<td>12.8</td>
<td>38.5</td>
<td>7.7</td>
<td>14.3</td>
<td>40.0</td>
<td>0</td>
<td>33.3</td>
<td>14.5</td>
</tr>
<tr>
<td>Other</td>
<td>6.3</td>
<td>12.8</td>
<td>7.7</td>
<td>0</td>
<td>0</td>
<td>6.7</td>
<td>0</td>
<td>11.1</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Response to Research Question Five. Behavioral, Nordoff-Robbins, and Orff music therapists employed singing/chanting most frequently. Creative music therapists employed singing/chanting and music and movement equally. Neurological music therapists employed songwriting most frequently. Psychoanalytical music therapists employed music listening and lyric analysis/song discussion equally, and GIM music therapists employed lyric analysis/song discussion and instrument improvisation equally. Eclectic music therapists employed instrumental improvisation most frequently. Overall, it appears that participants’ therapeutic approaches did influence the interventions they employed with children and teens who have behavior disorders.
CHAPTER 5

DISCUSSION

The purpose of this study was to examine the therapeutic approaches employed by music therapists servicing children and teens with behavior disorders. The therapeutic approaches were examined in relation to: (a) the frequency of approaches (behavioral, analytical, Nordoff-Robbins, etc.) employed by music therapists, (b) the degree to which interventions employed by music therapists followed the research literature on evidence-based practice with children and teens who have behavior disorders, (c) the degree to which selected approaches were influenced by music therapists’ academic training (approach stressed by their university program) and personal identity, and (d) the degree to which selected approaches influenced the goals addressed, and (e) the degree to which selected approaches influenced the interventions used with children and teens who have behavior disorders. In this study, 290 board-certified music therapists’ academic preparation, theoretical approaches, and music therapy practices were surveyed through an online questionnaire. Results indicated that the most frequently utilized approach was behavioral, followed closely by eclectic. Participants who perceived their university as having an eclectic, NMT, creative, and/or Orff-based identity continued to identify with the same approach. Ninety-three percent of participants who perceived their university as having a behavioral approach continued to identify with behaviorism. Overall, 79.40% of the respondents indicated that they continued to follow the theoretical approach of their university programs.

Despite participants’ different approaches to music therapy, they reported focusing on similar goals, with social goals being the most frequently addressed goal or equally to other goal domains. Other goal domains included emotional, communication, and behavioral. However, the frequency of interventions used by practicing music therapists and those investigated in the music therapy research literature varied. Music listening was the most frequently employed intervention among music therapists in the literature, while it was the third most frequently employed intervention among participants in the present study. Also, instrumental improvisation was the most frequently employed intervention among participants in the present study, though it was the fifth most frequently employed intervention among music therapists in the literature.
The therapeutic interventions employed by participants were influenced by their professional approaches. Though there were some similarities, there were also differences. Behavioral, Nordoff-Robbins, and Orff music therapists employed singing/chanting most frequently. Creative music therapists employed singing/chanting and music and movement equally. Neurological music therapists employed songwriting most frequently. Psychoanalytical music therapists employed music listening and lyric analysis/song discussion equally, and GIM music therapists employed lyric analysis/song discussion and instrument improvisation equally. Eclectic music therapists employed instrumental improvisation most frequently. None of the approaches had an intervention in common that they employed most frequently. However, participants reported using every intervention option, with the exception of music therapists who followed guided imagery and music and reported not using exercise to music as an intervention.

Limitations of the Present Study

There were three possible factors that may have limited the results of the study. First, since the study was only disseminated through Survey Monkey’s email distribution, it was limited in its ability to reach music therapists who did not have their email addresses listed in the AMTA Sourcebook. These music therapists may have participated if the researcher had mailed the survey through traditional U.S. mail. Second, the researcher failed to include the psychodynamic approach in the survey. However, participants who chose “other” as a theoretical identity did not comment that they followed a psychodynamic approach. This leads the researcher to believe that either the participants did not follow a psychodynamic approach or failed to cite using the approach while completing the questionnaire. Nevertheless, the study covered eight types of theoretical approaches in music therapy. Third, the cover letter informed prospective participants that the researcher attended Florida State University, which may have contributed to the greater number of responses from participants who attended Florida State University (N=8) and/or fewer responses from music therapists who attended other universities.

Relationship to Extant Literature

Results of the present study both corroborate and refute previous music therapy studies regarding the behavior disorders population. Jackson (2003) found that the interventions most frequently utilized by music therapists serving children with ADHD included music and movement, instrumental improvisation, musical play, and group singing. Similarly, results from the present study indicated that the interventions most frequently used by music therapists
serving children and teens with behavior disorders were instrument improvisation and singing/chanting. However, music therapists in the present study also reported the frequent use of listening and song writing. Additionally, while the music therapists in Jackson’s study most frequently focused on behavioral goals, followed by psychosocial goals and cognitive goals, music therapists from the current study most frequently focused on social goals, followed by behavioral and communication goals. This differences may be due to the fact that the music therapists in Jackson’s study only served children with ADHD, while respondents in the present study served children with a variety of behavior disorders.

Music therapists in the literature have incorporated interventions such as songwriting (Ficken, 1976; Freed, 1976; Frisch, 1990), music lessons (Kivland, 1986; Madsen & Madsen, 1976), music listening (Lindsey, 1998), instrument improvisation (Rickson, 2006), and active music making (Montello & Coons, 1998; Rickson & Watkins, 2003). Results from the present study revealed that music therapists used similar techniques in their practice with children and teens who have behavior disorders, including instrument improvisation, singing and chanting, listening, and songwriting. Similarly, researchers from previous studies used music interventions to focus on objectives including increased self-expression, self-esteem, attention, and socially appropriate behavior, and decreased motor activity, impulsivity, aggression, and hostility. Music therapists from the present study identified the objectives that they frequently addressed with children and teens who have behavior disorders as increasing emotional expression, communication skills, self-esteem, and self-control.

General Discussion

(a) The frequency of approaches employed by music therapists. Participants in this study most frequently identified with a behavioral approach. The strategies and techniques discussed in Chapter 2 that are rooted in behaviorism, such as behavior modification, applied behavior analysis, and positive behavioral support, may contribute to a greater number of music therapists identifying with a behavioral approach when serving children and teens with behavior disorders. Additionally, Choi (2008) discussed the difficulty of choosing one theoretical orientation to identify with since many music therapists employ all necessary techniques and methods in order to best serve their clients. The results of the present study corroborate Choi’s findings, as 52.6% of the participants reported that they followed more than one theoretical identity.
(b) The degree to which interventions employed by music therapists followed the research literature on evidence-based practice with children and teens who have behavior disorders. While music therapists in the literature and in the present study employed similar interventions (e.g. songwriting, music listening, instrumental improvisation, and instrument instruction), there is limited research with this population employing the interventions that were cited by participants in the present study. Participants in the present study reported using musical games, music for relaxation, music for exercise, and other interventions that are not supported by evidence-based research with the behavior disorder population. Additionally, music therapists in the literature used techniques (e.g. music as a contingency) while serving children and teens with behavior disorders but did not always specify the intervention they used to address their goals (e.g. music listening, active music making, etc.).

(c) The degree to which selected approaches were influenced by music therapists’ academic training (approach stressed by their university program) and personal identity. As the majority of participants continued to follow at least one approach that their university identified with, it is clear that academic training influenced participants’ personal identity. However, it is interesting to note that participants did not always agree on their university’s identity and that many participants chose to follow additional approaches once they were practicing music therapy. Some participants commented that they had to adopt additional approaches in order to meet their clients’ needs. Of the participants who did not follow the approach of their university, it may be that the techniques involved in their university’s approach did not apply to the needs of children and teens with behavior disorders so they did not follow that approach with this specific population of clients.

(d) The degree to which selected approaches influenced the goals addressed. Even though participants serving children and teens with behavior disorders had different theoretical approaches, they identified music therapy goals similarly. Participants from each theoretical approach focused on social goals most frequently or equally to other goals. Other frequently addressed goals included those in the communication, emotional, and behavioral domains. As the needs of these children did not change based on their music therapist’s personal identity, goals also remained the same across approaches. The treatment goals among children and teens with behavior disorders remained consistent.
The degree to which selected approaches influenced the interventions used with children and teens who have behavior disorders. Though participants’ personal approaches did not influence the goals addressed with these children, interventions varied. Singing and chanting was the intervention that most approaches had in common, though instrumental improvisation was the most frequently used approach across the board. It is interesting to note that neurological music therapists reported using songwriting most frequently with these children and teens. As neurological music therapists are better known for their work treating the brain using rhythm, one might assume these music therapists would utilize more rhythmic interventions, including music and movement and/or therapeutic instrument playing. Additionally, it is interesting that participants from some approaches reported using specific interventions with all of their behavior disordered clients: GIM reported using instrumental improvisation and lyric analysis/song discussion, Nordoff-Robbins music therapists reported using lyric analysis/song discussion, and Orff music therapists reported using singing/chanting. In these cases, approach influenced the interventions that music therapists used with this population.

Implications for Practice

Because no previous survey research has compared music therapists’ academic preparation and theoretical orientation with their approach to working with the behavior disorder population, findings of this study may be helpful for students just entering the field and for currently practicing professionals in understanding the importance of education and identity when treating this demanding population. Results from this study could lend insight into new ideas and techniques for music therapists to use in their practice with children and teens with behavior disorders (e.g. stepping, hop-hop therapy, etc.). Additionally, this study may help music therapists realize the relationship between their education, their theoretical identity, and their approach to serving clients. Results indicated that music therapists’ university program strongly influenced their approach to music therapy. It may be beneficial for beginning music therapy students to select a university that teaches a theory that best fits their personal philosophy and personality. While some students may be oriented toward the university’s favored approach, they may develop other approaches after they begin clinical practice.

Although music therapists are well qualified to practice in the field, children and teens with behavior disorders are known to be a challenging population to serve because of the diverse needs these children and teens present. It is important for the music therapist to be academically
and emotionally prepared to serve children and teens with behavior disorders. Questionnaire item #11 asked participants if they felt that their education prepared them to work with the behavior disorder population. Some of the participants’ comments included: “Unless your internship or practicum is with the severely behavioral, you can't prepare,” “there was some training but I think no college education can prepare you for working with behavior disorder population. You use the basic tools you learn and you gain more experience as you work with the population,” and “I was well-prepared, but nothing can replace real-life experience!” Additionally, some of the potential respondents (9.20%) informed the researcher that they no longer worked with the behavior disorder population. The following response came from a potential participant: “I do not presently work with behavior disorders. I wasn't aware I am listed that way—a mistake somewhere. I did work with duel-diagnosed teens for a while. Couldn't handle it. Scary, hazardous, draining work.”

Suggestions for Future Research

Replications of this study might be conducted to include a greater number of music and non-music strategies that music therapists use when serving the behavior disorder population, such as applied behavior analysis, positive behavioral supports, and other cognitive-behavioral techniques. Replications of this study could also link the intervention with the goal so that it is clear how music therapists are addressing specific clients’ goals. As children and teens often enjoy music in a variety of forms, future researchers might examine the effectiveness of the interventions that participants reported using with this population, including musical games, music for exercise, the use of electronic resources (ipods, garage band, music videos, etc.), and giving children opportunities to learn and care for music instruments. Research studies could be conducted that examine the effectiveness of music therapy with the behavior disorder population in conjunction with parent training programs. Lastly, in order to determine if theoretical identity is more related to academic preparation or to the clientele that music therapists serve, replications of this study might be conducted that examine the relationships between theoretical identity and music therapists’ approach to serving other populations, including adults with psychiatric disorders, children with autism, and/or geriatrics.

Conclusions

More participants in the present study identified with a behavioral or eclectic approach to music therapy than other approaches when serving children and teens with behavior disorders.
Participants also reported that they often continued to follow the theoretical identity of their university, or adopted additional approaches to meet their clients’ needs. While participants’ approaches did not influence the goals they addressed with children and teens who have behavior disorders, their interventions often varied and may have been influenced by their approaches. Participants employed many of the evidence-based interventions from the music therapy literature, and incorporated additional interventions that have yet to be substantiated through research.

Participants left comments at the end of the questionnaire that they felt was pertinent to the clinical practice of music therapy with children and teens who have behavior disorders. These comments included:

- “The most important thing is to be able to relate to them on a personal level without being friends while being honest that you do not know everything about being a teenager today. Do not be fake. Be real.”
- “Behavior disorders often accompany other disabilities, so the music therapist needs to be prepared to use appropriate behavioral, emotional, and sensory strategies to meet their needs. This is why I use an integrative approach with all children.”
- “I have been very successful teaching kids instruments—have been doing it 35 years—and the parents LOVE it. So do the kids. We are ignoring this part of music therapy. The public is willing to pay for private lessons ($90 and hour) and it is VERY successful in achieving goals.”
- “I've found that the deeper a child can be engaged in musical processes, the fewer disruptive issues occur and the greater the learning. Therefore, behavioral techniques are only ever aimed at bringing the child into the music processes, rather than for managing non-musical responses. Time spent on non-musical responses is time wasted for the child. In this view, it is in the child-music relationship where self-awareness, self-development, and subsequently social and emotional growth occurs.”

As children and teens with behavior disorders present challenges to themselves, their families, their schools, and their communities, it is important to continue to develop effective treatment strategies and techniques. Also, as children and teens are identified with behavior disorders, it is imperative that teachers, parents, clinicians, and music therapists understand how to manage their behavior and what strategies to employ in the classroom, in therapy, and at
home. Music therapists’ awareness of the roles of academic preparation and professional identity in shaping their approaches to serving children and teens with behavior disorders may result in increased evidence-based practice. By using evidence-based interventions and strategies that address the diverse needs of children and teens with behavior disorders, these children may be able to improve their behavior; which will in turn improve overall academic performance, social interactions, and daily living.
### APPENDIX A

#### SURVEY INSTRUMENT

1. Please indicate your gender.
   - Female
   - Male

2. In what age category do you fall?
   - 21-30
   - 31-40
   - 41-50
   - 51-60
   - over 60 years old

3. In what AOTA region do you live?
   - New England
   - Southeastern
   - Southwestern
   - Midwestern
   - Great Lakes
   - Mid-Atlantic
   - Western

4. What is your highest academic degree obtained?
   - Bachelor's degree
   - Graduate equivalency
   - Master's degree
   - Doctoral degree

5. Where did you earn your bachelor's degree? Please list.

6. Did you earn your bachelor's degree in somatic therapy?
   - Yes
   - No
   - Yes, please specify what your major was.

7. Did you earn a graduate equivalency or master's degree?
   - Yes
   - No
   - If yes, please list where you earned it.

8. Did you earn a doctoral degree?
   - Yes
   - No
   - If yes, please list where you earned it.

9. Did the school(s) from which you earned your somatic therapy degree(s) have a specific professional identity? (Check all that apply.)
   - Behavioral
   - Neurobiol
   - Homeopathic
   - Psychosomatic
   - Off
   - NMT
   - Creative
   - Eclectic
   - Other
   - I don't know
   - N/A
10. What identity do you follow, if any?
- Behavioral
- Non-ABR
- Guided imagery and music
- Bowenian
- Psychodynamic
- Off (please specify)

11. Do you feel that your education prepared you to work with the behavior disorder population?
- Yes
- No

12. How many years have you been a practicing music therapist?
- 0-5
- 6-10
- 11-15
- 16-20
- 21-25
- 26-30
- 31+

13. For how many years have you been a practicing music therapist serving children and teens with behavior disorders?
- 0-5
- 6-10
- 11-15
- 16-20
- 21-25
- 26-30
- 31+

14. Please indicate the ages of children and/or teens in this population with whom you commonly work and estimate the number in each age that constitutes your caseload.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1-5 clients</th>
<th>6-11 clients</th>
<th>11-15 clients</th>
<th>16-20 clients</th>
<th>21-25 clients</th>
<th>26-30 clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-7 years old</td>
<td></td>
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<tr>
<td>8-10 years old</td>
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<tr>
<td>11-12 years old</td>
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<tr>
<td>13-14 years old</td>
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<tr>
<td>15-16 years old</td>
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<tr>
<td>17-18 years old</td>
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</tr>
</tbody>
</table>

51
15. With what diagnostic population of children and teens with behavior disorders have you worked? (Check all that apply)

☐ Attention Deficit Hyperactivity Disorder
☐ Disruptive Behavioral Disorder
☐ Oppositional Defiant Behavioral Disorder
☐ Conduct Disorder
☐ Impulsive Behavior Disorder
☐ Other (please specify)

16. In what type of clinical facility do you serve children and teens with behavior disorders? (Check all that apply)

☐ Early childhood center
☐ Private clinic
☐ School (private or public including alternative)
☐ Client’s home
☐ Group home
☐ Other (please specify)

17. What type of sessions do you most frequently offer with this population?

☐ Individual
☐ Small group
☐ Large group
☐ Other (please specify)

18. What goals domains do you address when working with this population? (Check all that apply)

☐ Motor
☐ Social
☐ Communication
☐ Cognitive
☐ Other (please specify)

19. Briefly describe the process you use to determine therapeutic goals for this population.


20. What objectives have you focused on during the last week with children and teens that have behavior disorders? (Check all that apply)

☐ Socialization
☐ Communication
☐ Self-esteem
☐ Academic
☐ Coping skills
☐ Group cohesiveness
☐ Impulse control
☐ Emotional expression
☐ Self-image
☐ Other (please specify)


21. Which of the following objectives do you stress when working with this population? (Check all that apply).
- To increase appropriate verbal and nonverbal communication skills
- To promote the healthy and appropriate expression of emotion
- To minimize aggressive or hostile behavior
- To promote awareness of and empathy for others
- To facilitate the learning of academic skills
- To promote self-esteem
- To teach a musical concept
- To provide for appropriate release of anxiety, stress, or tension
- To promote the use of coping skills and stress reduction techniques
- To want to accept responsibility for oneself
- To promote acts of self-control within a structured musical environment
- To promote the labeling of specific emotions
- To promote group cohesiveness
- To promote self-control
- Other (please specify)

22. What therapeutic interventions do you use in your music therapy practice with this population? (Check all that apply).
- Singing/choir singing
- Listening
- Music and movement
- Lyric analysis/group discussion
- Song writing
- Instrument improvisation
- Creating a music audiophile recording
- Other (please specify)

23. What style(s) of music do you use with children and teens that have behavior disorders? (Check all that apply).
- Children's songs
- Popular
- Hip Hop
- Rap
- R & B
- Classic Rock
- Other (please specify)

24. Rank the three styles of music (from the list above) that you use most frequently with the behavior disorder population:
- One
- Two
- Three

25. Do you use live or recorded music most frequently with this population?
- Live
- Recorded

26. Do you use commercially available or therapist/client-composed music more frequently?
- Commerically available
- Therapist/client
27. What non-music techniques have you used in the past week when working with the behavior disorder population? (Check all that apply.)
- Seating the child in close proximity to you
- Using visual aids (e.g., schedule)
- Using a written contract between you and the child
- Communicating frequently with parents/guardians
- Providing structure with clear, consistent rules
- Modeling appropriate social behavior
- Prior to a new activity, reviewing how you expect the child to behave
- Using humor to defuse a potential problem situation
- Using frequent and immediate rewards and praise
- Ignoring minor disruption
- Allowing the child to take breaks to prevent loss of temper
- Using a daily report card
- Other (please specify): ........................................

28. Thank you for participating in this survey. If you have any additional information that you feel is pertinent to the clinical practice of music therapy with children and teens that have behavior disorders, please include that information below.

.................................................................
Dear Music Therapist,

My name is Jessie Crump and I am a graduate student at Florida State University. This email is an invitation to participate in a survey regarding your clinical practice of music therapy with children and teens that have behavior disorders. You have received this email because the 2009 AMTA Member Sourcebook has you listed as working with behavior disorders. To participate in this survey you should have at least one client under the age of 19 who has a behavior disorder.

The link below will lead you to the survey, which will take about 10-15 minutes to complete. Your responses will be confidential to the extent allowed by law and your name will not be associated with the research findings. As a participant, you will benefit because you will learn if your and your peers' academic preparation and professional identity affect the way you approach working with the behavior disorder population. Additionally, you will learn what other music therapists are doing with the same population in which you work. There are no anticipated risks of participation.

Completion of the survey is considered your voluntary consent to participate. You will have two weeks to complete the survey. You will receive a prompt to complete the survey in one week. If you would like additional information concerning this study please contact me by phone or email. Thank you for your time and your responses.

Sincerely,

Jessie Crump, MT-BC
913-940-3662
crump.jessica@gmail.com

Major Professor Contact
Dr. Alice-Ann Darrow
(850) 645-1438
aadarrow@fsu.edu

IRB Contact Information
If you have any questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you are encouraged to contact the FSU IRB at telephone number 850-644-8633. You may also contact this office by email at humansubjects@magnet.fsu.edu, or by writing or in person at 2010 Levy Street, Research Building B, Suite 276, FSU Human Subjects Committee, Tallahassee, FL 32306-2742.
APPENDIX C

INSTITUTIONAL REVIEW BOARD APPROVAL

Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8673 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 4/30/2010

To: Jessica Crump

Address: 2489B Talco Hills Dr
Dept.: MUSIC SCHOOL

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
The Relationship Between Music Therapists’ Academic Preparation and Professional Identity and their Approach to Working with Children and Teens with Behavior Disorders

The application that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human Subjects Committee. Your project is determined to be Expedited per 45 CFR § 46.110(7) and has been approved by an expedited review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If you submitted a proposed consent form with your application, the approved stamped consent form is attached to this approval notice. Only the stamped version of the consent form may be used in recruiting research subjects.

If the project has not been completed by 4/28/2011 you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the Committee.

You are advised that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol
change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report, in writing any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the Chair of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Human Research Protection. The Assurance Number is IRB00000446.

Cc: Alice-Ann Darrow, Advisor
HSC No. 2010.4205
REFERENCES


research. *European Psychologist, 6*(1), 36-64.


BIOGRAPHICAL SKETCH

Name: Jessica Christine Crump

Place of Birth: St. Louis, Missouri

Education: University of Missouri-Kansas City – Kansas City, MO
Bachelor of Arts in Music, Cum Laude (2008)


Certifications: Certification Board for Music Therapists
Neonatal Institute for Infant & Child Medical Music Therapy

Memberships: American Music Therapy Association

Professional Experience: Spofford Home – Kansas City, MO
Music Therapist (2008)