The Effect of Music Therapy on Social Skills Training in a Preschool Setting

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THE EFFECT OF MUSIC THERAPY ON SOCIAL SKILLS

TRAINING IN A PRESCHOOL SETTING

By

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I dedicate this to my sister, Jennifer, for always singing my song,

    even when the music stops.
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# TABLE OF CONTENTS

List of Tables ............................................................................................................................... vii
List of Figures .............................................................................................................................. viii
Abstract .......................................................................................................................................... ix

1. INTRODUCTION .......................................................................................................................1

2. LITERATURE REVIEW ............................................................................................................3
   Social Development in Children .................................................................3
   Social Skills Deficits .........................................................................................5
   Social Skills Training .........................................................................................8
   Music to Improve Social Skills .................................................................10
   Purpose .................................................................................................................13

3. METHOD ..................................................................................................................................14
   Setting .........................................................................................................................14
   Subjects ......................................................................................................................14
   Dependent Variables ..........................................................................................16
   Design .......................................................................................................................17
   Procedure ................................................................................................................17

4. RESULTS ..................................................................................................................................20
   Summary ...................................................................................................................25

5. DISCUSSION ............................................................................................................................26
   Anecdotal Observations ....................................................................................26
   Limitations ...........................................................................................................28
   Suggestions for Future Research ...........................................................................29
   Conclusions ............................................................................................................30

APPENDICES ...............................................................................................................................32

A. INSTITUTIONAL REVIEW BOARD APPROVAL LETTER .................................................32
B. GOODWILL EASTER SEALS PROGRAM DIRECTOR APPROVAL LETTER ..........33
C. APPROVED CONSENT FORM ..........................................................................................34
D. SAMPLE ASSENT SCRIPT .................................................................................................36
LIST OF TABLES

Table 1: Student Demographics by Gender, Age, and Disability.................................15
Table 2: Curriculum Scope and Sequence......................................................................19
Table 3: Pre-Test, Post-Test, and Change Score Raw Data.............................................20
Table 4: Mean Scores for Pre-Test and Post-Test Data....................................................21
Table 5: Pre-Test Items by Category Taught with Corresponding Session Number.........22
LIST OF FIGURES

Figure 1: Control and Experimental Group Mean Scores Broken Down by Session Number.....23
Figure 2: Percentages of On-Task Behavior During Sessions..........................................................25
ABSTRACT

The purpose of this study was to determine if music therapy aided in the acquisition of social skills in a preschool setting. Subjects were preschool students enrolled in the facility, including typically developing children and children with disabilities. Students were randomly assigned to either a control group receiving no music, or an experimental group in which music therapy techniques were utilized. Over a period of six weeks, one new social skill per week was introduced and previously demonstrated social skills were reviewed during a 30-minute session. Students in both groups were expected to participate in the activities generated by the researcher. Data were taken using a researcher-created social skills rating system forming pre-test and post-test scores on social functioning using Likert-type ratings. Behavioral observations of on-task social behavior during group sessions were also documented. Sessions took place in the preschool facility in a large, meeting room. Social skills discussed included interpersonal skills, self-management skills, nonverbal communication skills, verbal communication skills, and skill integration with social interaction. Results and suggestions for future research are discussed.
CHAPTER ONE
INTRODUCTION

Early infancy and childhood development of social skills are crucial for the successful transition from one stage of life into another. Social skills acquired during childhood impact the relationships, attitudes, and experiences that we seek later in life. Without proper formation of such social skills, deficits in social competency can lead towards maladjustment, inability to form successful social relationships, and even depression. It is imperative for children to receive adequate social skills training, either through family, schools, social skills training programs, or social opportunities within their typical environments.

Decades of research have been conducted on social skills training programs and their efficiency in teaching acceptable social behavior. As social development can start even as an infant, these programs have sought to cover appropriate training for all ages. Various methods have been attempted including, but not limited to, cognitive behavioral approaches, group versus individual sessions, social perception training, behavior modeling, direct teaching against unstructured play, and various other research-based interventions. Another approach was using music in conjunction with social skills training to increase social skills.

The social elements of music are vast in number and invaluable in their attempt to increase social skills. In an overview of their book, Cornelius & Natvig (2011) listed chapter titles as music and its relationship to multiple social elements encountered on a daily basis. These included experiencing music, listening to music, music ethnicity, music and gender, music and spirituality, music and politics, music and war, and music and love to list a few. Olteteanu
(2011) addresses the fact that music can also be used to change emotions, something shared by all in various social environments. Furthermore, when expressing such emotions, music tends to create a safe environment. “The emotional and yet structured aspect of music allows for intense emotional expression in a safe container” (Hinman, 2010). In addition to emotional connections made through music, strong ties between music and language exist. Not only can lyrics be used to convey a message within a song, but language and music are connected physically through the auditory-verbal modality (Olteteanu, 2011). Language, written or spoken, is by all factors social.

In addition to conceptual, emotional, and linguistic social properties of music, the very use of music is social in and of itself. Instrumentation, melody, harmony, rhythm, improvisation, and the orchestration of it all has powerful therapeutic properties. The identification of such properties “supports the cyclical process of goal-setting and music-making and strengthens the therapeutic experiences created in music” (Beer, 2011). The clinical application of these social aspects of music touches both the acquisition of social skills and the remediation where deficits are present. Group interventions in therapy utilizing music have been shown to provide an alternative means of social communication. Wright (2012) suggests that music may be a response to the question of how to build social capital. She beautifully states that music is “a way of reaching outside individual identities and co-constructing new shared ones: a new sensation of ‘we’.”
CHAPTER TWO

REVIEW OF LITERATURE

Social Development in Children

Childhood development physically, emotionally, and socially can be vastly different from one child to the next. While several factors affect a child’s development, environment and disabilities to name a few, several social norms remain across children from one generation to the next. Children learn to be social beginning with infancy and continue to acquire new social skills with each new level of development. Infants, toddlers, preschoolers, and adolescents, and teenagers all experience various levels of social skills introduction. Research on social interactions and development with these age groups over the last several years has produced valuable insight into early social skills development. Social skills are interactions with other people, involving initiation and response behaviors. These are learned behaviors that are socially reinforced and allow for competent and acceptable social exchanges (Cook, Gresham, Barreras, Thornton, & Crews, 2008).

Beginning with infancy, LeCroy (2007) determined that peer interactions aid in developing social skills and can provide fundamentals required for the acquisition of future social development. Also during infant social development is the acquisition of joint attention. This skill begins to develop between three and six months of age, and can include following another person’s gaze, pointing to direct attention, and looking towards a parent for direction in a social situation. This ability to focus attention on an individual while simultaneously holding
their attention, as well, is related to social understanding in later stages of development in the child’s life (Van Hecke, et al., 2007).

In early childhood, the building blocks of social relationships begin to form. Young children dependent upon parents or guardians for social interactions, start to move away from parallel play. When the toddler is about 18 months old, they begin to engage in peer interaction. By 26 months the toddler is beginning to indicate understanding and acceptance of the concept of sharing. Between this time and 30 months of age, toddlers begin to form attachments to or friendships with individual social peers. Berk (2007) suggests that it is this time, during early childhood development, that toddlers first initiate strong peer connections.

Later during childhood, preschool begins opening the child’s social environment to new experiences both during structured classroom teaching and free play. Relationships are no longer a new commodity as the bonds of friendship begin to form and become a new social norm. This makes the transition through kindergarten and into first grade socially seamless in forms of relationships. Around six years old, the child moves from early childhood to middle childhood, which lasts from around age 6 to about age 11. Social relations are multifaceted while fine distinctions in interactions begin to develop. Middle childhood is the stage where social acceptance and group inclusion become strong aspirations and can have a strong effect on their social environment (Berk, 2007).

After middle childhood, the stage of adolescence begins, typically with no abrupt diving line between the two stages. As emotions run strong and seemingly uncontrollably, it is imperative for adolescents to have obtained necessary social skills to handle social interactions appropriately. Peer interactions with those of the opposite sex become more prevalent. These
interactions force adolescents to learn how to maintain relationships with both peers and adults, and also how balance the two (Denham, Wyatt, Bassett, Echeverria, Knox, 2009). In learning how to handle the shared time and attention of peers and adults within their social environment, giving attention to family members also creates an opportunity for development. Adolescents slowly develop autonomy from family members or caregivers (Berk, 2007). These skills learned during adolescence of self-control, emotional regulation, attention sharing, and autonomy lay the groundwork for the future social relationships to emerge successfully.

**Social Skills Deficits**

Social development discussed is the standard development for typically developing children. However, deficits often occur in social skills due to a variety of reasons, including environment, circumstances, and disability. School-aged children suffering in social deficits from any of these situations need remediation and social skills training in order to function appropriately in society. Hoza (2007) found that poor social interactions occurring during childhood can even predict psychological functioning for their future, better than even IQ scores, grades, achievement tests, or teacher ratings. It is imperative that these students receive remediation early in childhood, as to develop skills necessary to adapt in various social environments.

One cause of social skills deficits is the high percentage of students with disabilities. The U. S. National Center for Education Statistics (2013) revealed that in the 2009-2010 school year, 6,481 students were enrolled in public school systems across the country, 13.1 percent of the total enrollment. For so many students, the development of social skills does not come naturally,
and children with disabilities are at a much higher risk of impaired social development than their typical peers (Milson & Glanville, 2009). These deficits in social learning can take on a variety of appearances, including problem solving, depression, aggressive behavior, lack of self-control, ineffective communication, fewer meaningful relationships, and even academic underachievement.

These negative effects of social skills deficits can affect typical students as well as students with disabilities. However, students with disabilities are at a greater risk for social rejection than their typical peers. Rick, Loo, Yang, Dang, and Smalley (2009) stated that in dealing with ADHD, an estimated 50-60 percent of children with ADHD are socially rejected by their peers, in contrast with a mere 13-16 percent of their peers who are typically developing. In conjunction, Milsom and Glanville (2009) also asserted that the lack of social skills in children with specific learning disabilities can yield decreased peer acceptance and even an increased number of instances of being bullied.

When dealing with problem solving deficits, Bellini (2007) reminds researchers that social problem solving involves two different types of analysis, that of the social situation and that of social competence. Only in analyzing both can the individual categorize and apply appropriate social behaviors to a variety of social situations. Children with specific learning disabilities have social skills deficits in the areas of communication, cooperation, self-control, and assertive behaviors (Milsom & Glanville, 2009). They also found that these students demonstrated inappropriate peer interactions by being overly aggressive with their peers and interacting ineffectively.
Much research has been conducted with students with Autism Spectrum Disorders (ASD) and the social deficits that accompany the diagnosis. These deficits can include difficulty with initiating conversation, making and maintaining eye contact, displaying emotions—especially empathy, and interpreting social cues. These persistent social deficits typically occur without regard to language or cognitive abilities. Students with ASD not only lack understanding in how to properly and appropriate demonstrate such skills, they often do not know the proper time to display these social skills, even if they are capable. As is typical of children with ASD, establishing meaningful relationships and having appropriate interactions proves to be both difficult and scarce. This in turn leads to a decreased social experience overall. Moreover, research has revealed that academic and occupational underachievement increases in students with ASD, along with mood and anxiety issues later in life resulting from a lack of proper social skills functioning (White, Keonig, & Scahill, 2007).

Social skills deficits are far too prevalent in today’s young children. Research attempts to discover a means to remediate social skills deficits through various therapies. One such therapy is a cognitive-behavioral approach. Kroeger, Schultz, and Newsom (2007) did a study with children with autism to compare two different social skills programs, one of direct teaching and the other of unstructured free play. They concluded that prosocial behaviors were increased in both groups. However, the group with direct instruction showed more significant gains than the group with no instruction. Furthermore, their study revealed that a social skills training format including groups not only allowed more children to benefit from services, but also allowed for greater number of peers with which students could interact.

This research study, among others, alludes to possible benefits of group social skills training programs. Kuehn’s (2007) study of children with mental illness investigates
effectiveness of a cognitive-behavioral approach to treatment of children with a group format. This study supports findings that children with depression, anxiety disorders, somatic disorders, and others such as abuse all benefitted from group cognitive-behavioral treatment. In these studies, children of varying disabilities, emotional disturbances, mental illness, and behavioral problems have all been found to benefit from the social skills training in a group setting.

**Social Skills Training**

Research-based social skills training programs have proven to be an effective approach in remediating social skills deficits. Through social skills training programs, a variety of students have been positively affected, including children and adolescents with problem behaviors and psychopathologies, emotional and behavioral disorders, conduct problems, racially and ethnically diverse backgrounds, and Autism Spectrum Disorders (Harrell, Mercer, & DeRosier, 2009; Cook, et al., 2008; Koegl, Farrington, Augimeri, & Day, 2008; Payton, et al., 2008; Rao, Beidel, & Murray, 2007). Social skills training with preschoolers revealed that children are not only motivated by rewards and incentives, but also possess the social desire to meet behavioral expectations to maintain positive relationships with those of importance in their social environment (Thompson & Raikes, 2007). With secondary-aged students, those receiving social skills training improved 66% while those in the control group improved only 34% (Cook, et al.).

There are several types of social skills training programs from which to choose when attempting to make a positive impact on students with social skills deficits. Durlak and Weissberg (2007) emphasize the value of using evidence-based programs when teaching social skills. Cornelius and Natvig (2011) suggest that starting with what the children know and building from there is a simple and effective learning strategy. Some researchers suggest basing
the program on skills to be taught. Harrell, Mercer, & DeRosier (2009) speculated that social
skills training programs that produce the most positive outcomes are those that combine
behavioral modeling, social perception, social problem solving, and self-regulation techniques.
Stichter, Randolph, Gage, and Schmidt (2007) state that self-related behaviors such as self-
estime, self-management, and the ability to recognize and understand cause and effect, are of
important consideration. These behaviors increase independence by allowing students to socially
interact with their peers without direct supervision.

Other debates involving which social skills training program is most effective do not
envelope what skills to be taught. Instead, these researchers argue which approach to teaching
social skills gains greater results. One study including social skills remediation, during and after
school, proposed that a social and emotional approach to social skills training was effective for
children with and without behavioral and emotional problems (Payton, et al., 2008).
Furthermore, findings from this study were indicative of an increase in positive prosocial skills,
social-emotional skills, and attitudes towards themselves and others.

LeCroy (2007) indicated that a cognitive-behavioral approach to group therapy is the
most commonly utilized type of social skills training with young children and adolescents. Sze
and Wood (2007) used an evidence-based cognitive-behavioral format for social skill
remediation with an adolescent girl with high-functioning autism. These findings signified that
social and adaptive functioning were improved, but also the young girl’s anxiety was effectively
reduced. A multi-faceted cognitive-behavioral group social skills training program was used by
Koegl, Farrington, Augimeri, and Day for social skills remediation with children ages 6 through
11 with conduct problems (2008). They found that after participation in this program, post
treatment delinquency and aggression has significantly decreased in the 80 children involved.
Music Therapy to Improve Social Skills

Several studies have been conducted examining the effect of music therapy on improving various social skills. Social elements of music have not only been identified, but have also been incorporated into the practice of improving such skills. Several steps are needed to impact a child’s social skills acquisition, the first of which is motivation to participate in the activity. Once motivation for the student is present, the child must personally make the decision to participate with both the therapist and the other children in the music setting. Next, the child must form a relationship with the music, the music therapist, and the other students within the group. Only after a trusting, open relationship is formed can the child begin to acquire and develop new social skills that may be transferred to other environments.

In working with students with special needs, it is important to consider that any change in the students’ environment may be unwelcomed and even perceived as abrasive. Students with special needs can occasionally have limited interests and may be reluctant to the therapists’ good intentions of introducing new ideas. However, these same students could simply be naïve to the possibilities of expanding their experiences within the music therapy session (Thompson, 2012). Gaining a student’s cooperation is vital to a successful session. Pasiali (2012) reveals that it is imperative to remember that “both temperament and quality of interactions contribute to differences in cooperation.”

Building relationships with the music, the music therapist, and the other group members could potentially prove to be difficult for the student. Using traditional instruments to accompany familiar music can assist in the development of relationships while also promoting a safe environment (Behrens, 2012). A relationship with the music therapist can be accomplished by fostering positive experiences for the student (Magee et al., 2011). This relationship may then
lend support to social skill acquisition and perhaps cognitive growth. Crowe and Ratner (2012) found that cooperative efforts in a group setting increased socialization significantly. In that particular study, participation levels increased by a dramatic 75%. Another study of group music therapy found that it was the supportive nature of group sessions that lent focus towards developing social skills (Smith, 2012). It is that supportive nature that allows participants in the group to form relationships with each other.

In order for the student to acquire social skills, the music activities and the structure of the music therapy session must work in conjunction with one another to create a proper environment for learning. Activities must be chosen based on the skill the student is to attain. Introduction of interpersonal skills, self-management skills, nonverbal communication skills, verbal communication skills, and social interactions all can be accomplished through group music therapy sessions with suitable music activities appropriate to each skill. “The cooperative nature of music activities allows children to use these…skills toward social goals of following directions, sharing, turn-taking, cooperation, and awareness of others” (Gfeller, Driscoll, Kenworthy, & Van Voorst, 2011). In a study conducted surveying paraeducators, the professionals learned that students that were engaged in music therapy sessions revealed their skills and preferences, were motivated by the music to elicit responses, and were relaxed and calmed by the music (Abbott & Sanders, 2012). Furthermore, paraeducators not only learned that the structure of group music therapy sessions impacted student performances, students were able to extrapolate skill acquisition done within the session to other environments.

When using a group cognitive-behavioral approach to remediate social skills deficits, music-based interventions appear to be effective (Koegl, et al., 2008). As previously stated, one of the largest groups of students in need of social skills training and/or remediation is that of
students with disabilities. A study on music teachers’ perceptions, opinions, and experiences with inclusion discovered the value of music for social gain (Scott, Jellison, Chappell, & Standridge, 2007). Through the aid of a music class, teachers noted a more positive attitude in their typically developing students towards students with disabilities. Furthermore, typical students that interacted with students with disabilities had an increase in awareness of those students’ capabilities and an increased sensitivity to those students.

Several other studies of music and social skills yielded positive results in the form of social skills acquisition. Henley, Caulfield, Wilson, and Wilkinson (2012) did a study in prisons of the positive effects of music through social music-making. They found that music was a catalyst for social change through increased communication between prisoners and a new level of confidence in themselves to continue to grow in their communication and coping skills. A study of infant attentiveness in structured group music classes showed that when there are high levels of appropriate response, imitation of peers is highly desirable. The group music activities yielded a direct benefit to those social learning opportunities (Standley, Walworth, Engel, & Hillmer, 2011). In a study on the effect of music to aid transitions in the early childhood classroom, Register and Humpal (2007) discovered that music-assisted transitions helped to gain the attention and focus of the students and created quick transitions. Geist and Geist (2012) point out that current music neuroscience research is demonstrating that the brain’s reaction to a rhythmic stimulus, such as a steady beat, aids in improved attention. In the early childhood classroom, music therapy clinicians often utilize rhythm-based techniques to facilitate improved attention and learning.

Music therapy’s effect on social skills has long been documented. Walworth (2009) indicated music therapy’s effectiveness in improving parent-child interactions, a crucial social
skill developed during infancy. In studying preschool age children with developmental disabilities, Sussman (2009) found that musical objects are successful in growing peer awareness as a social skill through music therapy interventions. Another study working with people who are homeless and mentally ill used the music therapy method of singing to provoke change (Iliya, 2011). This study concluded that singing, toning, and chanting was a social, accessible experience that created opportunities for social interactions.

**Purpose**

The study of social skills deficits and social skills training programs has a broad base in current literature. The effects of music on social skills training have also been studied in depth. However, studies implemented with a music therapy curriculum or guide are few and far between. This study sought to continue the research endeavor for a curriculum for preschool children with and without disabilities that would aid in social skills acquisition for appropriate social development. This study was not intended to benefit one disability, child, or gender more than another. Group music therapy interventions were used in a preschool setting with the goal of improving social behaviors over time in the areas of interpersonal skills, self-management skills, nonverbal communication skills, and verbal communication skills. The researcher hoped to ascertain information as to whether or not this curriculum would be appropriate and beneficial for preschool children, as well as if the curriculum would hold the attention of the students to reduce off-task behaviors during sessions. Results from the research were documented, and their implications are discussed.
CHAPTER THREE
METHOD

Setting

This research was conducted at Goodwill Easter Seals in Mobile, Alabama, a non-profit, United Way partner agency that serves 12 counties in the Alabama-Florida Gulf Coast area. Goodwill Easter Seals provides services and programs to aid individuals and families in overcoming challenges due to disabilities. Serving people with disabilities and their caregivers, undereducated adults, unemployed adults, at-risk youth, veterans and active military, and providing early childhood education, Goodwill Easter Seals served over 9,200 people in 2012. Students at Goodwill Easter Seals receive physical therapy, occupational therapy, speech therapy, and music therapy contracted services through Mobile County Public School System.

Subjects

Subjects (N=25) were any students currently enrolled in the Goodwill Easter Seals preschool program, including both typically developing students and students with disabilities. Only those students with frequent absences were excluded from the study. In total, there were 13 females and 12 males, ranging in age from 3-5 years of age. Table 1 displays individual student demographics regarding gender, age, and disability if a diagnosis was present. Consent was obtained from the Institutional Review Board at The Florida State University, Anne Falkenhagen, Director of Goodwill Easter Seals, and all parents of students before any data were
collected (See Appendices A, B, and C). Student assent was also acquired through a script read by the researcher before the beginning of the first session (See Appendix D).

Table 1. Student Demographics by Gender, Age, and Disability

<table>
<thead>
<tr>
<th>Student</th>
<th>Gender</th>
<th>Age</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>F</td>
<td>3</td>
<td>Speech Delay</td>
</tr>
<tr>
<td>B</td>
<td>F</td>
<td>3</td>
<td>Typical</td>
</tr>
<tr>
<td>G</td>
<td>M</td>
<td>3</td>
<td>Typical</td>
</tr>
<tr>
<td>I</td>
<td>M</td>
<td>5</td>
<td>Typical</td>
</tr>
<tr>
<td>J</td>
<td>F</td>
<td>3</td>
<td>Typical</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
<td>5</td>
<td>Typical</td>
</tr>
<tr>
<td>N</td>
<td>F</td>
<td>4</td>
<td>Microcephaly, Seizures, Chromosome 5 Deletion</td>
</tr>
<tr>
<td>O</td>
<td>M</td>
<td>3</td>
<td>Typical</td>
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<tr>
<td>Q</td>
<td>F</td>
<td>5</td>
<td>Typical</td>
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<tr>
<td>U</td>
<td>M</td>
<td>5</td>
<td>Typical</td>
</tr>
<tr>
<td>W</td>
<td>F</td>
<td>5</td>
<td>Typical</td>
</tr>
<tr>
<td>C</td>
<td>F</td>
<td>3</td>
<td>Developmental Delay</td>
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<tr>
<td>D</td>
<td>M</td>
<td>4</td>
<td>Congenital CMV</td>
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<tr>
<td>E</td>
<td>F</td>
<td>5</td>
<td>Autism</td>
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<td>F</td>
<td>M</td>
<td>3</td>
<td>TAR Syndrome</td>
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<td>H</td>
<td>M</td>
<td>4</td>
<td>Phelan-McDermid Syndrome</td>
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<td>K</td>
<td>M</td>
<td>5</td>
<td>Down Syndrome</td>
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<tr>
<td>L</td>
<td>F</td>
<td>3</td>
<td>Distal 18q Syndrome</td>
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<td>F</td>
<td>3</td>
<td>Williams-Beuren Syndrome</td>
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<td>F</td>
<td>5</td>
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<td>F</td>
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<td>DiGeorge Syndrome</td>
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<td>T</td>
<td>F</td>
<td>5</td>
<td>Developmental Delay</td>
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<tr>
<td>V</td>
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<td>4</td>
<td>Cerebral Palsy</td>
</tr>
<tr>
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<td>M</td>
<td>3</td>
<td>Down Syndrome</td>
</tr>
<tr>
<td>Y</td>
<td>M</td>
<td>3</td>
<td>Morquio Syndrome, Kyphoscoliosis, Developmental Delay</td>
</tr>
</tbody>
</table>
The mean age of the control group was 4.0, with 6 girls and 5 boys. Nine students had disabilities, and two were typically developing. The mean age of the experimental group was 3.8, with 7 girls and 7 boys. All fourteen students in the experimental group had disabilities.

**Dependent Variables**

A researcher-created assessment form, the Music Therapy Social Skills Brief Behavior Rating, adapted from the Social Skills Brief Behavior Rating (Gooding, 2010), was used to assess pretest and posttest social skills competency of the subjects (See Appendix E). The MTSS Brief Behavior Rating form was a 14-item questionnaire measuring 13 different social skills, the last question being that which asks for an overall competency score. Competency was defined as a developmentally appropriate skill demonstration for a typically developing child. Each item used a Likert scale rating from 1(not competent) to 10 (extremely competent). Teachers within the facility rated the students prior to the first session and immediately following the last session in order to gain pretest and posttest scores.

On-task and off-task behaviors of the groups were also observed and scored during sessions using the Group On-task/Off-task Form (See Appendix F). This form was adapted from Form H: Group On-Task/Off-Task Teacher Response (Madsen & Madsen, 1998). Six observers were trained to complete the forms during sessions for both the experimental and control groups. Three observers per session took data on the students’ on-task behavior for either the control group or the experimental group. The same three observers were used for each session. Students were observed once every three minutes during the 30-minute sessions, and the total number of on-task students was recorded. Observer reliability was calculated and an on-task behavior percentage was scored for each session for both groups.
Design

The two groups, control and experimental, were of a convenient sample with the children divided by the Goodwill Easter Seals facility administrator. Social skills pre-tests and post-tests were performed.

Procedure

Students were randomly assigned to either a control group receiving no music, or an experimental group in which music therapy techniques were utilized. Data were taken one week prior to the beginning of the first session using the Music Therapy Social Skills Brief Behavior Rating assessment sheet forming pre-test scores. Over a period of six weeks, one new social skill per week was introduced and previously demonstrated social skills were reviewed during a 30-minute session. Included in Table 2 is the curriculum scope and sequence used in this study and designed by Lori Gooding for her study on the effect of a music therapy-based social skills training program with children and adolescents (Gooding, 2010). Students in both groups were expected to participate in the activities generated by the researcher (See Appendix G).

Experimental group tasks included hello and goodbye songs, dancing, structured movement to music, free movement to music, instrument playing, books read to song, rhythmic chants, call- and-response songs, musical instructional of movement with various props such as ribbons and beanbags, songs with hand motions, and follow-the-leader type activities. Activities of the control group were similar, but no music was used. Control group activities consisted of spoken hellos and goodbyes, structured movement without music, books merely read instead of with song, call-and-response chants with no singing or specific rhythm, spoken instructional movement of various props, songs with hand motions performed by speaking lyrics with no
specific rhythm, movement of a parachute with verbal instruction, Simon Says game, and a story-telling activity. Session plans for both group behavioral observations of on-task social behavior during group sessions were also documented using the Group On-Task/Off-Task Form. Sessions took place in the Goodwill Easter Seals preschool facility in a large meeting room.

Social skills discussed included interpersonal skills, self-management skills, nonverbal communication skills, verbal communication skills, and skill integration with social interaction. One week after the conclusion of the final session, the Music Therapy Social Skills Brief Behavior Rating form was redistributed in order to collect posttest scores of social function on the students. Results and suggestions for future research are discussed.
<table>
<thead>
<tr>
<th>Social Skills</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Relations – Interpersonal Skills</td>
<td>Respect/Cooperation Participation Conversation Skills</td>
<td>Skill Review</td>
<td>Skill Review</td>
<td>Skill Review</td>
<td>Skill Review</td>
<td>Skill Review</td>
</tr>
<tr>
<td>Self-Management Skills</td>
<td></td>
<td>Focusing Attention Impulse Control Following Directions</td>
<td>Skill Review</td>
<td>Skill Review</td>
<td>Skill Review</td>
<td>Skill Review</td>
</tr>
<tr>
<td>Peer Relations – Nonverbal Communication Skills</td>
<td></td>
<td>Eye Contact Facial Expression/ Gestures</td>
<td>Skill Review</td>
<td>Skill Review</td>
<td>Skill Review</td>
<td>Skill Review</td>
</tr>
<tr>
<td>Peer Relations – Nonverbal Communication Skills</td>
<td></td>
<td>Personal Space</td>
<td>Skill Review</td>
<td></td>
<td>Skill Review</td>
<td>Skill Review</td>
</tr>
<tr>
<td>Peer Relations – Verbal Communication Skills</td>
<td></td>
<td>Taking Turns Listener Responsiveness</td>
<td></td>
<td>Skill Review</td>
<td></td>
<td>Skill Review</td>
</tr>
<tr>
<td>Skill Integration/ Social Interaction</td>
<td></td>
<td>Review of All Skills Skill Integration Skill Transfer</td>
<td></td>
<td>Skill Review</td>
<td></td>
<td>Skill Review</td>
</tr>
</tbody>
</table>
CHAPTER FOUR

RESULTS

Total scores were calculated for each student’s pre-test. Utilizing a Mann-Whitney U, a significant difference at a level of .05 was found between pre-test scores of the control group and the experimental group ($U=130.5; p>.05$). In order to account for the difference in the baseline level between groups, change scores were then calculated for each student to determine overall effect between pretest and posttest data. Change scores were then analyzed with a Mann-Whitney U test to determine significance level. There was no significant difference at a level of .05 in overall change scores between the pre-test and post-test data for control and experimental groups ($U=64.5; p>.05$). Raw scores of the pre-test and post-test are listed in the table below, along with the change scores for each student.

Table 3. Pre-Test, Post-Test, and Change Score Raw Data

<table>
<thead>
<tr>
<th>Student</th>
<th>Pre-test Score</th>
<th>Post-Test Score</th>
<th>Change Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>98</td>
<td>74</td>
<td>-24</td>
</tr>
<tr>
<td>B</td>
<td>119</td>
<td>107</td>
<td>-12</td>
</tr>
<tr>
<td>G</td>
<td>61</td>
<td>57</td>
<td>-4</td>
</tr>
<tr>
<td>I</td>
<td>127</td>
<td>127</td>
<td>0</td>
</tr>
<tr>
<td>J</td>
<td>127</td>
<td>111</td>
<td>-16</td>
</tr>
<tr>
<td>M</td>
<td>77</td>
<td>105</td>
<td>28</td>
</tr>
<tr>
<td>N</td>
<td>62</td>
<td>57</td>
<td>-5</td>
</tr>
<tr>
<td>O</td>
<td>109</td>
<td>121</td>
<td>12</td>
</tr>
<tr>
<td>Q</td>
<td>130</td>
<td>130</td>
<td>0</td>
</tr>
<tr>
<td>U</td>
<td>98</td>
<td>86</td>
<td>-12</td>
</tr>
<tr>
<td>W</td>
<td>108</td>
<td>113</td>
<td>5</td>
</tr>
</tbody>
</table>
### Table 3 - continued

<table>
<thead>
<tr>
<th>Student</th>
<th>Pre-test Score</th>
<th>Post-Test Score</th>
<th>Change Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>54</td>
<td>101</td>
<td>47</td>
</tr>
<tr>
<td>D</td>
<td>50</td>
<td>45</td>
<td>-5</td>
</tr>
<tr>
<td>E</td>
<td>116</td>
<td>110</td>
<td>-6</td>
</tr>
<tr>
<td>F</td>
<td>109</td>
<td>118</td>
<td>9</td>
</tr>
<tr>
<td>H</td>
<td>36</td>
<td>20</td>
<td>-16</td>
</tr>
<tr>
<td>K</td>
<td>55</td>
<td>91</td>
<td>36</td>
</tr>
<tr>
<td>L</td>
<td>29</td>
<td>20</td>
<td>-9</td>
</tr>
<tr>
<td>P</td>
<td>84</td>
<td>56</td>
<td>-28</td>
</tr>
<tr>
<td>R</td>
<td>81</td>
<td>64</td>
<td>-17</td>
</tr>
<tr>
<td>S</td>
<td>46</td>
<td>116</td>
<td>70</td>
</tr>
<tr>
<td>T</td>
<td>47</td>
<td>100</td>
<td>53</td>
</tr>
<tr>
<td>V</td>
<td>30</td>
<td>19</td>
<td>-11</td>
</tr>
<tr>
<td>X</td>
<td>105</td>
<td>99</td>
<td>-6</td>
</tr>
<tr>
<td>Y</td>
<td>60</td>
<td>120</td>
<td>60</td>
</tr>
</tbody>
</table>

Table 4 indicates vast differences on pre-test scores between the experimental and control groups. These differences were larger in size than change scores calculated for each participant from pre-test to post-test.

### Table 4. Mean Scores for Pre-Test and Post-Test Data

<table>
<thead>
<tr>
<th></th>
<th>Pre-Test Means</th>
<th>Post-Test Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>64.43</td>
<td>77.07</td>
</tr>
<tr>
<td>Control</td>
<td>101.45</td>
<td>98.91</td>
</tr>
</tbody>
</table>

Concluding that mean differences between groups’ pre-tests scores were vastly dissimilar, and because sample size was so low for the control group (N=11) and experimental group (N=14), no further pre- and post- test data were statistically analyzed. However, to look at this set of data on a more micro level, according to the curriculum scope and sequence, items on
the Music Therapy Brief Behavior Rating were broken down by skill-set category. Table 5 displays the session topics and their corresponding items scored on the test.

Table 5: *Pre-Test Items by Category Taught with Corresponding Session Number*

<table>
<thead>
<tr>
<th>Session 1</th>
<th>Greets others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Skills</td>
<td>Initiates conversations</td>
</tr>
<tr>
<td></td>
<td>Demonstrates verbal planning</td>
</tr>
<tr>
<td>Session 2</td>
<td>Demonstrates self-control</td>
</tr>
<tr>
<td>Self-Management Skills</td>
<td>Able to focus attention</td>
</tr>
<tr>
<td></td>
<td>Demonstrates impulse control</td>
</tr>
<tr>
<td></td>
<td>Follows Directions</td>
</tr>
<tr>
<td>Session 3</td>
<td>Appropriate eye contact</td>
</tr>
<tr>
<td>Nonverbal Communication Skills</td>
<td>Responds to nonverbal cues</td>
</tr>
<tr>
<td>Session 4</td>
<td>Awareness of others</td>
</tr>
<tr>
<td>Concept of Personal Space</td>
<td>Appropriate personal space</td>
</tr>
<tr>
<td>Session 5</td>
<td>Cooperates with peers</td>
</tr>
<tr>
<td>Verbal Communication Skills</td>
<td>Actively listens</td>
</tr>
</tbody>
</table>

With this information in mind, means were calculated from the pre-test and post-test scores based on individual categories. While overall change scores from pre-test to post-test were determined to be insignificant, experimental group scores increased on the post-test across all five categories. As session six was merely skill integration and transfer, and no new skills were introduced, it was excluded from this breakdown of categories. Furthermore, the final item on the Music Therapy Social Skills Brief Behavior Rating was excluded, as “overall social skills behavior” could not effectively been grouped with the other five skill sets.

Control group means increased from pre-test to post-test in only one category, self-management skills, during session 2. In all other categories, the control group decreased in mean scores over time. In contrast, however, the experimental group increased in mean scores from pre-test to post-test in every single category. The scores increased each week over the six-week
study, with the greatest increases in weeks 1 and 2, interpersonal skills and self-management skills. Included in Figure 2 is a graph for each group indicating mean score increases and decreases from pre-test to post-test according to session number.

Figure 1: *Control and Experimental Group Mean Scores Broken Down by Session Number*
Using the percentage data found of students on task during each session, averages for students’ on-task behavior over the course of the six-week study were found. Students in the control group had an average percentage of 91.3333% while students in the experimental group had an average percentage of 91.1667%, a difference of only .1667 between groups over time. A 2x6 Chi-square test was performed on the on-task behavior percentages over the six weeks of sessions. With a Chi-square value of 4.033 and 5 degrees of freedom, a $p$-value of .545 was obtained, showing that on-task percentages between the control and experimental groups were not significant. The only possible correlation noted with the control group was that on-task behaviors were greatest during weeks 1, 2, and 5, and the only increase found in pre-test and post test scores was from week 2. The control group, with the lesser amount of students with special needs, had a higher percentage of on-task behavior during sessions teaching interpersonal skills, self-management, and verbal communication. By contrast, the weeks in which the experimental group, the one with a greater number of students with special needs, had the highest percentages of on-task behavior were during the sessions pertaining to non-verbal communication skills. On-task behavior percentages for each session are listed below in Figure 1.
Figure 2: *Percentages of On-Task Behavior During Sessions*

Figure 1 demonstrates the rise in on-task behavior scores of the experimental group over time, and a decrease in the scores of the control group.

**Summary**

This study attempted to measure how group music therapy sessions affected social skills acquisition in preschool students. Over the six-week study, no significant differences were found in the pre-test and post-test overall scores of the control or experimental groups. Once broken down into skill-set categories, it was discovered that the experimental group increased mean scores from pre-test to post-test in each of the five skill areas. The control group only increased in one area. Percentages of on-task behavior during sessions were also found to have no significant difference.
CHAPTER FIVE
DISCUSSION

This study’s purpose was to determine if group music therapy social skills training had an influence on social skills acquisition in preschool-aged students. Data analysis revealed no significant differences between comparisons of control and experimental group data. Further analysis of skills acquisition by category demonstrated a rise in post-test mean scores across all five categories of the experimental group over the course of six weeks. While students showed no statistically significant improvement in social skills collectively, some individual student data, improved dramatically. These findings indicate that music during social skills training is an effective means of increasing social skills in preschool students.

Anecdotal Observations

Throughout the course of this study, the researcher recorded various behavioral observations of the students. Although these particular behaviors were not recorded as data, they do suggest that music therapy was, in some ways, an effective means of conducting social skills training with preschool students. The researcher noticed that during experimental group sessions, the students shifted attention between the researcher’s face and the instrument or prop used for that activity. Also, while shifting their attention, many children showed signs of positive affect, which implied a shared affective experience with the researcher. Furthermore, the students were not verbally instructed to play their instruments, yet many of them chose to play nonetheless. The same observation was made with singing. While the researcher was
singing, many students began to sing as well, without ever being instructed to do so. All four of these observations indicate that the use of music instruments or props was effective in gaining attention of preschool aged students. Focused attention, eye contact, shared affect, and participation all warrant consideration in using music therapy to obtain attention.

When selecting activities to implement with preschool-aged children, several observations were made by the researcher. As with instruments holding attention, activities involving a book or verbal story maintained attention of the students. This was particularly true with books set to song, rather than rhyme or steady beat. While an instrument may be new for each activity, a book holds several new illustrations within the same activity. In addition, activities involving movement were very well received through affect and laughing, but were also strong in participation. The researcher noticed, however, that activities involving following a leader around the room were much more chaotic than simple motions in place, and more off-task behavior was observed during the former. Finally, activities with a separate prop or instrument for each student had much less off-task behavior than activities that involved one prop, such as a parachute, for the entire group. These reflections may be helpful when selecting activities in future research.

Even though the numerical data showed no significant differences in pre-test and post-test scores, verbal reports from teachers and family members stated otherwise. One teacher commented on the post-test, “She imitates music now – tries to sing a lot and on beat! This has really done her good. In meeting with a parent after the final session of the study, she stated the following about her child who had been involved in this research:
I am so appreciative of the work you’re doing with my son. For the last three weeks or so, he has just come out of his shell socially, and the only thing that has changed for him lately has been his involvement in your study (A. Carpenter, personal communication, February 28, 2013).

Limitations

Several important limitations exist in this study that are necessary to consider when reviewing the results of this research. Limitations with the sample used are the disproportional representations of gender, age, and disability. As this was a sample of convenience, equal numbers of boys and girls were not obtained, nor were an equal number of students of each age group, ages 3, 4, and 5. The varying disabilities of these students may have accounted for on-task and off-task behavior due to the corresponding varying levels of capabilities. In addition, some students in this study had prior knowledge of music therapy and even some of the activities or songs used from previous music therapy experience. This may have skewed data in the form of on-task and off-task behavior in either the form of familiarity causing lack of attention due to boredom or familiarity causing increased attention due to experience.

Setting limitations consisted of group cohesiveness and of meeting space. Children enrolled in the Goodwill Easter Seals preschool program are divided into four small classrooms of about seven students in each room. It was a rare occurrence that all students enrolled in the preschool came into one room for a large group setting. Furthermore, in their classrooms they sat around a horseshoe table in small chairs. For the purposes of this research, all the students sat on the floor in the large meeting room with open space between them and the music therapist.
As this is rare, these setting limitations may also have affected on-task and off-task behavior during sessions.

Finally, there were several procedural limitations that existed in this research study. Each teacher completed the Music Therapy Social Skills Brief Behavior Rating form for the students in her class. With four separate classrooms, there were four different points of view lending values for the Likert scale rating of 1-10 of social competencies. Had one person completed the form for all the students in the study, pre-test and post-test data may have been more consistent, and perhaps could have even changed the results of this study. Also the time, length, and frequency of music therapy sessions were also a limitation to the study. Conducted in the spring semester of the school-year calendar, this study dealt with holidays and needed to reschedule some sessions to fit the school’s schedule. Restructuring the study’s set day each week may have played a role in the results of the research. Moreover, this study was conducted for only six weeks, a length of time perhaps too short for such young students needing more than just one week per skill. In conclusion, as the frequency of sessions was once per week, students may have needed more reinforcement for each social skill set taught before moving on to the next series of skills.

**Suggestions for Future Research**

Limitations of this study that were discussed imply several suggestions for future research. To avoid the boundaries listed with the sample itself, have equal numbers of boys and girls, equal number of students in each age group aged 3, 4, and 5, and an equal number of students with disabilities versus students who are typically developing. Not only would this level any disparities with poorly represented populations, it would allow for further analysis of
data between population classifications. Furthermore, controlling for the type of disability in future research could equalize the ability level of students as a collective group. Also, including several preschools in the study would achieve a greater sample size.

Procedural suggestions for future research would be to control for varied perspectives on the Music Therapy Social Skills Brief Behavior Rating. Doing so can be accomplished by having only one person fill out the form who is knowledgeable of all students in the study. Extending the study beyond six weeks is another suggestion that may allow for more in-depth introduction and integration of social skills presented. Moreover, increasing the number of sessions per week would reduce time between sessions to aid in skill retention.

Other suggestions for future research refer to limitations found in data analysis. Since overall scores of the pre-test and post-test were not significant in either group, future research endeavors could seek to discover if group curriculum is as effective as individual sessions. Researchers need to look into curriculum adaptations in order to reach this preschool population. Also, if individual change scores increased by such large numbers as 28, 36, 47, 53, 60, and even 70 points, research should be directed towards uncovering a reason as to why over half of the total scores decrease between pre-test and post-test. In paying special attention to the area of self-management skills, research should try to determine a reason why this is the only skill set in which both experimental and control group means increased over time.

Conclusions

“Each group has their own specific characteristic and needs, and the flexible nature of music makes it an effective medium for addressing these multifarious needs” (Kalas, 2012). Strong social skills are crucial for a student’s successful functioning the classroom, social
settings, and life in general. Without appropriate social skills, students’ ability to interact with others effectively is unattainable. It is imperative that clinicians continue to research social skills training with preschool children, as a deficit during childhood in social functioning has been linked to several negative outcomes later in life (Gooding, 2010). This study sought to use music therapy as an effective means of social skills training in preschool-aged students. Further research is needed to determine the ideal setting and procedure necessary to impact preschool students’ acquisition of social skills to increase their potential of a successful future.
Florida State University

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

APPROVAL MEMORANDUM

Date: 12/17/2012

To: Jessica Simpson

Address:

Dept.: MUSIC SCHOOL

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research

The Effect of Music Therapy on Social Skills Training in a Preschool Setting

The application that you submitted to this office in regard to the use of human subjects in the research proposal referenced above has been reviewed by the Human Subjects Committee at its meeting on 11/21/2012. Your project was approved by the Committee.

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 11/20/2013 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 chairman 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 IRB#00000446.

Cc: Jayne Standley <jstandley@music.fsu.edu>, Advisor

HSC No. 2012.9051
APPENDIX B

GOODWILL EASTER SEALS PROGRAM DIRECTOR APPROVAL LETTER

December 10, 2012

Ann Falkenhagen, Program Director
Goodwill Easter Seals
10 Westminster Way
Mobile, AL US 36608

Dear Human Subjects Committee:

It is my understanding that Jessica Simpson will be conducting a research study at Goodwill Easter Seals on “The Effect of Music Therapy on Social Skills Training in a Preschool Setting.” Ms. Simpson has informed me of the design of the study as well as the targeted population.

I support this effort and will provide any assistance necessary for the successful implementation of this study. If you have any questions, please do not hesitate to call. I can be reached at (251) 342-3122.

Sincerely,

Anne Falkenhagen, Program Director
Director, Goodwill Easter Seals
APPENDIX C

APPROVED CONSENT FORM

Consent for Research

Title of Project: The Effect of Music Therapy on Social Skills Training in a Preschool Setting

Principal Investigator: Jessica Simpson

Participant's Printed Name: ____________________________

1. Purpose of the Research

Your child is being offered the opportunity to take part in this research because your child is listed as a currently enrolled student at Goodwill Easter Seals of Mobile, Alabama. This research is being done to determine if music therapy can aid in the learning of social skills in a preschool setting. It is hypothesized that music therapy will be a beneficial tool in the acquisition of social skills for children in a preschool setting. Approximately 30 students will take part in this research nationwide, all of which will take place at Goodwill Easter Seals of Mobile, Alabama.

2. Procedures to Be Followed

PI will acquire signed consent forms from the parents or guardians of the students during the facility’s scheduled drop-off time in the spring semester of the 2012-2013 school year. After consent is received from parents for all students, PI will begin research at an agreed upon time with both the facility director and the classroom teachers. For a series of six weeks, PI will introduce one new social skill each week for six weeks and review previous skills learned during a 30 minute session. Participants will be randomly assigned to either a control group or an experimental group. In the control group, no music will be used. In the experimental group, music therapy techniques will be utilized. Students in both groups will be expected to participate in the activities generated by the PI. All activities performed are standard music therapy clinical procedures that may include puppets, bean bags, instrument playing, dancing, singing, book readings, and possible use of other props.

PI will take data using a researcher-created social skills rating system with two facility staff members (facility director, case manager, teacher, or paraprofessional) giving pre-test and post-test ratings on social functioning using Likert-type ratings, and they will give behavioral observations of on-task social behaviors during group sessions.

3. Risks and Benefits of Being in the Study

As music therapy is non-invasive, minimal risks are involved for participants. The possible benefits participants may experience from music therapy described in this research is the acquisition of social skills through peer interaction. There is no guarantee that participants will benefit from being in this research. The results of this research may guide the future teaching techniques of social skills with the aid of music therapy to students in a preschool setting.

4. Compensation for Participation:

You will not receive any compensation for being in this research study.

Consent for Research Template Rev 6-08
Version 9/19/06
FSU Human Subjects Committee Approved on 12/13/2012. Void after 11/20/2013. HSC # 2012.9051
5. **Statement of Confidentiality:**

Your research records that are reviewed, stored, and analyzed from the research conducted at Goodwill Easter Seals will be stored on the PI’s personal computer until December 31, 2013 in the form of Microsoft Word documents and video files. No one will have access to PI’s personal computer except PI during this time. Additionally, PI will use the "lock" option on the computer to maintain security and protect data, and no one but the PI will have access. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared.

11. **Voluntary Participation:**

Participation in this study is voluntary. You do not have to participate in this research. If you choose to take part, you have the right to stop at any time. If you decide not to participate or if you decide to stop taking part in the research at a later date, there will be no penalty or loss of relationship with Goodwill Easter Seals of Mobile, Alabama.

12. **Contact Information for Questions or Concerns:**

You have the right to ask any questions you may have about this research. If you have questions, complaints or concerns related to this research, contact Jessica Simpson at

If you have questions regarding your rights as a research participant or you have concerns or general questions about the research, contact the facility coordinator at Goodwill Easter Seals at (251) 342-3122. You may also call this number if you cannot reach the research team or wish to talk to someone else.

**Signature and Consent/Permission to be in the Research**

I have read the above information. I have asked questions and have received answers. I consent for my child to participate in the study.

<table>
<thead>
<tr>
<th>Signature of Participant's Legal Guardian</th>
<th>Date</th>
<th>Time</th>
<th>Printed Name</th>
</tr>
</thead>
</table>

Consent for Research Template Rev 6-08
Version 9/19/06
FSU Human Subjects Committee Approved on 12/13/2012. Void after 11/20/2013. HSC # 2012.9051
SAMPLE ASSENT SCRIPT FOR CHILDREN AGES 3-5

Hello, my name is Ms. Jessica Simpson. I am working on a project, and I am asking if you want to be a part of it.

Today we will be [playing games, playing with beanbags, playing instruments, dancing, reading a book, etc. – whatever the plan is that week]. We are going to have our group time in the activity room for about 30 minutes.

Now you get to choose if you want to be in the group. You don’t have to be in the group if you don’t want. It’s your choice. No one will be upset in any way if you do not want to participate. If you choose not to join the group you can stay in your classroom until the group time is over.

Would you like to come join the group?
APPENDIX E

MUSIC THERAPY SOCIAL SKILLS BRIEF BEHAVIOR RATING

MTSS Brief Behavior Rating

Name_____________________  Age________________  Date_______________

Group_____________________  Therapist/Teacher_______________________________

Rate each skill on a scale from 1 to 10 with 1 being significantly below competency and 10 being the highest level of competency. (Competency is defined as developmentally appropriate skill demonstration for a typically developing individual.) This scale may be used at different points during the training program to assess progress in the skills targeted within the program.

<table>
<thead>
<tr>
<th>Skill</th>
<th>Not competent</th>
<th>Average</th>
<th>Extremely Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of others</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dem. self control</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooperates with peers</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to focus attention</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dem. Impulse control</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actively listens</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appr. eye contact</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appr. personal space</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Res. to nonverbal cues</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greets others</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiates conversations</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dem. verbal planning (Thinks before speaking)</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows Directions</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall SS behavior</td>
<td>1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

*Adapted from Social Skills Brief Behavior Rating (Gooding 2010)
GROUP ON-TASK/OFF-TASK FORM

Observer______________________________________  Therapist_________________________
Reliability Observer______________________________  Group_______________ Date________
No. of group participants__________________________ Time: Start___________ End_________
Activity________________________________________ Page _______________ of ___________
Observation Interval_____________________________  Record Interval____________________
Behavior Recorded:  On-task_____________________ Off-task________________ (Circle One)
Behavior Defined:

_____________________________________________________________________________________

Instructions: For each interval, circle the behavior observed (on- or off-task) and write the number of
participants observed demonstrating the target behavior.

<table>
<thead>
<tr>
<th>Interval</th>
<th># Participants</th>
<th>On-task</th>
<th>Interval</th>
<th># Participants</th>
<th>On-task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>___________</td>
<td>Off-task</td>
<td>2</td>
<td>___________</td>
<td>Off-task</td>
</tr>
<tr>
<td>3</td>
<td>___________</td>
<td>Off-task</td>
<td>4</td>
<td>___________</td>
<td>Off-task</td>
</tr>
<tr>
<td>5</td>
<td>___________</td>
<td>Off-task</td>
<td>6</td>
<td>___________</td>
<td>Off-task</td>
</tr>
<tr>
<td>7</td>
<td>___________</td>
<td>Off-task</td>
<td>8</td>
<td>___________</td>
<td>Off-task</td>
</tr>
<tr>
<td>9</td>
<td>___________</td>
<td>Off-task</td>
<td>10</td>
<td>___________</td>
<td>Off-task</td>
</tr>
</tbody>
</table>

*Adapted from Form H: Group On-Task/Off-Task Teacher Response (Madsen & Madsen, 1998)
APPENDIX G

SAMPLE SESSION PLANS FOR EACH GROUP
Week 5 Session Plan
(Experimental Group- with music)

Goal: Peer Relations – Verbal Communication Skills
Objectives: Taking Turns, Listener Responsiveness

Introduction/Concept Review – 10 minutes
Hello Song: “My Right Hand’s Waving Hello”
- Children will be seated on a carpet with music therapist.
- Children will sing along, wave, and greet each other at the end of each repetition of the song.
- Children will practice various ways to say hello, prompted by music therapist.
- Words to “My Right Hand’s Waving Hello” are as follows:

“Hello, Ms. Jessica, how are you today?
My right hand says “hello,” and it’s giving you a wave.
Hello, Ms. Jessica, how are you today?
My right hand’s waving hello.”
- There will be a brief review of all social skills learned from previous sessions.

Skill Introduction/Warm-Up Activity: Leader of the Band (8 minutes)
Introduce skill for the day. Explain what it means to take turns, as well as what listener responsiveness means. Ask the children to describe what they do while they take turns (ex. sit quietly) and how they can practice good listening skills (ex. waiting for the other person to finish talking).
- Music therapist will distribute instruments to the children.
- Children must wait for their turn to be addressed to become the leader of the group.
- Each child will say, sign, or indicate “start/stop” command.
- Words to “Leader of the Band” are as follows:

“Ms. Jessica is the leader of the band
Ms. Jessica is the leader of the band
Ms. Jessica is the leader of the band
She tells us when to start and stop.”

Specific Skill Activity: Three Bears with a Beat (7 minutes)
Music therapist will introduce the story of “Goldilocks and the Three Bears” and begin to explain the activity. Students will be asked to listen for words such as “Papa Bear” or “Baby Bear” and appropriate responses will be explained. This particular version of the story has both rhymes and rhythm set to a steady beat.
- Music therapist will read the story and pat the steady beat.
- Children will be asked to pat their laps with the music therapist’s steady beat.
- When the key words are said, children will approximate the appropriate responses.

Wrap Up/Transfer/Goodbye Song: Book Reading (5 minutes)
Music therapist will sing the book Down by the Station. Students will be asked to sing along and/or say the last line of each page “... and off we go” when prompted by the music therapist. At the conclusion of the book, the music therapist will sing a goodbye song asking the children to wave goodbye.
Week 5 Session Plan
(Control Group- without music)

Goal: Peer Relations – Verbal Communication Skills
Objectives: Taking Turns, Listener Responsiveness

Introduction/Concept Review – 10 minutes
- Children will be seated on a carpet with music therapist.
- Music therapist will greet children by waving and saying hello.
- Children will practice various ways to say hello, prompted by music therapist.
- There will be a brief review of all social skills learned from previous sessions.

Skill Introduction/Warm-Up Activity: Simon Says (8 minutes)
Introduce skill for the day. Explain what it means to take turns, as well as what listener responsiveness means. Ask the children to describe what they do while they take turns (ex. sit quietly) and how they can practice good listening skills (ex. waiting for the other person to finish talking).
- Music therapist will ask the children to stand.
- Music therapist will demonstrate the rules of Simon Says.
- Music therapist will allow students to become the leader, based on participation in the group.
- Children must wait for their turn to be addressed to become the leader of the group.
- Each child will say, sign, or indicate their chosen command.
- At the conclusion of a turn, the student will return to his/her seat.

Specific Skill Activity: Three Bears with a Beat (7 minutes)
Music therapist will introduce the story of “Goldilocks and the Three Bears” and begin to explain the activity. Students will be asked to listen for words such as “Papa Bear” or “Baby Bear” and appropriate responses will be explained. This particular version of the story has both rhymes and rhythm set to a steady beat.
- Music therapist will read the story without emphasizing or patting the steady beat.
- When the key words are said, children will approximate the appropriate responses (ex. “GRRR”).

Wrap Up/Transfer/Goodbye: Book Reading (5 minutes)
Music therapist will read the book Down by the Station. Students will be asked to read along and/or say the last line of each page “… and off we go” when prompted by the music therapist. At the conclusion of the book, the music therapist will say goodbye to the children. Children will be asked to say and wave goodbye.


BIOGRAPHICAL SKETCH

Name: Jessica Simpson

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Higher Education: Auburn University
Auburn, AL
Major: Music Education
Degree: B. M. E.
Major: Psychology
Degree: B. A.

The Florida State University
Tallahassee, FL
Major: Music Therapy
Degree: M. M. (2013)

Experience: Mobile County Public School System
Mobile, AL (2011-2013)
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