A Music Therapy Vocal Intervention to Address Self-Esteem and Resilience in Female Adolescents At-Risk for School Failure

Jessica Power

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By: Jessica Power

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complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the final Examining Committee:

_____ Chair
Sandra Curtis

_____ Examiner
Guylaine Vaillancourt

_____ Examiner
Laurel Young

_____ Supervisor
Sandra Curtis

Approved by _____
Stephen Snow, Chair of the Department of Creative Arts Therapies

_____YEAR _____
Catherine Wild, Dean of the Faculty of Fine Arts

ABSTRACT

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Jessica Power

With the increased significance of a high school education in today's society, the modern public health system is focusing more on mediating factors, such as resilience, instead of risk factors, in an attempt to protect adolescents against school failure. The present research reports on the development of a program designed to strengthen resilience for female adolescents who are at-risk of school failure. As resilience is a complex, multi-layered construct, only one aspect, self-esteem, is addressed. Given the scope of the research, the first two steps of a five-step model for intervention design were completed in the development of an eight-session group vocal music therapy protocol. The program design is informed by analysis and application of pertinent literature and findings from semi-structured interviews with area experts – two music therapists, a school counsellor, and a special-care counsellor. This self-esteem vocal music therapy program design is intended to serve as one facet of a larger program aimed at improving resilience to mediate against school failure.

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Statement of the Problem

Over the past 20 years, Canada's shift from a manufacturing economy to a knowledge-based one has led to a dramatic increase in the significance of a high school education, with a large majority of new jobs requiring a minimum of a high school diploma (Brownell et al., 2010; Trypuc & Heller, 2008). Presently those who fail to reach this educational milestone face numerous challenges in both the personal and professional realms: lower self-esteem (Rosenbledt, 2002), lower earnings/poverty (Brownell et al., 2010; Edwards, Mumford, & Serra-Roldan, 2007; Trypuc & Heller, 2008), and a higher prevalence of unemployment (Brownell et al., 2010; Edwards et al., 2007; Trypuc & Heller, 2008). High school dropouts also have a higher incidence of delinquency (Rosenbledt, 2002), comprising 80% of the federal prison population (Trypuc & Heller, 2008).

Not all individuals have the same probability of leaving high school without a diploma. Certain groups are subject to risk factors that increase their vulnerability. Brownell et al. (2010) determined that youths who live below the poverty line, have teenage mothers, and/or are aided by child welfare services are at a higher risk for dropping out before finishing high school. Also, each added risk factor increases the level of impediment**,** with rates of school failure ranging from 41 to 57% in individuals with a single risk factor to 84% for those with all three; a cumulative effect also supported by other research (Anthony, 2006). Of the three factors, financial disadvantage is the most pervasive (Anthony, 2006; Brownell et al., 2010) and is frequently linked to a variety of co-morbid factors (Anthony, 2006). A study conducted by Brownell et al. examined but a

few of the many potential risk factors and their interactions, with much left to uncover about the lives of individuals considered to be at-risk. Despite any experiential commonalities outlined, Anthony (2006) argued that unique risk profiles must be considered in order for interventions to be effective in helping these individuals.

One significant aspect of a risk profile to consider, according to Anthony (2006), is gender. Numerous researchers highlight ways in which the female experience of risk differs from that of males. Criminal behavior in female adolescents is on the rise (Smith-Adcock, Webster, Leonard, & Walker, 2008; Zhang, 2008), as is attendance in alternative schools for female students expelled from mainstream schooling (Washington, 2008), which increases the risk for future delinquency and getting in trouble with the law (Zhang, 2008). Female youth deemed "high-risk" or "at-risk" also have unique experiences of: (a) decreased self-esteem (Rosenbledt, 2002); (b) substance use, abuse and violent behavior (Anthony, 2006; Smith-Adcock et al., 2008; Veltre & Hadley, 2012; Zhang, 2008); (c) mental health issues (Sausser &Waller, 2006; Smith-Adcock et al., 2008); (d) school and behavioral issues (Cobbett, 2009; Smith-Adcock et al., 2008; Washington, 2008; Zhang, 2008); (e) lack of parental support (Cobbett, 2009; Washington, 2008); (f) teen pregnancy (Brownell et. al., 2010; Smith-Adcock et al., 2008); and (g) various other traumas (Cobbett, 2009). Despite the increased prevalence and considerable needs of female adolescents at-risk, there is little programming in place to support them (Smith, 2012; Smith-Adcock et al., 2008; Zhang, 2008).

Risk, Protection and Resilience

As recently recognized by the American public health system, programming focused on risk factors alone has been deemed insufficient; there is now wide spread

recognition of the influence of protective factors on individual, familial, and community levels (Anthony, 2006). Unfortunately it is not as straightforward as merely decreasing risk factors and increasing protective factors; the relationships are far more multifaceted and interactive (Anthony, 2006). This belief underscores the study of resilience, which is defined as the investigation of the interplay between risk and protection, and the constructive development and growth that stem from the process (Anthony, 2006).

With vulnerability and adverse conditions as obligatory precursors, the study of risk and protection often spotlights the disadvantages faced by those who are at-risk, which many argue may unjustly pathologize and pigeonhole them (Anthony, 2006; Edwards et al., 2007). A movement toward positive, resilience-focused intervention and prevention research, however, is gaining traction internationally (Edwards et al., 2007). As indicated by studies spanning numerous cultures and ethnicities, resilience is possible for a wide range of people, and understanding how this interactional process relates to high school completion could greatly influence future programming for adolescents who are at-risk for school failure (Edwards et al., 2007).

Music Therapy and the Voice

One mode of intervention that is currently used with adolescents at-risk is music therapy. Music alone can play a valuable role in the coping processes of this population; pertinent themes and emotions can be reflected and regulated though music listening and with today's technology, music can be obtained, transported, and easily accessed by teenagers whenever needed (Austin, 2010; Laiho, 2004). When trained music therapists harness this powerful tool, they stand in a unique position to help adolescents; Laiho (2004) asserts that, "[Music] is an endless resource for identifying, understanding,

intensifying, changing, communicating, enjoying, releasing, and regulating different emotional states" (p. 56) and can be safer or less intimidating than addressing them verbally. Rüütel, Ratnik, Tamm, & Zilensk (2004), recognizing this connection, explicitly address the development of coping skills in female adolescents through music therapy programming.

Another way that music therapy is employed with female adolescents is in the use of voice for self-exploration and self-expression (Austin, 2010). The voice is inextricably linked to personhood and self-identity (Chong, 2000; Gackle, 2006), and is so essential to self-image that it sometimes goes unnoticed (Monks, 2003). It is for this reason that several authors contend that there is potential for increasing the self-esteem of adolescent females through the use of voice (Austin, 2010; Gackle, 2006).

Statement of Purpose

In light of the current dearth of gender-specific programming for this population (Brownell et al., 2010; Rosenbledt, 2002) and the potential benefit of a resilience-based intervention, the aim of this research is to devise a program designed for female adolescents who are at-risk for school failure, which strengthens their resilience. Resilience is a complex construct involving numerous elements on various ecological levels. Due to the necessarily limited scope of this research, focus is brought to a single aspect of resilience, the protective factor self-esteem, with an intention to explore other facets in future projects. The task of strengthening self-esteem in this program design is addressed through vocal and other music therapy interventions and is created to be implemented in the future with small groups of early adolescents in the school setting.

Music therapy with adolescents at-risk is an area of the field in which relatively little has been published, and what has been published focuses primarily on clinical descriptions of therapists' work with this population (Austin, 2010; Cobbett, 2009; Derrington, 2011; Nöcker-Ribaupierre & Wölfl, 2010; Veltre & Hadley, 2012). A limited number of research-based accounts have recently come to light (Gooding, 2011; Smith, 2012). It is intended that this research will serve to expand the solid base of clinical literature with a research-based program design for use with this population.

Assumptions and Bias

As a feminist and woman with my own personal story of self-esteem building through music, I am predisposed to believe in the potential of gender-specific music therapy programming for augmenting self-esteem in female adolescents. Also, my background as a vocalist gives me a biased perspective on the value of using the voice in this process, and my music therapy training leads me to believe that this could be an effective intervention. I have accumulated assumptions and knowledge about working with this population, having worked with adolescents who are at-risk in an alternative school setting for a period of 7 months during my Master's level internship placement. I will adhere to established intervention research standards in an attempt to minimize the impact of my personal assumptions and bias.

Chapter Outline

Chapter 2 of this thesis reviews the literature as it pertains to the developmental stage of adolescence for females who are at-risk, resilience and self-esteem for female adolescents, the role of music and current music therapy interventions for this population, and how use of the voice addresses the construct of self-esteem in a music therapy

program design. In Chapter 3, the intervention research methodology is outlined. The results and proposed music therapy intervention program design are discussed in Chapter 4, and the final chapter consists of the discussion, conclusion, and recommendations for future research.

Chapter 2. Literature Review

In this literature review, the developmental stage of adolescence is explored, with special attention paid to how this phase unfolds for females who are at-risk. The concepts of resilience and self-esteem are then examined through the same frame of reference, followed by a review of the literature on music, music therapy, and the use of voice for this population. The chapter concludes with a formalized statement of the research questions.

Female Adolescents At-risk

The transition from childhood to adulthood is one filled with challenge and radical change; adolescents must navigate academic, emotional, and social developments and increased expectations while coping with the stress brought on by these changes (Laiho, 2004; Rüütel, Ratnik, Tamm, & Zilensk, 2004). Additionally, physical maturation introduces vacillation and uncertainty in the arenas of body image, sexual identity, and sexual relationships (Laiho, 2004; Veltre & Hadley, 2012). While males and females may face similar challenges, there are also factors at play that are gender-specific.

The interpersonal landscapes and external pressures of adolescent females are markedly different from those of adolescent males (Turner, 2003), as is their level of social connectedness (Kim et al, 2006). Female adolescents are at a much higher risk for depressive symptomology at this stage of life (Kim et al, 2006; Smith-Adcock et al., 2008; Turner, 2003) and are more likely to experience abuse and issues with self-esteem (Smith-Adcock et al., 2008). The most noteworthy task of the teenage years in Western individualist cultures is the development of an autonomous, independent self, separate from parental influence (Kim et al., 2006; Laiho, 2004; Nelson, 1996). Some feminist

theorists question if this process is the same for both sexes. Nelson (1996) argues that it is not. In her view, females have a way of being that preferences connection, and thus they may experience 'individuation' differently. She suggests that growth in relation to others, or *relational competence*, should be considered a valid alternative when working with adolescent females.

Moreover, the goals and content of programming must be further adapted when the female adolescents involved are also considered to be at-risk. In some studies and programs, youth are included based on the risk factors to which they are subject, for example: "divorce in the family, death in the family and an incarcerated parent" (Edwards et al., 2007, p. 33), or youth "involved with child welfare services, living in poverty, and/or having a mother who was a teen at first childbirth" (Brownell et al., 2010, p. 804). Risk factors include aspects of the individual or the individual's environment that augment their chances, over others, to experience negative life circumstances in the future (Fraser, 2004). However, according to Edwards, Mumford, and Serra-Roldan (2007), human, relational, and environmental complexity make it difficult to predict if these factors will indeed lead to negative outcomes. Others consider certain high-risk behaviors (e.g. substance use, truancy, etc.) as the benchmark for inclusion in their studies, but it can be said that the selection and definition of behaviors is a somewhat subjective process (Edwards et al., 2007). In perhaps the most comprehensive model of risk and protection, Anthony (2006) identifies distinct clusters subsumed under the at-risk umbrella based on, "interpersonal/social factors (i.e., peer problems), microsystem transactions (i.e., social support), and individual characteristics (i.e., coping skills)" (p. 114). However the term risk is defined, interventions can be tailored to meet the needs of

those being served in a way that highlights their abilities and potential rather than the adversities they face.

Resilience

Resilience has been identified as a mediating factor between school failure and school achievement (Richman, Bowen, and Woolley, 2004) and can thus be considered one lens through which positive programming for youths considered at-risk for school failure can be developed. The term resilience has been used in a variety of ways in prior research, thus some confusion exists. In the past, resilience has been thought of as a internal force or set of characteristics that an individual possessed or did not possess: "Resilience is traditionally defined as the ability to 'bounce back' from adversity, to manage stress effectively, and to withstand physical or psychological pressures without showing major debilitation or dysfunction," (Jordan, 2005, p. 79). Others have used it to signify only the positive outcomes achieved by those faced with adversity (Anthony, 2006). In more recent studies, however, the concept has come to represent a "developmental process," rather than a personal trait or positive outcome (Anthony, 2006, p. 43). When viewed through an ecological lens, resilience becomes a series of interactions on multiple levels (i.e., individual, family, community) wherein a person is influenced by and influences his or her environment.

The importance of external factors has also been asserted by Jordan (2005), who cites "growth-fostering connection," (p. 80) as one of the core elements of resilience. Just as Nelson (1996) reimagines the Western notion of individuation for female adolescents in the form of relational competence, Jordan (2005) posits a similar movement away from the 'separate self' mindset in resilience, noting, "resilience resides not in the individual but in the capacity for connection," (p. 79). She communicates how important *relational*

resilience is for female adolescents, who she says can have a tendancy to cater to the needs of others to maintain a semblance of friendship. The type of relationship that is necessary for relational resilience is one of mutuality, wherein both counterparts are supported, engaged, and empowered, and where there is growth potential for both parties (Jordan, 2005).

Resilience, and relational resilience in particular, appear to be closely linked with other known protective factors such as self-esteem (Rosenbledt, 2002). Youths who are resilient are said to have higher self-esteem (Edwards et al., 2007), which gives them confidence to seek out relationships and handle difficult circumstances (Anthony, 2006). Both social connectedness and self-esteem are represented in the definition of resilience put forth by Richman, Bowen, and Woolley (2004) in which the concept is broken in to five components: "1) social competence, 2) autonomy, 3) a sense of purpose, 4) contextual factors, and 5) problem solving skills" (p. 143). A central aspect of the second component, autonomy, is "self-esteem, self-efficacy, and self-discipline" (Richman et al., 2004, p. 143).

Self-Esteem and Female Adolescents

Aside from being a necessary aspect of resilience, self-esteem/self-concept is also noted as a central area of inquiry for many therapists who work with this population (Boyd, 2000; Higenbottam, 2003; Scott, 2003; Smith, 2012). Smith-Adcock, Webster, Leonard, & Walker (2008) identify fostering self-direction and self-understanding as vital to successful psychotherapy with this group, while Sausser & Waller (2006) identify self-esteem as both a client need prior to treatment and primary goal of the music therapy

intervention, and Elmaleh (2002) acknowledges "impaired self-concept" (p. 17) as a crucial area of change in his art therapy work with a female adolescent considered at-risk.

Terms like self-concept, self-confidence, and self-esteem are frequently used interchangeably within the literature (Brown & Marshall, 2006; Rosenbledt, 2002), but some researchers argue for separate and distinct definitions. In a disection of the term self-esteem, Mruk (2006a) considers two common meanings. The first is self-esteem as a sense of worthiness. Mruk (2006a) points out that while this 'internal' understanding of the term can make for easy measurement through self-assessment scales, it comes with the risk of oversimplifying the construct. The second explanation is self-esteem as competent behavior. When self-esteem moves from the realm of feelings to the observation of a person's development of skills that aid in the realization of their goals, the study of the construct becomes less subjective. The drawback of this standpoint, however, is that one may excel at something and not feel satisfied with their achievement, and/or may choose to strive for competence in behaviors that are antithetical to healthy self-esteem. Thus, Mruk (2006a) contends, following Branden (1969), that the weakness of each view is eradicated by combining them: "On one hand, then, self-esteem involves worthiness, but worthiness must be earned, meaning that it depends upon behaving competently. On the other hand, in order for competence to result in feelings, attitudes, or beliefs of worthiness, such behavior must involve actions that are worthy, not meaningless successes or destructive activity," (pp. 12-13).

Brown and Marshall (2006), outline another divide in the field with their comparison of the notions of *state* self-esteem and *trait* self-esteem. State self-esteem, they say, refers to evaluative affective reactions (e.g., feeling pride, shame, etc.) that

change from day-to-day, whereas trait or global self-esteem is a long-term, relatively consistent view of the self. State self-esteem is thought of as a cognitive (or bottom-up) model, with self-evaluations (which are influenced by success/failure, acceptance/rejection) forming the base of self-esteem. Researchers who are proponents of trait self-esteem are said to take a more affective (or top down) approach, with the self-esteem developed early in life enduring and coloring future self-evaluation. Brown and Marshall (2006) argue not for the use of one version over another, but rather for continued distinction between them.

There are several researchers who focus specifically on what self-esteem looks like in adolescent females. Lapinski (2002) notes that although experiences of success may improve the self-esteem of both males and females in a similar fashion, the skills and traits that are deemed important by each group vary significantly. Rosenbledt (2002) also draws attention to the differences between male and female self-esteem in this life stage, stating that female youth experience a significant decrease in self-esteem in early adolescence, creating a perceptible 'gender gap', which negatively effects their academic performance. In line with Jordan's (2005) conception of female resilience in a relational context, she proposes 'social-esteem' rather than the internal, individualistic idea of self-esteem. She posits that the way in which a person interacts with others (the extent to which they derive strength and worth from mutual relationships) is a better marker of well-being than self-esteem, a focus that she says places people in comparison rather than congruence.

Role of Music in the Lives of Adolescents

Relationships are utilized by female adolescents in the construction of their identity (Rosenbledt, 2002) and can provide the scaffolding necessary to sustain coping efforts (Washington, 2008). Ability and opportunity to connect with others (i.e., interpersonal relationships) are directly affected by social skills, which are also intricately intertwined with other spheres of life (i.e., emotional/mental health, and fulfillment/success in school, career, and recreation; Gooding, 2011). Gooding asserts that there are several social skills that are inherently reinforced by active music making: impulse control, practice of non-verbal communication, collaboration, and attention to and respect for others, to name a few. Music can also align youth with significant peers and groups and can be a means of upholding connections (Austin, 2010; Laiho, 2004).

The musical preferences of adolescents can speak volumes about their internal state (Austin, 2010; Rüütel et al., 2004), can reflect and strengthen elements of their personal and social selves (Austin, 2010; Laiho, 2004), and can link them to their musical past (e.g., familial/cultural heritage) and present (e.g., adolescent culture) (Cobbett, 2009). Music may also help structure the process of identity formation for adolescents. Laiho (2004) notes that music "is an emotional framework for the interpretative activity of composing constructs related to the self" and can serve "as a meta-structure into which one can place personal meanings" (p. 54). While both females and males are said to mobilize music in their day-to-day coping, there are also differences in how music is employed, with females aiming to manage feelings related to external conflicts, and males endeavoring to elevate mood (Laiho, 2004).

Music Therapy and Adolescents

More and more, professionals in the field of music therapy are embracing the potential power of engaging youth and youth considered at-risk in music: In a survey conducted by Carr and Wigram (2009), few music therapists reported working with adolescents with extreme behavioral issues and/or those that had been expelled from the mainstream school system. Since then, numerous descriptive accounts of music therapists' clinical work with this population have emerged (Austin, 2010; Cobbett, 2009; Derrington, 2011; Nöcker-Ribaupierre & Wölfl, 2010; Veltre & Hadley, 2012), and some were research-based (Gooding, 2011; Sharma & Jagdev, 2012; Smith, 2012).

Music therapists working with this population report utilizing techniques such as singing, listening to, and discussing pre-composed music, song-writing, and improvisation, among others, with an emphasis placed on the music culture of the teens (e.g., rap and hip-hop) and the employment of music technology (Carr & Wigram, 2009; Cobbett, 2009; Smith, 2012; Veltre & Hadley, 2012). Therapeutic interventions employed with this population must be tailored to best suit their unique needs and may occasionally push traditional parameters of the field. Cobbett (2009) notes that both therapist and therapeutic boundaries must remain flexible, and that musical experiences may need to be re-imagined to achieve the highest possible level of accessibility and effectiveness.

There is much anecdotal evidence to support the effectiveness of music therapy interventions with adolescents at-risk. Austin (2010), Cobbett (2009) and Derrington (2011) provide a window into their work with adolescents, outlining positive responses and outcomes in descriptive case study accounts. Veltre and Hadley (2012) describe how

their method of hip-hop based music therapy empowers the adolescent females with whom they work and helps them gain self-esteem; Nöcker-Ribaupierre and Wölfl (2010) delineate the ways in which their music therapy program, established to counter violence in adolescents, helps with the development of social skills.

Recently a research base regarding the efficacy of music therapy with adolescents has emerged. Sharma and Jagdev's (2012) study reports a statistically significant improvement in the self-esteem of academically stressed adolescents after music therapy treatment. The intervention, however was not designed or conducted by music therapists and was limited to passive, independent music listening experiences. Gooding's (2011) multiple-site study, to determine the efficacy of a music therapy intervention targeting social skills of children and adolescents, reports a significant improvement in measures of participant, researcher, and social worker pre and post ratings, as well as in behavioral observations. Finally, in a pilot project for female adolescents at-risk, Smith (2012) determines that music therapy techniques such as song-writing, movement to music, and music video production encourage self-expression and relationship building.

Therapeutic Use of Voice

Whie singing is a music therapy technique used in diverse settings, Austin's (2010) descriptive account of her work with this population reveals the power of vocal intervention specifically for female adolescents who are considered to be at-risk. She champions the use of singing to reconnect female adolescents with the self (body and emotion) and to empower them to "recover or perhaps find their voices metaphorically and physically for the first time" (p. 182). Whether the voice is experienced through the singing and/or performing of pre-composed songs, or through writing and/or recording

new songs, Austin (2010) contends that "experiencing one's creativity" (p. 183) in such a way can act as a means for increasing self-esteem in this population.

Several vocal pedagogues have also explored the connection between female adolescent self-esteem and their singing voices. Gackle (2006), through informal inquiry, notes that a large majority of adolescent female respondents gave high ratings to phrases such as, "When I sing, I feel better about myself and my abilities," (p. 35) suggesting the potential for encouraging improved self-esteem through singing. In her work with adolescent singers, Monks (2003) notes that singers are motivated to improve their singing voices for self-satisfaction, suggesting a deep connection with self-concept. In her research she also finds that the way adolescents sing and speak conveys messages about their self-esteem. She maintains that level of commitment to completion of phrases and words, and to clearly executing articulation when singing reveals much about the singers' self-esteem. The concept that sonic elements of the singing voice communicate level of self-esteem is reinforced by Chong's (2000) findings. These results reflect that a singer's average volume is a predicting factor of self-esteem scores on the Multidimensional Self-Esteem Inventory (MSEI). She highlights the interconnectivity between the voice and self-concept saying, "As the use of the voice is an important medium of communication for expressing one's self the voice certainly may not only communicate one's psychological and emotional make-up but also the self-concept" (Chong, 2000, pp. 35-36).

The highly personal nature of the act of singing also presents challenges for its use in a group setting with this population. Although much more literature exists examining the adolescent male voice change, significant patterns of change have also

been noted in the female voice. The characteristic breaks in the voice between registers experienced by males exists to a lesser degree in females as well, along with a decrease in vocal range, increased breathiness when singing, and difficulty initiating sound (Gackle 2006; Monks 2003). Through the study of the response of female adolescents to group vocal lessons, McRoy (2011) finds that group members report "fear of judgment", "sense of comparison", and preoccupation with others' perceptions when singing amongst peers (p. 120). Similarly, Monks (2003) finds adolescent females to be highly aware of the changeability of their voices during this developmental stage.

These challenges, however, are surmountable according to McRoy (2011) and Monks (2003). Lightner (1991) notes that group singing experiences can actually help female adolescents realize that their vocal problems are common amongst their peers, thus normalizing their insecurities. McRoy (2011) recommends first developing an environment in which the singers feel safe, and then encourags them to voice their concerns openly to ease their fears. Monks (2003) contends that directly addressing the aspects of the female adolescent vocal transition that may cause apprehension can help to alleviate discomfort. It should also be noted that in a pedagogical context more emphasis is placed on the musical product. In the music therapy space this outcome can be decentralized allowing for the focus to remain on the process.

Summary

As females proceed through the developmental stage of adolescence, they encounter trials and triumphs that are uniquely female (Kim et al, 2006; Smith-Adcock et al., 2008; Turner, 2003), and should thus be supported in ways modified for their specific needs (Brownell et al., 2010). There is a need for further programming for female

adolescents at-risk for school failure (Rosenbledt, 2002) and one approach is to provide preventative, resilience-based interventions that augment the positive, rather than negative, aspects of their lives (Anthony, 2006).

Self-esteem is considered a protective factor against risk (Rosenbledt, 2002), is associated with resilient individuals (Anthony, 2006; Edwards et al., 2007), and can be considered a part of resilience (Richman et al., 2004). Self-esteem is defined as an interaction between competence and worthiness (Mruk, 2006a).

Music can act as a tool for strengthening the sense of self (Austin, 2010; Laiho, 2004), and reinforcing social connectedness (Austin, 2010; Gooding, 2011; Laiho, 2004). One intervention utilized by music therapists, singing, has been noted for its salient connection with self-esteem (Chong 2000; Gackle, 2006; Monks 2003). Increasingly music therapists are cultivating this connection, and both anecdotal and research-based evidence support the potential efficacy of this treatment modality with this population (Austin, 2010; Cobbett, 2009; Derrington, 2011; Gooding, 2011: Nöcker-Ribaupierre & Wölfl, 2010; Sharma & Jagdev, 2012; Smith, 2012; Veltre & Hadley, 2012). Although the base is growing, there remains a lack of music therapy research aimed at this population. There is a need for tangible music therapy programming for female adolescents at-risk.

Research Questions

In light of the literature presented, the central research question for this thesis is: What might a music therapy program look like that is designed to address the development of self-esteem for female adolescents who are at-risk? This primary question will be supported by the following subsidiary question: In what way could the

voice be used in a music therapy program designed to address the development of self-esteem for female adolescents who are at-risk?

It should be noted that although the unique experiences of both adolescent males and females are equally valid and demand equal attention, due to the necessarily limited scope of this study, only that of females will be explored. This choice was made based on this researcher's interest in the female experience.

The chapter that follows outlines the methodology chosen to answer the research questions. The choice for intervention research methodology is discussed and operational definitions and delimitations are given. An outline is also provided of how the opinions of practitioners working with this population and information gathered from the literature are used in the formulation of a music therapy program designed to address self-esteem and resilience in female adolescents at-risk for school failure. The chapter concludes with a listing of the music-based intervention research criteria to which the proposed program design will adhere.

Chapter 3. Methodology

Program Design

The methodology utilized in this research was program design, also known as intervention research. Intervention research is a means through which researchers can contribute to the knowledge base of the field in a way that directly relates with clinical practice. Fraser and Galinsky (2010) defined intervention research as "the systematic study of purposive change strategies… characterized by both the design and development of interventions" (p. 459). Due to the necessarily limited scope of this research, only the first and part of the second step of Fraser and Galinsky's five-step model were completed. Step one, *developing problem and program theories*, consisted of discerning the risk and protective factors that shaped the problem theory, identifying the malleable mediators that made up the program theory, and delineating the specifics of the program such as the level, setting, and agents. From this information, action strategies and a theory of change were developed. Of the second step, *specifying the program's structure and processes*, only one component was addressed: a draft of the program design protocol was developed based on the information gathered through literature review and interviews. The program design protocol was constructed within the format of a session-by-session description of essential elements (e.g., content and goals; Fraser & Galinsky, 2010).

This methodology was chosen specifically to serve the goal of creating tangible, functional music therapy programming to help fill the existing void for this underserved population, and to provide concrete examples of techniques for music therapists, developing and encouraging growth in this specialized area of the field.

Operational Definitions

For the purposes of this program design, the terms *at-risk* and *high-risk* were used to mean at-risk for academic failure. Rosenbledt (2002) defined "at-risk for school failure" through a comprehensive list of risk behaviors.

For inclusion in her study, participants had to exhibit a minimum of two of these criteria:

> a) poor academic achievement with a history of poor grades (two or more Ds or Fs) or being academically ineligible to participate in extracurricular activities (below 2.0 grade point average GPA), b) at risk for retention by performing below the 25%ile on the Stanford Achievement Test (SAT-9) in comprehension and mathematics, c) behavioral problems resulting in five or more disciplinary referrals to administrators, five or more detentions per quarter, one or more suspensions, or teacher observations of frequent discipline problems, d) poor attendance by exhibiting truancy, high absenteeism, or tardiness, or e) socio-emotional/psychological issues established through staff or parent observation and referrals to counselors for aggressive, passive, or withdrawn behavior, lacking consistent, significant peer relationships, or displaying low self-perception, (pp. 19-20).

The same criteria were used in this study to clarify the meaning of at-risk for school failure, with the added consideration of Anthony's (2006) concept of risk profile due to the gender-specific nature of the program design.

Resilience was defined as, "a universal capacity that is the result of normative and adaptive responses at the individual, family, and community level," (Anthony, 2006), and

self-esteem was defined as "a sense of personal efficacy and a sense of personal worth," (Branden, 1969, p.104).

Delimitations

As noted earlier, a focus was directed only to the experience of adolescent females, not males. Aside from the researcher's personal interests, the decision was also reinforced by the research supporting the adaptation of programming to account for gender differences. Gender-specific programming that deals sensitively with the unique experiences of female adolescents has been implemented and advocated for in the fields of music and creative arts therapies (Austin, 2010; Boyd, 2000; Elmaleh, 2000; Higenbottam, 2004; Rüütel et al., 2004; Scott, 2003; Veltre & Hadley, 2012), psychology (Nelson, 1996; Smith-Adcock et al., 2008; Turner, 2003), education (Washington, 2008; Zhang, 2008), and psychiatric nursing (Kim et al., 2006).

Females in early adolescence (defined here as middle school aged, or 12 to 15 years old) were targeted specifically. The program was limited to work with this age group because patterns of risk and protection often materialize during this stage, early intervention may help youths negotiate the later stages of adolescence; also self-esteem has been noted as paramount during early adolescence (Anthony, 2006).

With the concepts of relational competence (Nelson, 1996) and relational resilience (Jordan, 2005) in mind, the program was designed to serve female youth in the group rather than individual setting. Group interventions are beneficial for female adolescents at-risk, in the realms of both personal and social development (Rosenbledt, 2002). Interventions in a group setting may also allow more individuals to benefit simultaneously, and may make the program more feasible for funding agencies.

Participants

Given the limited body of music therapy literature focused on work with this population, professionals with extensive experience with youth at-risk were consulted to support the development of the program design. After the study had been approved by Concordia University Human Research Ethics Committee (HREC), music therapists were recruited by means of a participant recruitment email sent via an international Music Therapy Listserv. Two of the three music therapists who responded (all of whom were from the United States of America) met the criteria for participation and were selected to be interviewed. One music therapist was working through the school system in a juvenile dentention center with adolescents aged 12 to 18, who were admitted short-term while awaiting charges after having committed a crime. The other music therapist worked in a long-term adolescent treatment center with a school component designed specifically for students aged 10 to 17 with Axis I (and possibly Axis II and III) diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM), aiming to re-enter the mainstream system. Through my Master Degree practicum at an alternative school in a large Canadian city, I became acquainted with and subsequently recruited the school counselor and the special-care counselor. The admission criteria for students at the alternative school were to have been expelled from mainstream school for behavioral and/or learning difficulties and to fall within the 12 to 16 age range.

Of the four interview participants, the school counselor and special-care counselor had 15 and 16-years of experience respectively, and each music therapist had 3-years experience. Only the special-care counselor had received specialized training to work

with adolescents, although three of four participants had graduate level training in their fields. All four participants were female.

Ethical Issues

Potential ethical issues arising from my pre-existing relationships with both the school and special-care councelors were diminished by waiting for completion of my practicum before conducting interviews. Being a previous supervisee of the school counselor presented an ethical issue of a dual relationship and thus an interview was not conducted until all supervisory duties had been concluded. Potential confidentiality issues were mitigated by insuring that the researcher alone had access to personal and professional identifying information. Also, all information offered was communicated as representative of the participants alone and not their facilities. The researcher also participated in regular supervision and journal writing to maintain, as much as possible, a reflective and unbiased stance throughout the course of the research.

Data Collection

Each of the four participants engaged in a single, semi-structured phone interview that ranged from 30 minutes to 1 hour in length and consisted of nine to eleven questions. Interview questions were tailored specifically to consider the specializations of the participants, with one set for the school counselor and special care counselor, and a slightly varied set for the music therapists (See Appendices C & D). Questions centered on the efficacy of interventions observed and facilitated, the perceived needs of and process of forming an alliance with this population, the relationship between self-esteem and female adolescents at-risk, and the optimal length of both session and program. Music therapists were asked further questions about how music was used specifically to

fit their clients' needs. Audio recordings of each interview were made for later transcription and analysis. Upon completion, transcriptions were submitted to participants for fact checking and further clarification of the information previously given.

Data Analysis

Once approved by participants, the transcripts were analyzed using the steps to qualitative coding outlined by Neuman (2006): open, axial, and selective coding. Each transcript was reviewed to get a sense of the whole, then four separate transcript maps were created by applying to each section one of six themes created from the interview questions: length of program, length of session, significant needs, therapeutic alliance, self-esteem, and interventions. Sub-categories arose through open coding (some interview-specific, others common to multiple interviews), which were then combined and grouped into larger categories during axial coding. Finally sections of the transcribed text were selected to represent each category through selective coding.

Step one: Development of problem and program theories. The problem and program theories were identified through the review of pertinent literature and the analysis (open and axial coding) of the interview transcripts. Malleable mediators were defined and action strategies developed through the application of coded data and the researcher's personal experience in working with this population.

Step two: Program structures and processes. The data gathered and synthesized in the previous step was used to generate an intervention program design, which consisted of a description of the goals and essential content for each session.

Intervention Reporting Criteria

The majority of existing music therapy intervention research represented studies in later stages (testing program effectiveness and communicating findings), but Burns (2012) and Robb and Carpenter (2009) noted that regardless of the stage of research, certain components were frequently missing in the use of this methodology. In order to improve the standard to which intervention research is held, Robb, Carpenter, and Burns (2010) communicated guidelines for music-based interventions. The seven variables deemed essential to intervention research reporting are: 1) Intervention theory; 2) Intervention content: a. Who selects the music, b. Music, c. Music delivery method, d. Intervention materials, e. Intervention strategies; 3) Intervention delivery schedule; 4) Interventionist; 5) Fidelity strategies for treatment delivery; 6) Setting; and 7) Unit of delivery. Adherence to the criteria outlined here supports the transferability of this intervention research into the clinical setting (Robb, Carpenter, & Burns, 2010).

Chapter 4. Results

This chapter begins with a summary of the interview findings, followed by steps one and two of program design (Fraser & Galinsky, 2010). Step one includes delineating the key features of the program, the problem or problem theory, and the program theory (malleable mediators and action strategies). Step two consists of the program length, materials, goals and objectives, intake procedures, and a session-by-session outline of the protocol (session goals, essential content and session plan).

Interview Findings

Six major themes emerged from the interviews: length of program, length of session, significant needs, therapeutic alliance, self-esteem, and interventions. These will be explored in the following section.

Length of program. While participants mentioned the importance of many factors, such as the students, activity/program, funding, facility, and administration, proposed program length ranged from a 3 to 4-week minimum to 8-month minimum. Two participants, however, settled somewhere in between, with one recommending 6 weeks and the other 6 to 9 weeks.

Length of session. All four participants reported conducting sessions 50 minutes in length at their facilities. Two suggested 50 minutes as the maximum length for students, while another noted that it becomes difficult to complete the designated material in sessions shorter then 50 minutes. The final participant suggested that length should vary depending on the type of work, suggesting 1 to 1.5 hours for psycho-educational groups.

Significant needs. This theme was comprised of five sub-categories: expression of self, connection to self, connection to adults, support from others, and recognition of feelings.

Expression of self. Both participants with a music therapy background listed self-expression as a considerable need of the female adolescents with whom they work, with a public outlet for self-expression as a potential long-term goal.

Connection to self. Participants listed a link between client needs and self-esteem, a sense of identity, confidence, and mastery as areas of need.

Connection to adults. All four participants, as typified by this quote, emphasized a healthy, stable relationship with an adult figure: "they need attention, they need accounting for, they need an adult to discuss things with." Also foregrounded under this subcategory was the importance of a positive support system at home.

Support from others. In a more general reference to connection with others, issues such as acceptance, love, attention, care, respect, and validation were mentioned: "They need someone to look them in the eye and show them kindness and be respectful".

Recognition of feelings. Finally, one participant mentioned identification and naming of feelings as being of crucial importance.

When each of the music therapists was asked how they used music specifically to meet the needs of their clients, performance for mastery needs and singing for needs of self-expression were cited.

Therapeutic alliance. Six subcategories exist under this theme: supporting them, empowering them, assigning specific roles, allowing for other ways in, therapist approach (internal), and therapist approach (external).

Supporting them. Themes such as attention, care, respect, and validation were found both here and in significant needs. Added to the list were to be non-judgmental, show concern, and be on their team. One participant commented, "I find they respect me more that way because they feel like I do care and that I understand them."

Empowering them. Another way said to be effective was to allow them to contribute content (musical and otherwise), give them choices, let them take the lead, and where appropriate, let the group govern themselves as much as possible.

Assigning specific roles. Assigning leadership positions within the group (e.g., DJ, clean-up crew, etc.) and aiding in the filling of and transition into roles was said to be helpful. Roles were said to bring members back to the group and give them a sense of importance. Also, "it does kind of build familiarity and I think it builds the interpersonal connections that they might not already have."

Allowing for other ways in. Creating a low-pressure situation, seemingly unrelated to the program, where students can engage casually in some hands-on activity was said to assist in the formation of a bond.

Therapist approach (internal). Therapeutic approach, according to the participants, should be flexible, relaxed, patient, and subtle in reaction. Also, appropriate self-disclosure was suggested, as long as personal values were not asserted. An intention for genuine connection and commitment to seeing the best in the client were highly valued.

Therapist approach (external). Participants expressed that therapists should create a safe, structured environment governed by respect, and be a part of the group while maintaining a professional rapport and awareness of her role in the setting. The therapist should work to get to know the clients, and meet them where they are, but never try to force connection/engagement, or comment on teens' choices before the alliance is formed. Two participants also mentioned bringing food or eating together.

Some challenges said to obstruct alliance formation were high-absenteeism, lack of knowledge about client history, and keeping group members accountable to each other. When asked how long connection typically takes, two participants said it depends entirely on the person (personality, background, experiences, etc.), another said barring rare exceptions there is a 1-month minimum timeframe, and the final participant emphasized the slow pace of bonding, specifying 3 months to see real progress.

Self-esteem. This theme was subdivided into five sub-categories: self-esteem – an issue, self-esteem – not always an issue, lack of awareness, higher standards for teens, and techniques for self-esteem groups.

Self-esteem – an issue. All four participants reported some issues with self-esteem for female adolescents at-risk. Some thought the majority of their clients had low self-esteem or perhaps would not be in their current position if they had healthy esteem. One participant reported, "It's hard on them […] it's always been an issue," and half of the participants said the media creates issues with appearance and body image. Behaviors stemming from low self-esteem were thought to be more damaging to teens than to adults. It was felt by one participant that all adolescent females struggle with self-esteem

as they search for a sense of identity and another purported that maintaining healthy self-esteem was particularly challenging for middle school aged students (aged 12 to 15).

Self-esteem – not always an issue. Half of the participants, while acknowledging that some self-esteem issues exist, were adamant that generalizations could not be made: "I wouldn't be able to say one way or the other 100 percent […] they don't all have bad self-esteem." The same participant voiced that the adolescent's support system (e.g., parenting, home environment, romantic relationships, etc.) plays a big role.

Lack of awareness. One respondent highlighted a lack of awareness of level of self-esteem not just in teenagers, but also in people of all ages. "Sometimes they might think that they feel really good about themselves but then they do things that just don't really indicate that." She felt people often claim to have healthy self-esteem but then exhibit incongruent behaviors.

Higher standards for teens. The same participant stated that teenagers are judged more harshly in terms of low self-esteem behaviors and attitudes as compared to adults.

Techniques for self-esteem groups. Participants who had led self-esteem groups offered that programs should focus on abilities, preferences, passions, and positive feelings about the self, avoiding conversations about insecurities. A participant suggested building mastery and confidence through public display of accomplishments or talents to provide an opportunity to receive praise and make their own talents more obvious. Also focusing on a specific activity or project was recommended, for example where individual voices/perspectives can be joined into a whole.

Interventions. Ten subcategories materialized when discussing the interventions themselves: therapist/client relationship, tactics, structure, grouping, content, interventions used, singing, mindfulness, most effective, and least effective.

Therapist/client relationship. Participants felt it important to be sensitive to aspects of the therapist/client relationship such as cultural differences between client and therapist, client curiosity about the therapist's relationship to the content (in this case self-esteem), and how client motivation is affected by how they perceive adults to view them.

Tactics. Tactics to promote intervention effectiveness included the show of concern, flexibility, honesty in responses, personal engagement with content, and never asking a client to do something you are not willing to do. Respectful differences in experience should be allowed for, and participation encouraged through modeling and/or gentle invitation. Concerning attendance issues, it was said therapists should acknowledge absent members, and get students to ask their peers in the hallway why they missed group and/or when they are coming back.

Structure. Structured activities, although secondary to process, were said to be a good starting point for work with this population. One participant found maintaining a consistent session structure (warm-up, experientials, and cool-down) and placement/spacing in the room to be helpful. Sessions structured with time allotted for individual work or contemplation before group discussions were also considered effective.

Grouping. Two participants found the manner in which students are grouped to be of great importance: "…I think a lot of the formation process has to do with the success of the process." Groupings chosen by staff, in concert with clients, were said to

minimize conflict and increase productivity more so than random grouping. Since not all client preferences best serve their own needs, therapists were directed to make final decisions based on psychosocial level, background, and existing relationships. Having at least one stable member with regular attendance in each group was said to help others connect. Groups were said to average four to six members.

Content. Participants asserted that content should be guided by clients and presented in achievable amounts so as not to overwhelm them. Backup content should be available, perhaps approaching the same topic from a different angle. Three of four participants also mentioned introducing content in levels, for example, safer topics to more personal topics, passive to active music making, personal understanding of a topic to a community-wide or global understanding. One participant found providing visual representation of the content to be covered helpful in orienting clients.

Interventions used. The interventions used by the school and special-care counselors were group and individual talk therapy and activities centered on specific themes. Improvisation, songwriting, lyric analysis, performance, instrument playing, listening, art and movement to music, music education, singing/use of voice, and mindfulness meditation were the interventions listed by the music therapists. Due to additional information provided, the latter two categories, singing and mindfulness meditation, will be discussed below. Both music therapist participants spotlighted the music educator role as crucial to the success of interventions, as with a formal introduction to techniques or an opportunity to gain familiarity, clients tended to doubt their abilities less and not shut things down.

Singing. Although both music therapist participants discussed how females tended to get more involved in vocal interventions than males (singing along, requesting songs, etc.), one indicated that vocal interventions should be used primarily with those who have experience, who like to sing, or are working to find their voice. Popular, pre-recorded music of the client's preference was used more often than vocal improvisation, although free-style rapping was done with those who felt comfortable. One music therapist participant said she often saw increased confidence in singing ability, especially when small steps where given (e.g., sing with others, then in front of one person, then a few people). She found in one particular case that singing helped a client with low self-esteem gain confidence and connect to others.

Mindfulness. Mindfulness meditation was noted to be such a positive intervention that both students and therapist participants were surprised by its effectiveness. Negative associations with meditation were diminished through education about its definition and benefits, and by allowing participation at whatever level clients felt comfortable.

Most effective. Among the interventions considered most effective were passive participation options such as music listening (because it helps build trust and encourage more sharing) and mindfulness meditation (because it is less intimidating than active music making), interdisciplinary co-treatment, structured group discussion and individual counseling, positive reinforcement, and topics of specific interest to the clients.

Least effective. Interventions found to be least effective were broad, unstructured topics, anything that could feel like schoolwork (e.g., lyric-analysis), music chosen by the therapist, a confrontational approach, and content not tailored specifically to the needs of female adolescents at-risk (e.g., non-population specific conferences). Two participants

also mentioned that the effectiveness of an intervention depends on the approach of the facilitator.

The information outlined here was reconfigured into a diagram, with connections drawn from the researcher's interpretation (see Figure 1). In the diagram major themes were connected to their sub-categories with a single line, sub-categories that were repeated in more than one major theme were connected with a double line, participant ideas that fundamentally linked major themes were connected with a crossed line, and sub-categories containing similar ideas were connected with a dotted line. Length of session, length of program, and information gathered to contextualize the participants (e.g., experience, setting, etc.) were excluded from the diagram due to the nature of those categories. The data gathered from the interviews was synthesized with related literature findings in the development of this research's program design. Details of the program, its design, and nature will be outlined in the section that follows.

Step One: Development of Problem and Program Theories

This first step of the process of any program design consists of ascertaining the key features of the program, outlining the problem or problem theory, and delineating the malleable mediators and action strategies that constitute the program theory.

Key features. The intended level and setting for the intervention is a group intervention in a school setting. Groups should consist of no more than eight students, with an ideal maximum, as expressed by research participants, of four to six. Several researchers contend that the school setting is particularly well suited for such work (Cobbett, 2009; Kim et al., 2006; Washington, 2008). Teens spend considerable amounts

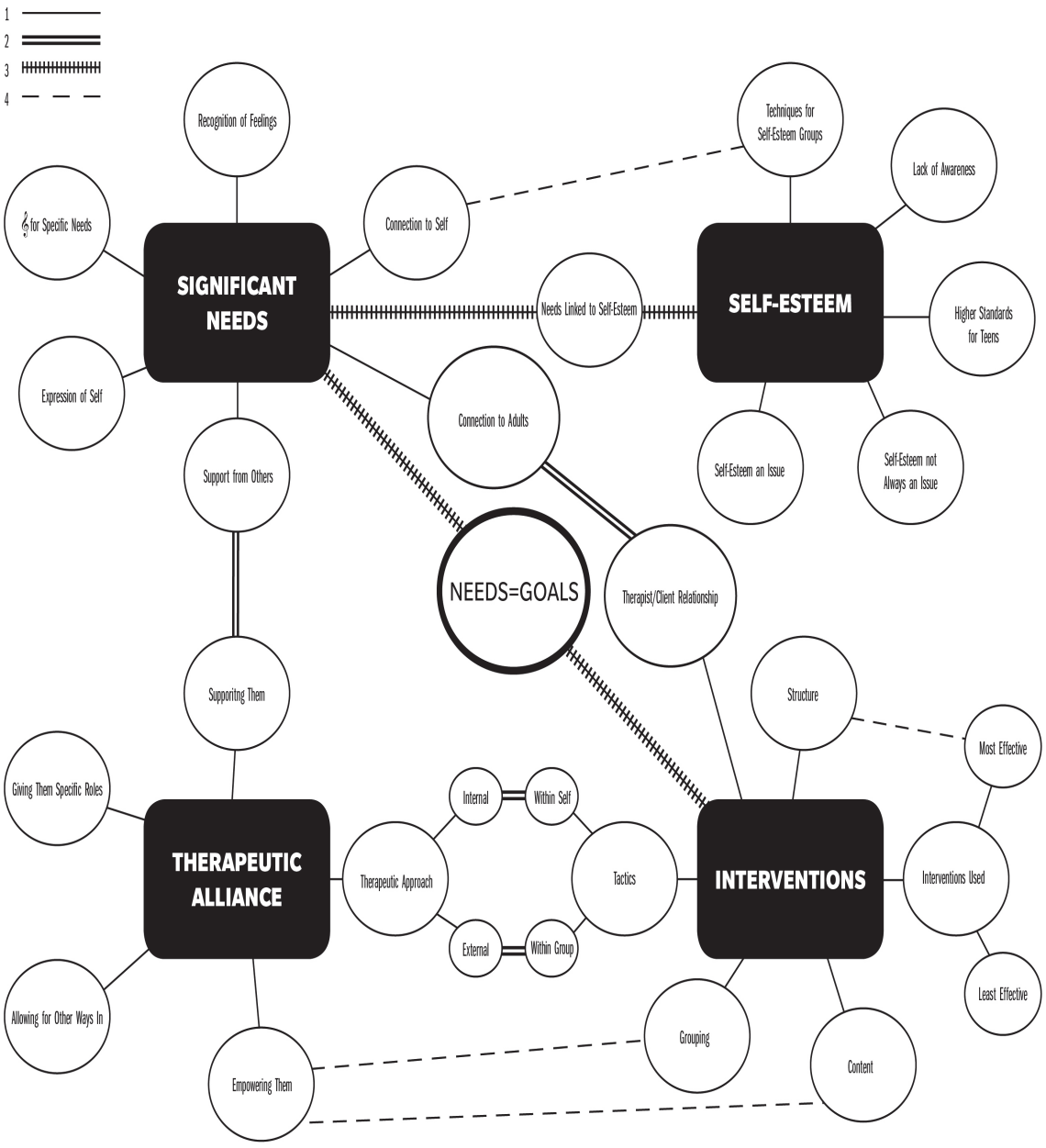

Figure 1. Visual representation of interview findings. Four of the major themes that arose from interview questions are represented and similarities drawn between them with connecting lines.

of time at school and their peer groups are already established there (Del Rosso, 2012), thus the therapist can have insight into the existing frame. Any negative connotations about visiting a facility or office to receive treatment are eradicated (Kim et al., 2006), as is the added challenge of having a student attend sessions at an alternate location (i.e., transportation, tardiness, absences; Cobbett, 2009). Also, the physical space is more familiar for the teens, which may ease anxiety about participating in treatment. A private, preferably isolated room in the school is ideal to minimize issues of hearing others and being heard. Due to the specialized musical and therapeutic skills of credentialed music therapists, the intended intervention agent is a music therapist with a fundamental knowledge of vocal technique.

Summary of the problem. A high school education is of increased importance in today's society (Brownell et al., 2010; Trypuc & Heller, 2008) and without one there is potential for negative personal and professional outcomes (Brownell et al., 2010; Edwards et al., 2007; Rosenbledt, 2002; Trypuc & Heller, 2008). There are individuals who are at increased risk for school failure because of factors at play in their lives (Anthony, 2006; Brownell et al., 2010) or risk behaviors in which they partake (Rosenbledt, 2002). The risks that affect a person and the extent to which they are detrimental differ greatly depending on the individual's risk profile (i.e., gender, support system, etc.) (Anthony, 2006). Female adolescents, for example, are at heightened risk for decreased self-esteem (Rosenbledt, 2002), among other things. Self-esteem and resilience (of which self-esteem is a component) are said to act as protective factors against school-failure (Richman et al., 2004; Rosenbledt, 2002).

Program theory. The proposed program theory is based on the assertion that music therapy, and singing in particular, are effective means through which to improve the self-esteem of adolescent females (Austin, 2010; Gackle, 2006).

Malleable mediators. Resilience mediates between risk factors and school failure (Richman et al., 2004). Self-esteem is a crucial component of resilience (Richman et al., 2004) and resilient individuals often have higher self-esteem (Edwards et al., 2007). Under Branden's (1969) definition of self-esteem, both competence and worthiness must be addressed in order to effectively improve one's self-esteem. For competence, interview participants suggested focusing on the abilities of their clients and helping client's to see what their talents are. Developing mastery in the musical domain was also mentioned. Worthiness was also referenced when participants recommended helping clients to focus on positive feelings and thoughts about the self and by providing opportunities for them to receive praise, or, as described by Mruk (2006b), positive feedback. Another clinical technique noted in the literature is cognitive restructuring to realize worthiness (Mruk, 2006b).

Action strategies.

To increase active engagement with talents. The members of the group will be aided in the process of identifying and exploring some area of talent or ability. Strategies for sharing or showcasing their talents (potentially within the group) will also be discussed.

To increase musical knowledge and competence. Throughout the program, the members will be taught the fundamentals of healthy singing and be introduced to various music concepts, thus improving their knowledge base and competence in music.

To increase positive evaluative feedback. In addition to incidental positive reinforcement given by the therapist throughout the course of each session, specific portions of the program will be designated for each group member to receive positive feedback from both therapist and peers.

To increase perceived worthiness through cognitive restructuring. Thoughts about worthiness will be explored through structured group discussions of situations and events in their daily lives. Negative self-perceptions will be challenged through feedback from therapist and peers.

Step Two: Program Structures and Processes

In accordance with the research data, the group will meet for 50 minutes once a week. Because there is no consensus over length of program, the program design will run for 8 sessions. While slightly higher than the lowest and dramatically lower than the highest recommended, the length suits the confines of a time-limited, school-based, psychosocial program. This format is also more feasible for funding agencies then a 6 to 8 month program.

Essential materials for the program include: Equipment for playing recorded music (e.g., computer with speakers and internet access for last minute suggestions, CD player), a surface for writing group rules and song-writing exercises (e.g., chalkboard, cardstock, large note pad), personal folders with space for both writing and lyric sheets (1 per member), art materials (e.g., magazines, paint, markers), and equipment for the group project (e.g., audio or visual recording devices, microphones).

Program goals and objectives. The goal and objectives of the program are as follows:

Goal 1: To improve self-esteem

Objective 1.1: Participants will identify and explore an area of talent to develop competence in that arena

Objective 1.2: Participants will engage in both passive and active musical experiences to increase music competence

Objective 1.3: Participants will receive positive evaluative feedback from both therapist and peers to develop an increased sense of worthiness

Objective 1.4: Participants will participate in group discussions and activities regarding cognitive restructuring to allow for an increased sense of worthiness

Program intake procedures. Students meeting the criteria for at-risk for school failure (see Chapter 3, p.21) will be referred by teachers or other staff and assessed individually by the music therapist. The assessment session will consist of an introduction to the content and purpose of the program and an informal interview about musical background, music preferences, and current and past self-esteem. There will be an opportunity to listen to and discuss music chosen by student and therapist from their personal collections, and the student will participate in one aspect of Well's (1988) Individual Music Therapy Assessment Procedure for Emotionally Disturbed Young Adolescents – song choice. The student will be asked to choose a song from a list of selections that best represents them. The list should contain current songs from a variety of popular music genres with varying messages about the self. The therapist will provide a lyric sheet for the chosen song and encourage the student to participate however they

feel comfortable (listening or singing) as the song is played. Before and after the song, the student will be asked to describe how the song relates to them and additional information (decision making, self-image, etc.) will be gathered and recorded on the corresponding chart created by Wells (1988; see Appendix E).

The session will conclude with an introduction to mindfulness meditation, so that all students are given a chance to experience it in a less intimidating one-on-one session before attempting it in the group. Mindfulness meditation is a component of this program design, not only because it was lauded by half of the research participants, but also because of support found in the literature. Although the existing body is small and not without limitations, Wisner, Jones, and Gwin (2010) outline in their literature review of school-based meditation programs for adolescents, that benefits include increased self-esteem and improved academic performance and school climate, among many others.

At the end of the session the adolescent will be asked whether or not they would like to participate in the group, so as not to force involvement. As recommended in the research data, adolescents and school staff will be consulted regarding grouping preferences to minimize conflict between members.

Session one.

Session goals.

1. For group members to interact with therapist and peers in a way that facilitates future bonding or connection.
2. For group members to contribute to the establishment of parameters they deem necessary for a comfortable, safe, therapeutic environment.

Essential content.

1. To aid in positive, respectful group interaction.
2. To establish, together with group members, the ground rules and group song.
3. To lay the groundwork for a group understanding of self-esteem as a combination of competence and worthiness (Branden, 1969).

Session plan. The first session will begin with a 1-minute mindfulness meditation. The length of meditation will be increased each session by increments of 30 seconds. Each member of the group, including the therapist, will then be asked to introduce themselves, stating their name and favorite style of music and/or favorite band or singer. Then, as suggested by Corder and Whiteside (1990), members will develop and record group rules to be displayed during each subsequent session. The therapist may help by making suggestions about important topics that have yet to be included (e.g., confidentiality, respect, etc.) only after the group is finished.

Group members will be requested during the assessment session to bring in a song suggestion (with appropriate content) that they feel could act as the group's theme. The therapist will bring in several selections as back up as well. When the group rules are established, the group will listen to portions of each selection and vote on which song should be used as the group song. Discussions about lyrical content and musical elements can be led to aid in the decision making process.

The therapist will then review the purpose of the program, showing a visual representation of the content (See Figure 2), and introduce the idea of self-esteem as a combination of competence and worthiness. Participants will be allowed to ask any questions they may have at this point. Finally, the song chosen as the group theme will

then be played as the closing, with all those familiar invited to sing along if they so choose.

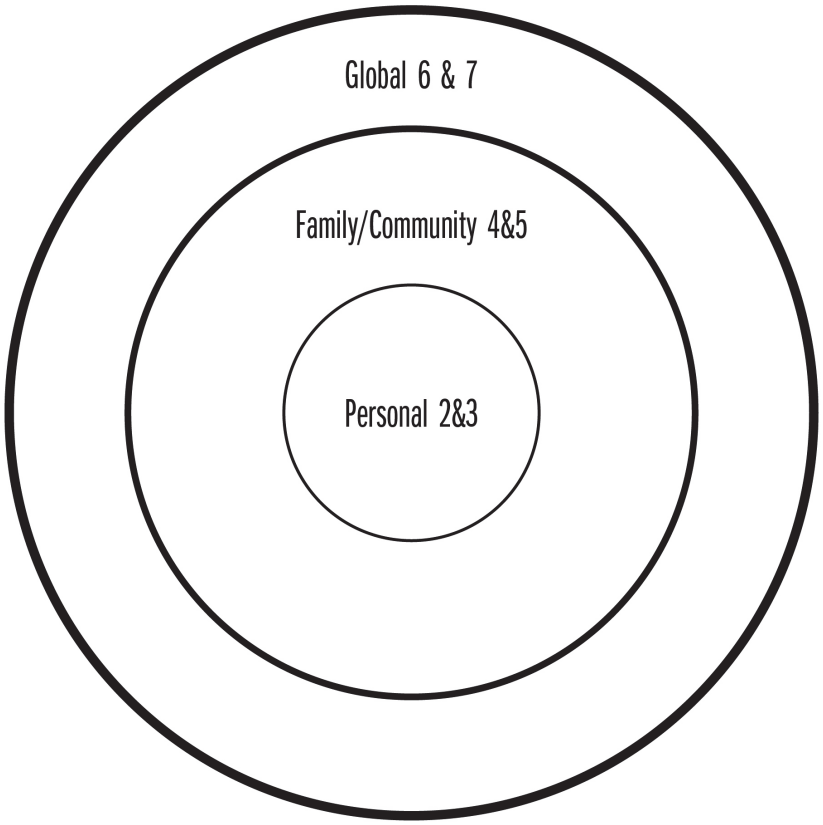

Figure 2. Visual representation of program. Topics and session numbers delineate the structure of the program design.

The voice will be used regularly throughout the program, but in small increments initially to ensure the comfort level of all members. The challenges of utilizing vocal

interventions with this population were listed in Chapter 2 and reinforced through a participant's assertions, thus group members will be given options of participating at the level of their choosing.

Session two.

Session goals.

1. For each group member to identify an area of talent or ability on which to focus for the duration of the group.
2. For group members to determine one to five aspects of self-esteem that are central to their personal definition.
3. For group members to participate in basic physical and vocal warm-up exercises.

Essential content.

1. To create a safe place for participants to divulge a hobby, pastime, or passion they feel comfortable developing.
2. To provide examples of aspects of self-esteem (e.g., behaviors, attitudes, etc.).
3. To present basic vocal techniques in an achievable, unintimidating, and engaging manner.

Session plan. The session will once again begin with a brief mindfulness meditation, followed by a Personal Passions experience. Joss Stone's song, "Girl, You Won't Believe It," (Stone & Saadiq, 2007), or another appropriate song selection, will be sung and played by the therapist, with each member given a copy of the lyrics to read and/or sing. This song was chosen for its strong female perspective aimed at other females, positive lyrics encouraging exploration of personal aspirations, and its upbeat, modern pop music aesthetic that is not childish. The song will serve as a jumping off

point for discussions about each member's passion, talent, or hobby. Each person, including the therapist, will be asked to choose one talent to focus on during the group. Depending on group engagement and time constraints, the therapist could use lyric substitution to sing a few lines about each member and their choice.

After a brief explanation of different representations of self-esteem (e.g., feelings, behaviors, etc.), students will be asked to write their own definition of what self-esteem means to them in a personal folder provided by the therapist. Lapinsky (2002) said that teens, "are able to improve their own self-esteem through the process of personally defining and exploring the phenomenon's definition," (p. 26) and an interview participant asserted that it helps reinforce the adolescents' sense of identity and build confidence in their own perceptions.

The group will come together again to participate in a brief warm-up consisting of physical (shoulder and neck rolls, stretching up and folding over) and vocal (lip trills, glissandos, and consonant articulation) exercises. The vocal requirements and intensity of exercises will increase each time a warm-up is led. Insecurities will be diminished through these group vocal lessons, as endorsed by Lightner (1991), and through explanation of vocal problems common to the female adolescent vocal transition, as recommended by Monks (2003). Finally, the group will be invited to sing along (with lyric sheets provided in their personal folders) to the group song as it is sung and played by the music therapist.

Session three.

Session goals.

1. For members to take on a leadership role, and thus a level of responsibility, within the group.
2. For members to offer a way in which they did or handled something well during the week (Corder & Whiteside, 1990).
3. For members to establish an achievable personal goal for themselves regarding their area of ability.

Essential content.

1. To establish various leadership roles and aid in the process of assigning them according to student strengths and preferences.
2. To provide feedback and encourage positive feedback from group members in response to students' actions or behaviors.
3. To facilitate supportive conversation around members' personal goals and aid in the choice of achievable objectives.

Session plan. After the opening mindfulness meditation, therapist and group members will decide which leadership role will be assigned to each group member. This was cited by an interview participant as a means to development of therapeutic alliance, with roles like clean-up crew, check-in people, and DJ among suggestions. Corder and Whiteside (1990) also recommend assigning roles (e.g., rules enforcer, encourager, or protector) to guarantee that all group members get involved. Group roles will be consistent throughout the group unless problems arise, at which point revisions can be made.

Another of Corder and Whiteside's (1990) activities, the Self-Concept Improvement Exercise, will then be incorporated. Group members will each be asked to

list one situation they handled well or something they did well over the course of the week, for which they will receive positive feedback from therapist and peers. When this experience is complete, members will be asked to share verbally or by writing in their personal folders examples of when they, according to their own definitions, exhibited positive self-esteem. The therapist and students will then contribute lyrical content from their examples and/or personal definitions to a group song-writing experience. The melody of an existing song preferred by the group will be used to ensure familiarity.

With the area of talent established in the previous session, students will be guided in the creation of an achievable personal goal, which will be recorded in their personal folders, or goal books as they are referred to by Corder and Whiteside (1990). The session will again conclude with a physical and vocal warm-up and the singing of the group song.

Session four.

Session goals.

1. For group members to work together in making choices about session content.
2. For group members to offer positive feedback to each other during the self-concept exercise.
3. For group members to recognize the aspects of their personal definition of self-esteem in someone from their support system.

Essential content.

1. To facilitate communication during decision-making processes and provide viable options for the group project based on group preferences and abilities.

2. To remind participants of aspects of self-esteem and support them as they search for these elements within their own support system.

Session plan. This session will begin with the group's choice of mindfulness or singing the group song (with warm-up), followed by the Self-Concept Improvement exercise (Corder & Whiteside, 1990) of the previous session. Presenting content in levels and the exploration of support systems to establish greater connectivity were recommended by interview participants, thus self-esteem will next be investigated on the family or community level. Students will be asked to identity members of their support system who display healthy self-esteem as they themselves have defined it (Lapinsky, 2002).

Members must then choose (from choices offered by the therapist or feasible options presented by the group) a group musical project to be worked on in each subsequent session. Examples include: write and sing a song together, change the lyrics of an existing song and perform it for teachers and/or friends, make a recording of a pre-existing or created song, etc. Planning for and work on the project will take up the remainder of the session until the closing (either meditation or group song).

Session five.

Session goals.

1. For students to report honestly and openly about the progress of personal goals.
2. For members to gain awareness of the healthy (and by contrast unhealthy) aspects of their support system.
3. For members to actively participate and contribute to progress of group project.

Essential content.

1. To encourage positive interaction between group members during group discussion and work on group project.
2. To provide emotional support during exploration of support system.

Session plan. Again, members will be allowed to choose either the mindfulness or group song experiences for the opening. Each group member will then check-in about progress made on, or challenges to, completing their personal goals. Adjustments can then be made, problems tackled by the group, and/or new goals formed.

As a concluding portion to the support system component of the self-esteem program design, a lyric substitution experience will be led by the therapist in an attempt to help members realize which people in their life support their positive self-esteem behaviors. Either an appropriate song that has arisen from the process can be used, or the song "With a Little Help From My Friends" by The Beatles (Lennon & McCartney, 1967). The simplicity of the Beatles' song lyrics and form lend themselves well to lyric substitution, while exploring the intended themes of identifying members of the support system (e.g., "I get by with a little help from _____") and uncovering what is needed from them (e.g., "I just need someone to _____"). This exercise was chosen because several interview participants highlighted the importance of the support system, and the ability to distinguish healthy from unhealthy aspects of it. This will be followed by continued work on the group music project and the closing experience of their choosing (meditation or group song and warm-up). All members will be asked to bring in a song, singer or band for the next session that embodies what they have learned about self-esteem (Lapinsky, 2002).

Session six.

Session goals.

1. For members to provide at least one example of a musician with healthy self-esteem, proving generalization of knowledge acquired.
2. For members to demonstrate increased knowledge in musical experiences, through contribution to vocal warm-up and group music project.
3. For group members to offer positive feedback to each other during the self-concept exercise.

Essential content.

1. To provide an opportunity for group members to take on leadership roles in musical experiences (e.g., have students lead vocal warm-ups and offer suggestions for improvement during group music project).
2. To provide students with honest evaluative feedback.

Session plan. After the students' choice of meditation or group song has finished, the Self-Concept Improvement exercise (Corder & Whiteside, 1990) will take place once again. The group will then be provided with a variety of art materials and magazines to create paintings and/or collages that symbolize what self-esteem means to them (Lapinsky, 2002), while listening to the selections of musicians who represent positive self-esteem that they have brought in. This way self-esteem is presented on yet another level, globally. A group discussion about the art created and music listened to will ensue.

The students will then be given time to work on their group music project before the closing meditation or song with warm-up.

Session seven.

Session goals.

1. For group members to account their progress on personal goals in an accurate yet becoming light.
2. For group members to independently identify behaviors, actions, as demonstrated through song lyrics, associated with both healthy and unhealthy self-esteem.

Essential content.

1. To aid students in seeing their progress, personally and as a group, toward their goals and the group music project.
2. To provide examples of songs depicting healthy and unhealthy self-esteem for the group's analysis.
3. To allow space for and support group members in preparation for termination of the group.
4. To provide students with honest evaluative feedback.

Session plan. The regular choice of opening experience will be followed by another goal check-in/revision with group and therapist feedback. To conclude the global self-esteem portion of the program design, the therapist will bring in two songs with lyric sheets, one representing or expressing positive self-esteem and the other negative. The group will then be encouraged to analyze the songs and their impressions of them in light of all they have experienced in the group. This will also act as a chance to express whatever feelings exist about the impending termination of the group.

There will be a last chance to work on the group music project and prepare for the final presentation (in whatever form that may take in the next session), followed by the meditation or group song and warm-up closure.

Session eight.

Session goals.

1. For group members to acknowledge their achievements in personal goal areas and to commend others in their progress.
2. For group members to contribute to the development of "individualized self-esteem action plan for the future," (Mruk, 167, 2006b).
3. For members to demonstrate increased musical knowledge and competence through the presentation of the group music project.
4. To sensitively and effectively close the program as a group.

Essential content.

1. To provide structure and ideas for the completion of personalized action plans.
2. To provide the optimal environment for the presentation of the final project.
3. To allow space for and support group members during the termination process.
4. To provide students with honest evaluative feedback.

Session plan. The group will once more be allowed to choose either the meditation or warm-up and group song experience for the opening of the session. There will be a final check-in about progress made on individual goals with honest feedback provided by the therapist. Group members will also be encouraged to offer positive feedback about their peers' accomplishments. Students will be asked what they need going forward to maintain their self-esteem (Lapinsky, 2002) as they work together with

the therapist to create an action plan for the future (Mruk, 2006b) which will include goals for their particular talent areas, but more importantly for their self-esteem.

The group project will then be presented to members of the group and/or invited guests depending on the nature of the project and the consensus of the group. A celebratory atmosphere will be encouraged with a selection of group-preferred recorded music, and, as suggested by several interview participants, food to share. The session will then conclude for a final time with the group's choice of meditation or a warm-up and the group song.

Chapter 5. Discussion

Through consolidation of insights from interviews with professionals, literature in the fields of the creative arts therapies, psychology, and music pedagogy, and the researcher's clinical training, this music therapy intervention program design for female adolescents at-risk was constructed to address self-esteem. As self-esteem has been shown to be only one of the many critical aspects of resilience, it is intended that this program design would be used in concert with other programs exploring the remaining facets in an attempt to bolster resilience and mediate school failure. As indicated in Chapter 3, the checklist of criteria essential to accurate reporting of music-based interventions developed by Robb et al. (2010) served as grounding for the development and presentation of this program design. Six of the seven standards were fully applied. Intervention theory (rationale for and intended impact of music), specifics of intervention content (including who chooses music, references for selections, delivery method, materials, and strategies), intervention delivery schedule (number, length, and frequency of sessions), interventionist, setting, and unit of delivery (individual or group) were all outlined clearly in steps one and two of the program design. The seventh and only unaddressed item was the creation of fidelity strategies for treatment delivery. Given the limited scope of the current research, this would need to be explored in future research.

Adherence to the criteria made the program design more easily transferable to the clinical realm and linkages to the existing base of literature further fortified it. Aside from connections determined in Chapter 4 between participant response and the literature regarding meditation (Wisner et al., 2010) and assigning group roles (Corder & Whiteside, 1990), there were also similarities in the musical interventions used (e.g.,

singing, listening, song-writing, lyric analysis and improvisation), and in the use of the client's preferred music (Carr & Wigram, 2009; Cobbett, 2009; Smith, 2012; Veltre & Hadley, 2012). Cobbett (2009) along with several participants noted the significance of remaining flexible. The population-specific needs articulated by participants (expression of and connection to self) line up with the fundamentality of self-esteem and self-concept outlined in the literature (Boyd, 2000; Elmaleh, 2002; Higenbottam, 2003; Sausser & Waller, 2006; Scott, 2003; Smith, 2012; Smith-Adcock et al., 2008).

Other themes found in both literature and interview findings were akin more to the larger systemic view rather than minutiae of the program. The recommendation of one interview participant to examine self-esteem on various levels (personal, support system, and global) was mirrored in exercises put forth by Lapinsky (2002) and also in the definition of resilience posed by Richman et al. (2004); they too imagined the concept from an ecological or systemic perspective. Also, the emphasis on the support system itself uncovered in interview categories (such as supporting them, connection to adults, and support from others) buttressed the centrality of Nelson's (1996) relational competence and Jordan's (2005) relational resilience. Connection to others was in fact found to be salient in both definitions of resilience (Jordan, 2005; Richman et al., 2004). Jordan (2005) described "growth fostering" relationships (p.80) as being ones in which both parties are empowered, supported, and engaged, which coordinates with participant ideas about alliance formation (empowering them, supporting them, and being a part of the group). The notions submitted by participants that music listening builds trust and that the group should develop rules and work on a single project together also all align with my clinical experience.

Clear links to literature and clinical practice validate the relevance of the data uncovered. The value of the resulting program design is found in the positive, ecological approach to the treatment adolescents. A place has been created where they can be empowered to critically explore how self-esteem is manifested in their life, personally and systemically, where they can be viewed holistically with a focus on their positive attributes. The framework provided could be adapted for use with differing populations or for addressing other concepts. Because participants are to contribute so much of the content, cultural adaptations for use in different locations or communities would be minimal. In this program design, a functional, detailed protocol for use by professionals has been contributed to the field of music therapy. It fills a gap for evidenced-based music therapy programming for adolescents and also the need for gender-specific programming for adolescents at-risk. Professionals in other fields (creative arts or otherwise) could also use the malleable mediators presented here and alter the action strategies to incorporate techniques used in their fields.

The necessarily limited parameters of this study leave a few obvious paths for future research. The first is to complete Fraser and Galinsky's (2010) five-step model of intervention design through a pilot study of this program design and efficacy testing with feedback from those administering and receiving the program. The other is to develop curriculum to address directly the components of resilience yet to be undertaken: social competence, a sense of purpose, contextual factors, and problem-solving skills (Richman et al., 2004). One area of further study inspired by interview findings involves exploration of the process of therapeutic alliance development between therapists and adolescents. It is a complex endeavor, rife with population-specific challenges, which

may affect the number of therapists who choose to work with teens. With all of the emphasis put on empowering the adolescent client in both the literature and interview findings, another potentially fruitful area of study would be a consultation with teenagers themselves about their needs and ideas for creating programming to best suit them. There should also be an exploration of how music therapy interventions can be used to meet the needs of male adolescents.

Limitations

The scope of this study was restricted to consideration of the views of professionals currently working with female adolescents, as they were more likely to be aware of recent developments in the field than those who practiced in the past. The scope was further limited to a North American perspective, as all four participants were residents of Canada or the United States. With only four participants consulted, the information gathered offers limited potential for generalization. The fact that all participants were female could be considered both a limitation and strength. The intimacy with and investment in the subject matter expressed by several participants (e.g., a personal experience of being a female adolescent at-risk, a personal experience of low self-esteem as a teenager) offer a deeper connection with the issues, but possibly a personal bias as well. Also a male perspective on the issue could have provided additional insight.

Further limitations lie in the relationships between researcher and participants. The fact that the researcher knew two of four participants and their facility impacted the interview process. In reviewing those two transcripts I found less detail was requested about context, population, and participant's role in the setting. In interviews with all four

participants it is possible that self-esteem and vocal interventions received greater focus from the participants, as details of the proposed program were made clear in the consent form.

Because so few music therapists responded to the recruitment email there were aspects of the population and setting of the two participants chosen that did not align perfectly with that of the proposed program design. One participant worked with adolescents at-risk but these additionally had diagnosed mental health conditions, the other worked with students in the juvenile detention center without knowledge of their academic standing, and both facilities had residential components, which changed the frequency and dynamic of the participants' relationships with their students.

The manner in which the term at-risk was defined at the time of the first interview was broader and focused more on risk factors at play in the lives of the teenagers, which may have affected the direction and content of the interview. This process was, however, used to refine the definition as it was to be used for the remainder of the research.

Conclusion

Self-esteem and resilience were identified as malleable mediators that protect female adolescents at-risk from failing out of school, and thus became the main focus of the 8-week music therapy intervention presented here. From the literature review and interview findings, four action strategies were developed, and this information coupled with the researcher's clinical experience with female adolescents, was utilized to delineate the particulars of each session of the program design. It is my hope that this program will prove beneficial for practitioners and researchers interested in this population, as well as for the female adolescents themselves.

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Appendix A: Participant Recruitment Letter

Designing Group Music Therapy Vocal Interventions for Adolescent Females Who Are At-risk

Hello, my name is Jessica Power, and I am a Master's student in the MA of Creative Arts Therapies (Music Therapy option) at Concordia University, in Montreal, Quebec, Canada. My faculty supervisor is Dr. Sandra Curtis of Concordia University, in Montreal, Quebec, Canada. I am seeking credentialed Music Therapists who work with female adolescents considered to be at-risk to volunteer to participate in one 60-minute interview (telephone, videoconference, or in person) about their experience in working with this population. In the context of this research, the term *at-risk* is used to refer to adolescents at-risk for academic failure, delinquency, or involvement with the law due to a variety of risk factors at play in their lives. The aim of this research is to develop a music therapy program design for later testing and implementation.

A foreseeable benefit to participating in this research is a sense of satisfaction from contributing to the development of specific music therapy programming, which will in turn develop an under-researched area of the field and expand treatment options for this population. Potential risks or harms that could arise for participants as a result of this research are minimal, with an inconvenience of time spent for the interview and review of transcript, and possible use of the internet conferencing applications (such as Skype) as the only known factors. Nothing disclosed about the participants' facilities or previous interventions will be communicated to outside parties or affect their current job standing.

Due to the limited scope of this research project, only English speaking participants practicing in Canada or the United States will be considered for an interview. Anyone who is interested in participating in this study can contact me directly off list at jessicaannepower@gmail.com to discuss possible arrangements. Please feel free to contact me, or my research supervisor, with any further questions.

Sincerely,

Researcher:
Ms. Jessica Power, Grad. Cert. in MT, MT-BC
MA Creative Arts Therapies, Music Therapy Option
Concordia University
Department of Creative Arts Therapies
1395 Rene Levesque Blvd. Ouest, VA 264,
Montreal, Quebec, Canada, H3G 1M8
Email: jessicaannepower@gmail.com

Faculty Research Supervisor:
Sandra Curtis, PhD, MT-BC, MTA
Professor & Graduate MT Coordinator
Concordia University
Department of Creative Arts Therapies
1455 de Maisonneuve O, VA 260
Montreal, Quebec, Canada, H3G 1M8
Email: Sandi.Curtis@concordia.ca
Phone: 514.848.2424 ext.4679
Fax: 514.848.4969

If at any time you have questions regarding your rights as a research participant, you may contact Research Ethics and Compliance Advisor, Ms. Adela Reid, in the Office of Research.
Building: GM-910 03, Concordia University, Montreal, Quebec H3G 1M8
Email: Adela.Reid@concordia.ca
Phone: 514-848-2424 ext. 7481

Appendix B: Research Consent Form

Consent To Participate In:

Designing Group Music Therapy Vocal Interventions for Adolescent Females At-risk

I understand that I have been asked to participate in a research project being conducted by Jessica Power of the Creative Arts Therapies Department, Faculty of Fine Arts of Concordia University (*438-821-5356; jessicaannepower@gmail.com*) under the supervision of Dr. Sandra Curtis of the Creative Arts Therapies Department, Faculty of Fine Arts of Concordia University (*514-848-2424 ext. 4679; sandi.curtis@concordia.ca).*

A. PURPOSE

I have been informed that the purpose of the research is to design a music therapy program using vocal interventions for at-risk female adolescents. In the future, this program may be tested in school settings for the purpose of strengthening resilience and adaptive growth.

B. PROCEDURES

I understand that I will participate in a 60-minute interview with the researcher at a private place and time of my choosing (in person, over the phone, or via internet conferencing). If over the phone or internet, I agree to locate myself in a quiet, private place for the interview. I understand that during this interview, I will discuss my experiences with adolescents who are at-risk and the existing interventions designed for them. I understand that the interview will be recorded for later analysis and that I will have the opportunity to review and revise the analyzed transcriptions of those recordings. I also understand that my identity and my place of work will only be known to the researcher and to her thesis adviser.

C. RISKS AND BENEFITS

I understand that the benefits of participating in this research include a sense of satisfaction in contributing to the development of specific music therapy programming, which will in turn develop an under-researched area of the field and potentially expand treatment options for this population.

I understand that potential risks or harms of participating in this research are minimal, with an inconvenience of time spent for the interview and review of transcript, and possible use of the computer application, Skype, as the only known factors. I understand that no specifics about my facility or previous interventions will be communicated to outside parties or affect my current job standing, but that the information disclosed about previous interventions may be included as a part of the final paper.

D. CONDITIONS OF PARTICIPATION

- I understand that I am free to withdraw my consent and discontinue my participation at anytime (prior to reviewing and approving the analyzed transcripts of my interview) without negative consequences.

- I understand that my participation in this study is CONFIDENTIAL (i.e., the researcher will know, but will not disclose my identity)

- I understand that the data from this study may be published or may be the subject of future presentations.

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT.
I FREELY CONSENT AND VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

NAME (please print) _____

SIGNATURE _____

If at any time you have questions about the proposed research, please contact the study's Principal Investigator, Jessica Power of the Creative Arts Therapies Department, Concordia University, 438-821-5356, jessicaannepower@gmail.com; or Dr. Sandra Curtis of the Creative Arts Therapies Department of Concordia University, 514-848-2424 ext. 4679; sandi.curtis@concordia.ca.

If at any time you have questions about your rights as a research participant, please contact the Research Ethics and Compliance Advisor, Concordia University, 514.848.2424 ex. 7481 ethics@alcor.concordia.ca

Appendix C: Interview Questions for the School Counselor and Social Worker

1. Can you tell me about your experience with adolescent females who have been expelled from or failed out of the mainstream school system?

2. What types of interventions for this population have you facilitated or observed?

3. Which methods/interventions were the most effective?

Follow-up: What was it, in your opinion, which made them so effective?

4. Do any methods or interventions stand out to you as being particularly ineffective?

Follow-up: Which elements of them contributed to their ineffectiveness?

5. Based on your experience with at-risk female adolescents, what do you think their most significant needs are?

6. Based on your previous experience with this population, can you tell me a bit about forming a therapeutic alliance in a group setting?

Follow-up: How long does it usually take?

Follow-up: Are there any specific ways in which you go about strengthening the bond?

7. What do you think the optimal length would be for a group program with the female adolescents you work with?

8. What do you think the optimal length would be for the session?

9. How would you describe the relationship between self-esteem and the female adolescents with whom you work?

Appendix D: Interview Questions for the Music Therapists

1. Can you tell me about your experience with adolescent females who have been expelled from or failed out of the mainstream school system?

2. What, if any, specialized music therapy training did you receive for this population?

3. What types of interventions for this population have you facilitated or observed?

4. Which methods/interventions were the most effective?

Follow-up: What was it, in your opinion, which made them so effective?

5. Do any methods or interventions stand out to you as being particularly ineffective?

Follow-up: Which elements of them contributed to their ineffectiveness?

6. Based on your experience with at-risk female adolescents, what do you think their most significant needs are?

7. Can you tell me about how you use music therapy to fit those needs?

8. Based on your previous experience with this population, can you tell me a bit about forming a therapeutic alliance in a group setting?

Follow-up: How long does it usually take?

Follow-up: Are there any specific ways in which you go about strengthening the bond?

9. What do you think the optimal length would be for a group program with the female adolescents you work with?

10. What do you think the optimal length would be for the session?

11. How would you describe the relationship between self-esteem and the female adolescents with whom you work?

Appendix E: Song Choice Assessment Tool

Common musical/behavioral criteria indicators

Areas of assessment	Assets	Deficits
Level of anxiety	Waits for direction	Motor restlessness, excessive verbalizations; concerned about mistakes or quality of his/her voice; impulsivity
Decision making	Chooses song independently	Unable to find song independently
Reality orientation	Song choice reflects current conflict or feeling	Shows little or no understanding of directions; chooses song for someone else
Abstracting ability	Associates song choice to current problems &/or aspect of personality	Song choice and/or association is concrete and simple
Self-image	Song reflects positive attributes or feelings; patient talks about past musical experiences	Negative self-statements; compliments therapist; song choice reflects negative feelings of behaviors
Emotional constriction	Sings with the therapist; moderate tone of voice	Does not sing with therapist; vocal sounds inaudible
Music ability	As demonstrated by vocal productions	Patient demonstrates tone deafness

(Wells, 1988)

Appendix F: Certificate of Ethical Acceptability

CERTIFICATION OF ETHICAL ACCEPTABILITY
FOR RESEARCH INVOLVING HUMAN SUBJECTS

Name of Applicant:	Ms. Jessica Power
Department:	Creative Arts Therapies
Agency:	N/A
Title of Project:	Designing Group Music Therapy Vocal Interventions for Adolescent Females Who are At-Risk
Certification Number:	30001693
Valid From: July 26, 2013	to: July 25, 2014

The members of the University Human Research Ethics Committee have examined the application for a grant to support the above-named project, and consider the experimental procedures, as outlined by the applicant, to be acceptable on ethical grounds for research involving human subjects.

Dr. James Pfaus, Chair, University Human Research Ethics Committee

01/29/2009