Therapeutic Songwriting in Adolescent Inpatient Mental Health Care: A Program Intervention Research to Address Psychosocial Strengths and Needs

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A Thesis
in
The Department
of
Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts (Creative Arts Therapies, Music Therapy Option)
Concordia University
Montreal, Quebec, Canada

April, 2021

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the thesis prepared

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Entitled: Therapeutic Songwriting in Adolescent Inpatient Mental Health Care: A Program Intervention Research to Address Psychosocial Strengths and Needs

and submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Creative Arts Therapies, Music Therapy Option)

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

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ABSTRACT

Therapeutic Songwriting in Adolescent Inpatient Mental Health Care: A Program Intervention Research to Address Psychosocial Strengths and Needs

Trina Chakrabarti

This research study explores the development of a therapeutic songwriting-based program intervention for adolescents in inpatient mental health care contexts.

The related literature looked at how music therapy songwriting methods are used to address the psychosocial strengths and needs of youth in inpatient mental health care, particularly, needs of emotional processing, identity formation, and being connected, as reported by McFerran et al., (2019). The intervention research design followed the first one-and-a-half steps of the Fraser and Galinsky (2010) model. These steps included an analysis of risk and protective factors through deductive coding of relevant literature, which led to a program theory. The program intervention protocol involves a referral, an intake, and a three-phase model that is ideally realized within three 45- to 60-minute individual sessions. The phases of the model are (1) assessment, (2) free writing and exploration, and (3) structured implementation leading to the completion of a song composition. Music therapists using this program intervention should have knowledge of adolescents' unique mental health care needs, be proficient in a variety of music genres, and have a flexible therapeutic approach. Future research could aim to develop the intervention further and to evaluate the effects of its implementation in an inpatient adolescent psychiatric unit.

ACKNOWLEDGEMENTS

I would like to thank my supervisor Annabelle Brault for guiding me through the thesis writing process, as well as the entire Concordia music therapy faculty, particularly Dr. Laurel Young and Dr. Guylaine Vaillancourt for being great resources throughout the entire experience and being understanding and accommodating towards my mental health needs. The music therapy faculty opened my eyes to a world of opportunity and passion, which I will be forever grateful for.

I would also like to thank my family, particularly my parents and brother for being so encouraging. I want to thank my friends for believing in me, my best friend Ciana for her kindness, and uplifting words, and my partner Ahmed for being so supportive on this journey and always being there to help me along the way.

Lastly, I would like to thank my music therapy peers for all the virtual study sessions and support, and particularly Miranda for online writing sessions almost every day. I truly could not have done this project without my colleagues cheering me on the whole time.

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Chapter 1. Introduction

Music is a critical psychosocial resource for adolescents as it may assist them in navigating the development of agency, relationships, and emotional processing (Laiho, 2004). Therapeutic songwriting helps youth process a variety of emotions, that in turn provides a narrative within which they can explore culturally contextual expression (McFerran, 2019). Wigram and Baker (2005) state that the therapeutic songwriting process can help clients feel a sense of autonomy through the expression of their thoughts, preferences, emotions, and needs, which is often a focus in mental health care. In a study conducted by Haines (1989), adolescents receiving music therapy were more motivated to express their feelings, as opposed to those receiving verbal therapy. One possible explanation for this is that music therapy gives adolescents an opportunity to express emotions through creativity (Tervo, 2005). Patterson et al. (2015) conducted a study in an adolescent inpatient unit in which over 90% of the 43 participants reported feeling better, and staff indicated that music therapy was an effective tool in adolescent emotional expression. Therefore, the research suggests benefits for adolescents engaging in creative expression in terms of addressing psychosocial strengths and needs. However, the creation of a program intervention focusing on music therapy songwriting in adolescent inpatient mental health care has not been substantially explored.

Therapeutic songwriting is a technique that falls under *Composition*, one of the four methods of music therapy as defined by Bruscia (1989). It can address a variety of psychosocial strengths and needs by providing clients with safety and support, an opportunity to reflect on a variety of life experiences, and a chance to address difficulties in relationships (Wigram & Baker, 2005). In nonclinical songwriting, individuals or groups express emotions and tell stories through lyrics and music (Baker, 2015). Therapeutic songwriting is defined as "the process of creating, notating, and/or recording lyrics and music by the client or clients and therapist within a therapeutic relationship to address psychosocial, emotional, cognitive, and communication needs of the client" (Wigram & Baker, 2005, p. 16). Therapeutic songwriting is a beneficial method to use when working specifically with adolescents, as it supports the expression of thoughts and feelings, which can enhance overall self-esteem (Robarts, 2003). Songwriting may enhance adolescents' confidence and independence, ultimately creating a sense of fulfillment (Derrington, 2005).

Significance and Need

Erkkila (2011) states that adolescents benefit from engaging in creative musical experiences in order to examine their emotional awareness in relation to the self, which can be explored through therapeutic songwriting specifically. Furthermore, Muller (2008) suggests that the presence of the music therapist (as opposed to engaging in independent music experiences) plays an important role during emotional processing: the music therapist provides a safe space where the adolescent can express their inner positive and negative experiences while the therapist bears witness. These experiences, in turn, shape the therapeutic relationship.

A study by Rosado (2019) found that adolescents in an inpatient setting who participated in music therapy, including therapeutic songwriting, reported feeling increased comfort levels and emotional expression, positively modulated affect, better social connection, a deeper sense of empathy, and greater emotional expression and personal insight. In another study, participants engaging in therapeutic songwriting within the context of acute inpatient care stated that this method was enjoyable and that it effectively addressed, challenged, and conceptualized self-stigma, and helped them develop coping mechanisms (Silverman, 2013). To address the current rise in mental health challenges such as depression and anxiety in adolescents, Sarvet (2017) calls for a greater variety, as well as alternative methods, of mental health care resources. Wigram and Baker (2005) discussed using songwriting techniques with adolescents, as well as using songwriting techniques in mental health. However, there are few case studies from their book and others (Goldstein, 1990; Derrington, 2005; Dalton & Krout, 2006; Baker, 2016; Viega, 2016; McFerran, 2010) that address therapeutic songwriting resources explicitly for adolescents in inpatient mental health care settings.

Relevance to Music Therapy

The relevance of this topic in relation to music therapy arose from the substantial amount of research on music therapy with this age group, but the limited amount of research on the specific population of adolescent inpatients. While music therapy with adolescents and therapeutic songwriting interventions are topics thoroughly examined in the literature, more research is needed on using therapeutic songwriting in inpatient mental health care where creative forms of therapy have been shown to be effective (Haines, 1989; Erkkila, 2011). This research could positively contribute to current literature and practice. Adolescents have emotional needs, identity needs, and a need for connection.Therapeutic songwriting has the

ability to address all these needs within the therapeutic relationship (McFerran et al., 2019). Compiling therapeutic songwriting techniques and methods into a program intervention can be beneficial for music therapists working with adolescents on addressing their psychosocial needs, particularly in an inpatient mental health care context.

Personal Relationship to Topic

My interest in this topic began with songwriting experiences as a teenager struggling with mental health related challenges and noticing that traditional verbal therapy lacked creative resources. During my music therapy internship at a general hospital children's psychiatry department, I noticed the effectiveness of music therapy composition techniques, including songwriting. Compared to other techniques, songwriting was generally most effective in addressing emotions, identity, and connection, in my own experience as an intern. Therefore, as a student-researcher, I wanted to propose a songwriting-focused music therapy program intervention to provide adolescents receiving inpatient mental health care with opportunities to creatively address psychosocial strengths and needs.

Key Terms

Therapeutic Songwriting

Therapeutic songwriting is a compositional music therapy method, which involves a client and music therapist creating, notating, and sometimes recording music within a therapeutic relationship, to address psychosocial needs (Wigram & Baker, 2005). Songwriting methods may include improvisational songwriting, parody techniques, and free composition (Wigram & Baker, 2005), just to name a few. For the purposes of this research, songwriting and therapeutic songwriting will be used interchangeably.

Adolescents

Adolescents are defined as youth between 13 and 19 years old (Csikszentmihalyi, 2019).

Music Therapy

"Music therapy is a discipline in which Certified Music Therapists (MTA) use music purposefully within therapeutic relationships to support development, health, and well-being. Music therapists use music safely and ethically to address human needs within cognitive, communicative, emotional, musical, physical, social, and spiritual domains." (Canadian Association of Music Therapists, 2020, What is Music Therapy, para. 1).

Inpatient Mental Health Care

This refers to hospitals and psychiatric facilities providing emergency psychiatric services focused on stabilizing severe mental health and addiction conditions (Canadian Institute for Health Information [CIHI], 2019).

Psychosocial Strengths and Needs

For the purpose of this research, this refers to the psychological and social strengths and needs of adolescents that are closely related to music engagement as described by McFerran et al. (2019): processing emotions, performing identity, and being connected. These three strengths and needs are considered integral to adolescents' mental health, and music is a beneficial way to address them.

Research Questions

The primary research question was "How can a program intervention utilizing therapeutic songwriting be designed to address psychosocial strengths and needs of adolescents receiving inpatient mental health care?'' The subsidiary research questions were: "What are the psychosocial strengths and needs of adolescents receiving inpatient mental health care?" and "What are the songwriting techniques used with adolescents to support psychosocial strengths and needs?"

Chapter Summary

Chapter one explored the context and relevance of this research. This included examining the significance and need of the research, the relevance to music therapy, the student researcher's relationship to the topic, key terms, and the research questions. Chapter two provides an overview of literature related to Canadian adolescent mental health care, adolescent psychosocial needs, music therapy methods, and songwriting techniques used to address adolescent psychosocial needs. Chapter three outlines the program intervention methodology used for this research. Chapter four presents the resulting program intervention. Chapter five presents a discussion of the findings.

Chapter 2. Related Literature

This chapter examines the strengths, needs, and goals commonly addressed in adolescent music therapy, with a focus on the use of songwriting in music therapy with adolescents in inpatient mental health care. Topics addressed include adolescent mental health care in Canada, psychosocial strengths and needs of adolescents, music therapy in adolescent mental health care, and therapeutic songwriting in adolescent mental health care.

Adolescent Mental Health: Canadian Context

One in five Canadians experiences mental health challenges in any given year (Smetanin et al., 2011, p. 6). Within this statistic, about 10%–20% of Canadian youth are affected by mental illness, and 5% of males as well as 12% of females will experience a major depressive disorder between the ages of 12 and 19 (Mental Health Commission of Canada [MHCC], 2013).

In the Canadian school system, though physical health issues have always been a priority, mental health concerns remain limited from a national education agenda perspective, even given the high prevalence of the onset of mental disorders during adolescence (Wei et al., 2011). Mental illness can severely impact young people's learning (Wei et al., 2011). Having a mental illness also puts youth at risk for substance abuse and self-harm behaviour (Wei et al., 2011). Mental health challenges must be addressed with culturally and contextually appropriate and effective interventions,to produce the most beneficial results (Wei et al., 2011). Therefore, it is important to examine the contexts in which current treatments are offered, in order to understand how to create interventions that best serve the strengths and needs of adolescents experiencing mental illness.

Levels of Care within Adolescent Mental Health Care in Canada

Within Canada, mental health care services are divided into community care and acute care. Community care services include primary care clinics, social services, mental health and addiction clinics, and residential services. Acute care services include emergency department hospital services and inpatient psychiatric services.

Community Care. Community mental health care may involve primary care clinics, social services, mental health and addiction (MHA) service clinics, and residential services (CIHI, 2019). Community programs include MHA clinics or programs that are community-based, which may involve night and day programs, home services, and health promotion and education (CIHI, 2019). Residential care is also a form of community care, which includes

support for those living with mental health needs or addiction challenges in a community or group home setting (CIHI, 2019). Hospital outpatient care (or ambulatory care) is considered a part of community psychological services that include treating and assessing behavioural challenges, and diagnosis, consultation, and teaching within an MHA framework (CIHI, 2019).

Acute Care. Acute care involves hospital emergency department (ED) and inpatient or psychiatric services (CIHI, 2019). Inpatient care includes "services provided for beds designated for inpatients with MHA needs in general facilities and in psychiatric facilities (e.g., nursing care, teaching, counselling services)" (CIHI, 2019, p. 16). Youth who receive inpatient mental health care are most often diagnosed with mood disorders that have comorbidities whos likelihood increases with the inpatient's age (Johansen & Fines, 2015). Substance abuse is common among multiple age groups including youth in inpatient care (Johansen & Fines, 2015). Other common comorbidities among multiple age groups including adolescents, are anxiety and personality disorders (Johansen & Fines, 2015).

Inpatient care is intensive in nature, as evidenced by patients' short-term overnight stays and their practitioners' medical focus on stabilization. Providing a creative outlet to patients is a primary motivation for examining the potential use of therapeutic songwriting in the current inpatient adolescent mental health care system.

Psychosocial Strengths and Needs of Adolescents

All adolescents have psychosocial strengths and needs regardless of whether or not they are experiencing challenges with their own personal mental health (McFerran, 2019). McFerran et al. (2019) conceptualize three major adolescent psychosocial strengths and needs categories relevant to youth's musical engagement: "Processing emotions, performing identity, and being connected" (p. x). The following section will explore these concepts.

Processing Emotions

Adolescents tend to use music as a means to match their emotions (McFerran & Saarikallio, 2013). When adolescents have mental health difficulties, they may experience intensified connection to and understanding of their emotions (McFerran et al., 2016). Music may be used as an effective coping mechanism. A strength that adolescents utilize in times of distress is using music to regulate affect and promote a positive mood (Saarikallio, 2011). In certain contexts where youth experience great mental health challenges (e.g., unstable home lives), they may experience distress and pessimism. Yet they may turn to music in a way that is

helpful or hopeful (McFerran, 2019). Because young people often cope by using musical engagement, building on this strength in a therapeutic setting may help to address emotional needs (Travis, 2013). Additionally, while some adolescents crave emotional control during mental health challenges, others may seek the freedom that may be associated with emotional expression, therefore, it is important to gather the contextual information from the individual (McFerran, 2019). It is important that music therapists keep a balance between expression and containment, as well as experience and cognition, while also following the lead of the client. Specific emotional challenges that adolescents may experience while coping with mental illness include aggression, violence, depression, and anxiety (McFerran, 2019). Adolescents may turn to music to immerse themselves in a different reality or as a means of regulating their affect (McFerran, 2019).

Aggression. Aggression can take multiple forms (e.g., physical, verbal, non-verbal, relational), and it can be exhibited passively or directly. It can be used as a response when feeling provoked, or as a proactive measure to achieve something. Ultimately, it is part of complex social processes (Santos, 2019). Youth experiencing mental health challenges may exhibit aggression as a means to fulfill a variety of psychosocial needs, including health, resilience, empowerment, identity, self-concept, status, belonging, and success (Santos, 2019). When working with adolescents who have displayed aggression, it is important to know that this behaviour may lie among strengths such as self-determination and agency (Daddis, 2011), which should be utilized in the therapeutic space. It is important for the therapist to differentiate between when aggression results in damage, versus when it is adaptive and functional (Olthof et al., 2011).

Violence. Violence is considered a more extreme form of aggression that has a goal of severe harm, whether or not the attempt is successful (Allen & Anderson, 2017). Violence in terms of mental health involves interpersonal violence such as threatening or intimidating behaviours and armed conflicts as well as personal behaviours such as suicidal tendencies (Wolfl, 2019). Violence in youth is often associated with an increase in potentially aggressive moods, feelings, and behaviours. However, through protection factors, violence and its associated actions and consequences may be decreased (Wolfl, 2019). Risk factors include lacking in affect regulation, holding aggressive attitudes, lacking empathy, having a normative attitude towards violence, and having educational and social struggles (World Health

Organization [WHO], 2002). Identifying and preventing patterns at an early age is an effective way to prevent violence (WHO, 2002). Adolescents show strength in using music as a way to promote calm and deal with aggressive emotions (Wolfl, 2019). Music therapists can therefore use music as a tool to promote positive social impulses and prosocial atmospheres, and strengthen community to address violence among youth (Wolfl, 2019).

Depression. Depression is one of the most common mental illness diagnoses among adolescents (Geipel, 2019). This involves individuals experiencing depressed mood, loss of interest in previously enjoyed activities, decreased energy, changes in sleeping patterns and/or appetite, and feelings of guilt and low self-worth (Geipel, 2019). In adolescents, depression often leads to social withdrawal, poor performance in school, and difficulties with familial and peer relationships (Geipel, 2019). Treatment usually involves medication and therapy, with advocacy for allied professional approaches such as mindfulness and creative arts therapies (Cheung et al., 2007). In a music therapy context, adolescents can be guided to use their strength of musical coping as a way to foster interaction and to find a source of pleasure (Giepel, 2019). A meta-analysis by Gold et al. (2004) which included 11 studies examining overall effects of music therapy for children and adolescents with psychpathology, suggested music therapy to be a beneficial method of treatment.

Anxiety. Anxiety disorders are prevalent among children and adolescents, and show comorbidity with attention deficit hyperactivity disorder (ADHD) and major depression, as well as dysthymia (Costello et al., 2005). These disorders cause distress that often interferes with family life, academics, and social abilities (Costello et al., 2005). In general, youth who are in need of hospital services often have high rates of anxiety and are often dissociated from their emotions (Shuman et al., 2016), therefore, music therapy could be a beneficial way to help these adolescents both get in touch with and process emotions. Studies have shown that music therapy decreases anxiety symptoms in hospital settings with youth (Evans, 2002). When working with adolescents who have anxiety disorders, music therapists may work with their strengths such as courage, persistence, and overcoming challenges to address their emotional needs (Kwok, 2018).

Performing Identity

Identity formation, which includes defining sexuality, relationships, career paths, values, and worldviews, is crucial for youth to make major life decisions (Saarikallio, 2019). Adolescents affected by mental health problems may experience challenges when trying to

balance internal and external demands, resources and owning their emerging selves, especially when trying to understand agency, self-control, and self-esteem (Saarikallio, 2019). Furthermore, adolescents are not always able to make all their own decisions or to accomplish all their goals due to some external factors such as social and cultural expectations (Saarikallio, 2019). Risk factors such as dropping out of school and a depression diagnosis, both of which can be linked to lowered levels of perceived control, self-efficacy, and competence, may prevent the development of agency (Seiffge-Krenke, 2000). In a music therapy context, adolescents can use music as a way to understand themselves as well as their choices (Saarikallio, 2019). Adolescents show strength in the use of music as a resource for health and identity (Ruud, 1997), as well as the formation of agency (Kreuger, 2011). When constructing identity, adolescents may need to tackle multiple aspects of themselves including their personality, the bridge from youth to adulthood, and their gender and sexuality, as well as their relationship with disability. Music can be used as a potential resource for social identity and participation (Saarikallio, 2019).

Personality. Fleeson (2001) describes personality traits as stable patterns of emotions, cognitions, and behaviours.These traits are organized via the Five Factor Model (Big 5) of extraversion, agreeableness, conscientiousness, neuroticism, and openness (John et al, 2008). From a music therapy research perspective, there are correlations between music preferences and both active and passive personality types. Specifically, when looking to the Big 5 personality types, certain personalities tend to lean towards particular musical scenes and genres (Miranda, 2019). In some studies conducted in western countries, extraversion has been associated with heavy metal, pop, and rap music preferences, agreeableness has been linked to pop and rap preferences, conscientiousness has been associated with pop music preferences, emotional stability has been linked to western classical music preferences, and, finally, openness has been associated with classical and heavy metal music preferences (Rentfrow & Gosling, 2003; Delsing et al., 2008; Zweigenhaft, 2008; Langmeyer et al., 2012). These musical and personality type associations, while not infallible, show how music may be a way to perform personality traits and identity, which may be used to facilitate the transition towards adulthood.

Bridge from Youth to Adulthood. Adolescence involves becoming emotionally autonomous and independent, fostering peer relationships, and going through multiple transitions (Laiho, 2004). Because of the contradictory nature of these transitions, adolescents are often at odds with being an adult versus still having child-like tendencies. Turning to music may afford

adolescents the opportunity to experience the self in multiple time periods, whether that relates to features, behaviours, attitudes, or emotions from a variety of ages (De Nora, 2019). Shifting roles in youth may lead to turmoil, anxiety, heightened emotions, and hormonal changes (De Nora, 2019).

Children and adults sometimes tend to use music slightly differently; while adults often use music as a way to connect with their inner teen, adolescents use music to feel rejuvenated, sometimes in ways that mimic play, which is a strength that encourages creativity (De Nora, 2019). Both adolescents and adults use music as a tool for social connection, independence from family, and heightening emotions. Therefore, there is a need to consider how people shift between these uses, how to help them shift, and how to be more socially open. Therapists may help adolescents to avoid using music as a destructive tool within a musically assisted safe space (De Nora, 2019). Musical coping may not always be positive; for example, young people who use music for coping sometimes ruminate in it, isolating themselves from their social surroundings (McFerran & Saarikallio, 2014). The use of music in an isolating manner, rather than an intentional manner, is what can lead to negative consequences, such as feeling sadder, angrier, or having more negative energy, as opposed to the music in and of itself leading to these things (McFerran & Saarikallio, 2014). Music therapists must keep this in mind and use caution in suggesting music as a coping mechanism when working with adolescents.

Gender and Sexuality. LGBTQIA+ youth are significantly more likely to experience poor mental health when compared to the general population (Robinson et al., 2014). Specifically, according to the Canadian Mental Health Association (CMHA, 2021), LGBTQ+ individuals are at double the risk of developing post-traumatic stress disorder (PTSD) as compared to cisgender, heterosexual individuals. Furthermore, LGBTQ+ youth face 14 times the risk of suicide and substance abuse compared to their heterosexual peers (CMHA, 2021). In an Ontario based survey, 77% of trans participants reported having considered suicide and 45% reported attempted suicide (Bauer et al., 2015). It is important for the therapist to understand and engage in shifting political discourse, such as current issues surrounding queer activism (Scrine, 2019). Creative arts modalities give youth the opportunity to explore their social locators in a way that is meaningful and engaging (Scrine, 2019). These are media in which adolescents can fuel their creative strengths in a safe environment in order to potentially transform oppressive cultures and practices (Renold, 2018). Therapists can take an after-queer approach, which is

defined as a belief system that gender and sexuality are topics that everyone who works with young people should consider, not only those working specifically with LGBTQIA+ youth (Scrine, 2019). When used as an anti-oppressive practice, music therapy links power struggles to personal struggles. The therapist is called upon confronting their own beliefs in order to better understand the attitudes of clients (Scrine, 2019). Prioritising the safety of the space brings comfort to clients when triggering subject matter emerges. Therefore, it is important to understand when marginalized youth are experiencing a lack of safe spaces (Scrine, 2019). The music therapist may work as a collaborator to support youth activism in their sessions (Scrine, 2019).

Disability. Disabled adolescents may benefit from music therapy that considers individual physical, cognitive, emotional, and social strengths and challenges in order to contribute to a positive sense of well-being (Rickson, 2019). Humans need to feel a sense of belonging (Rickson, 2019). Disabled adolescents face multiple challenges, including navigating physical and neurodivergent labels (Pineda, 2014), and confronting discrimination and inequality (Aslam, 2013). Therefore, feeling a sense of belonging is difficult for some disabled individuals. When working with disabled adolescents in a group setting, therapists may need to foster meaningful relationship development through the self-expression within a shared identity (Rickson, 2019). Music therapy may focus on fostering positive social experiences, identity development, emotional expression, and connection among disabled youth (Rickson, 2019). However, it is more challenging for disabled adolescents to be independent and autonomous when held back by authority figures in their lives who have preconceived assumptions of their abilities (Shifrer, 2013). Supporting disabled adolescents within music therapy and their personal community may help to combat their feelings of apathy and doubt (Pineda, 2014).

Being Connected

Adolescents have a need for a strong sense of belonging, which is important in self-development (Derrington, 2019). Connectedness is necessary for positive mental health and emotional well-being (Saeri et al., 2017). When adolescents experience mental health challenges, their sense of connectedness is lower. This can lead to risky behaviours such as self-harm, violence, premature sexual activity, eating disorders, and suicidal ideation (Malekoff, 2014). Connectedness can take a variety of forms in ways that encourage physical, emotional, and social growth (Geldard & Geldard, 2004). The creative arts may promote relational experiences and

opportunities for communication and connectedness through a variety of art forms, including music (Rose, 2017). Group art activities help communities to foster connection by building authenticity and empathy in a safe environment (Sassen et al., 2005). Storytelling though art, which can include songwriting collaborations, collaborative art making, and community theatre, allows for both connection through excitement of creation, and understanding of multiple perspectives in a group setting (Sassen et al., 2005). Music therapy supports opportunities for connectedness, well-being, and development in both individual and group settings (Rickson and McFerran, 2014). Clients in the therapeutic space must feel safe in order to examine emotional responses and participate in musical dialogue (Derrington, 2019). When considering adolescent connections, it is important to consider online experiences and social media, because bullying, peer pressure, and social difficulties often occur in the digital space (Derrington, 2019). These social difficulties may even lead to addiction and suicidal ideation, which will be addressed later in this section.

Online Experiences and Social Media. Online experiences are beneficial but must be used with caution and properly prepared for, because they can sometimes magnify isolation (Derrington, 2019). Online music platforms have the potential to support young people in building relationships, through music playlist sharing and listening. This can help build the therapeutic relationship as well as peer connections in a therapeutic context (Derrington, 2019). Additionally, using online music platforms is a way of showing respect to adolescent clients (Epstein, 2010) by acknowledging the ongoing role of online musical resources in their lives, as well as their strength in utilizing these resources.

Social media is a large part of adolescent lives. A newsletter company by the name of Media in Canada surveyed 2,270 adolescents aged 12 to 17 (Anthony, 2020). The survey noted that 72% use social media, and only 25% of teens are just on one social media platform (Anthony, 2020). According to the survey report, 67% of adolescents use Instagram, 65% use Facebook, and 57% use Snapchat (Anthony, 2020). Those using multiple platforms reported Instagram and Snapchat to be the platforms they used the most (Anthony, 2020). The Pew Research Center reported that 85% of American teens use YouTube, with 32% indicating that it is their most-used form of online media. And overall, 45% of teens reported being on social media almost constantly (Anderson & Jiang, 2018). With a large number of social media platforms having the ability to stream music, it is likely that many young people use social media

as a tool to access music (Pluretti & Bobkowski, 2019), as there are currently upward trends in YouTube usage (Anderson & Jiang, 2018).

Youth who use social media to communicate with friends and increase their sense of belonging generally relate their relationships on these platforms to positive social experiences (Davis, 2012). This feeling of connection that can come through communication on social media can be used in music therapy, for example, using YouTube as a platform for preferred song sharing in a group therapy session. Unfortunately, social media also comes with a risk of cyberbullying. In a nationally representative sample of Canadian youth aged 12 to 18, 42% reported being cyberbullied, with boys and minorities reporting higher levels of both perpetrating and experiencing cyberbullying (Li et al., 2015). Adolescents who have public profiles, interact with online-only contacts, and share private information tend to be targeted by cyberbullies at a higher rate than those who do not (Staksrud et al., 2013). It is important to keep in mind the increasing online presence of adolescents, and to minimize risks of isolation and bullying when using online platforms as a tool in music therapy. Additionally, privacy becomes an ethical issue when using online resources both in and outside of therapy, therefore, it is important to make sure user settings prevent any outside viewing of content.

Electronic Music Technology. Electronic music technologies have made music creation more accessible than ever, allowing a new avenue for adolescents to express their individuality (Viega, 2019). In a music therapy context, therapists may utilize tools such as drum machines, audio interfaces and digital workstations, synthesizers, and other vehicles to meet therapeutic goals and enhance relationships (Viega, 2019). Adolescents may be open to exploring new platforms with the therapist to build on the therapeutic relationship (Viega, 2019). This can be initiated by both the client and the therapist. Technology also expands the kinds of music that can be used in therapy, enhancing the potential to use client-preferred music, which has shown to be beneficial for self-reflection within a mental health context (Cheong-Clinch, 2019). A young person who has or is struggling with suicidal thoughts sometimes has difficulty describing the experiences that have led to their distress; however, using technology to share or create a song that expresses how they feel may be a way to begin the conversation as it may provide more distance between the client and the difficult emotions (Cheong-Clinch, 2019). Music technology also gives room for connection from inside the hospital to a client's peers outside. For example, a

client could record a piece of music that they later share with family members, should they want to (Viega, 2019).

Music-making software such as GarageBand offers expanded songwriting opportunities as it provides the users with accessible ways to explore looping, beat-making, and even remixing, which is quite popular in hip hop, electronic, and dance music (Viega, 2019). Creating sounds within these platforms can restore a sense of agency and feel rewarding for many adolescents experiencing mental health challenges. Additionally, adolescents can connect with themselves by bringing in music from their own communities and using technology to share it in therapy, whether that be through receptive or re-creative methods (Viega, 2010). The use of technology may give clients opportunities to explore a variety of genres. However, clients sharing songs created in therapy may put them at risk for social harassment (Baker, 2015). Therefore, it is important that therapists discuss these risks, as well as issues of confidentiality, with clients.

Relationship between Connectedness, Addiction, and Suicide. A major risk for developing addiction, according to Young et al. (2003), is disconnection and rejection, which can include isolation, abandonment, shame, and emotional abuse. Substance abuse is often comorbid with suicidal ideation due to impaired judgement, depression, isolation, and reduced inhibition (Bryan & Rudd, 2006). The risk of suicidal ideation is increased in individuals who experience mental health challenges (Jacobs et al., 2003). In addition to mood disorders, in an inpatient adolescent context, suicidal ideation and addiction are both reasons why youth may be in this setting. Specifically, drug abuse in adolescence is one of the most severe illnesses that can lead to a variety of challenges including difficulties in school, limited social networks, and comorbid disorders (Bojed & Nikmanesh, 2013).

A key protective factor in combatting both suicide and addiction is access to positive social environments (Bryan & Rudd, 2006). Adolescents have the need for a strong sense of belonging (Derrington, 2019), and connectedness with others is crucial to their emotional well-being and mental health (Saeri et al., 2017). Music therapists can utilize these protective factors through creating musical community, developing programs, and offering opportunities for young people to connect (Rickson & McFerran, 2014). In the context of songwriting, a reminder of shared experience and connection can be obtained using recording (Derrington, 2019).

The next section will look at music therapy methods that address strengths and needs including processing emotions, constructing identity, and being connected in adolescent mental health care.

Music Therapy Methods in Adolescent Mental Health Care

Before focusing on the use of songwriting in adolescent mental health care, this section will briefly review how receptive, re-creative, improvisational, and compositional methods (Bruscia, 1989) are used with this population.

Receptive Music Therapy Methods

There are various receptive music therapy methods used with adolescents. These include music listening, song choosing and discussion, and music games (Doak, 2013), as well as music and imagery (Grocke & Wigram, 2007). Clients may choose songs to listen to with the music therapist and group members that improve mood or relax them (Doak, 2013). Goals of music listening experiences with adolescents include sharing individual stories, connecting with the therapist and group members, expressing emotions, and gaining personal insight (McFerran, 2010). An adaptation to this experience with adolescents in mental health care may be drawing or writing while listening to the music, or using technology for individual music listening (Doak, 2013).

Song discussions involve the client or music therapist choosing a song that reflects the client's life experiences, as well as analyzing and discussing the client's relationship to the song (Doak, 2013). This experience can be adapted in a group adolescent mental health care setting by choosing songs that relate to the theme of the session (Doak, 2013). Lyric analysis techniques may involve goals that include establishing rapport, eliciting memories, encouraging verbal processing, and promoting emotional expression with adolescents (McFerran, 2010). Clients can also participate in games that involve musical content as the basis of the experience (Doak, 2013).

Music and imagery can be used to regroup the receptive music therapy experiences where clients listen to music in a relaxed state while being guided by the therapist through a visualization journey (Grocke & Wigram, 2007). This may include the use of directed music imaging, unguided music imaging, group music and imagery, and Guided Imagery and Music (Bonny, 2002; Grocke & Wigram, 2007).

Re-Creative Music Therapy Methods

Re-creative music therapy methods may include both instrumental and vocal re-creation. In re-creative instrumental experiences**,** the therapist supports the client in playing a piece of music on an instrument to meet therapeutic goals (Doak, 2013). The goals of re-creative experiences with adolescents may include musical expression, feeling confidence, and communication (McFerran, 2010). In a group setting, re-creative methods can be particularly effective for facilitating feelings of connection. Sometimes re-creative playing may lead to songwriting or a follow-up discussion (Doak, 2013), which is particularly beneficial in adolescent mental health care in encouraging clients to express emotions and perform identity (McFerran, 2010). In re-creative singing, the client sings a chosen song while the therapist accompanies them (Doak, 2013). In a group setting, group members may also accompany on a variety of instruments (Doak, 2013). Adolescents often resist singing before rapport is established, therefore, starting with instrumental re-creation before singing may help them to gain comfort (McFerran, 2010).

Improvisational Music Therapy Methods

Improvisational music therapy methods can be utilized in a variety of ways, however, when working with adolescents, drumming improvisation is the most common (Doak, 2013). Adolescents in mental health care often describe improvisation as providing fun, freedom, and control (McFerran-Skewes, 2000). Clients may start by learning some drum rhythms and slowly transition into using free play as a form of self expression. With adolescents, this may sometimes turn into improvisational songwriting (Doak, 2013). This method may be adapted using non-pitched and pitched instruments, as well as through musical conversation between two clients. Goals for adolescents in mental health care participating in improvisation may include identity formation, creative expression, group connection, and listening (McFerran, 2010).

Compositional Music Therapy Methods

Compositional methods may include both individual and group songwriting. Compositions may be with or without lyrics. Music therapists may support clients in creating lyrics to an existing song (as in the case of song parody), or in creating a completely new song with an original melody (Doak, 2013). Songwriting can be used in individual sessions, or as collaboration in dyad and group sessions using a flexible structure, depending on clients' needs (Doak, 2013). When working with adolescents, particularly in mental health care, goals of

songwriting may include fostering understanding, offering acceptance, and facilitating development (McFerran, 2010). Therapeutic songwriting provides a space where adolescents may access support, show creative expression, develop a trusting therapeutic relationship, reflect on experiences, experience enjoyment, and feel greater confidence (McFerran, 2010). Methods may include improvisational songwriting, parody songwriting, and free songwriting (Wigram & Baker, 2005). As the focus of this research is on therapeutic songwriting, the next section will examine further how this technique may be used to address the needs of adolescents receiving inpatient mental health care.

Therapeutic Songwriting in Adolescent Mental Health Care

In an adolescent mental health care setting, songwriting may be used in a variety of ways to address the needs of adolescents. These needs include processing emotions, constructing identities, and being connected.

Songwriting for Processing Emotions

As a musical and verbal reflection tool, songwriting can be a useful resource when addressing emotional topics (Giepel, 2019). Music listening is both popular among youth and a useful starting point in the songwriting process, as it generally promotes well-being and relaxation in their daily lives (Saarikallio et al., 2017). Although verse-chorus form is a good choice due to familiarity among youth (Doll, 2011), other choices may be indicated based on specific clinical occurrences within the therapeutic context (Giepel, 2019).

Prior to beginning the songwriting process for the goal of processing emotions, clients may engage in discussing topics and ideas, specifically in relation to emotional events, perhaps that they have previously discussed, before choosing one to write about (Giepel, 2019). This discussion may support and facilitate emotional processing and expression (Stewart & McAlpin, 2016). Lyrics may emerge in a variety of ways, as precomposed, written by the client while playing or talking with the music therapist, or based on previously written material by the client, such as poetry (Giepel, 2019). Research indicates that lyric writing has shown to be most beneficial in terms of emotional expression (Stewart & McAlpin, 2016). The music itself can either be precomposed or written by the client, with the therapist accompanying, as well as with an option for recording if the client would like (Giepel, 2019). When using songwriting as a tool for emotional processing, the goals involve a greater understanding of the client's emotions and

how they impact the self, encouraging feeling, fostering a space of empowerment over emotions and events, validation, and reflection (Giepel, 2019).

Songwriting for Constructing Identities

In a songwriting context, music can be a powerful way for youth to form, express, and communicate their views (Kruger, 2019). Expressing views through songwriting may be a way for adolescents to create meaning in everyday life, to create space for personal reflection within the developing social environment, and even to challenge positions of power (Kruger, 2019).

Individuals create identity through making meaning in everyday life, as well as through everyday interactions (Lave, 1988; Kruger, 2019). An experience, such as songwriting, can trigger other activities, such a discussion, therefore these two elements influence each other (Kruger, 2019). Songwriting is an experience that can produce a variety of resources as it includes objects, lyrics, and conversation that is internal and external (Kruger, 2019). When considering adolescents who have lost the understanding of their sense of self due to a mental illness diagnosis, the process of brainstorming, lyric creation, and examining their past, present, and future impacts the reintegration of the self into their identity (Marese, 2020). The inherent structure of songwriting that the therapist uses to address relationship and community can lead to some forms of identity construction as a result of the songwriting process (Kruger, 2019). Additionally, research has shown that the songwriting process may help adolescents find balance in their lives, as well as recontextualize their experiences (McGillen & McMillan, 2005). Specifically, when looking to the effects of therapeutic songwriting with adolescents who are experiencing eating disorders, insight was gained into the client's sense of self and how that related to their disorder (McFerran et al., 2006). The actual process of shaping the music to accompany the lyrics helped in the expression of identities (Baker, 2016). The last need presented in this paper in relation to how music can assist adolescents is connectedness.

Songwriting for Connectedness

Music is a flexible way to communicate, and it helps adolescents to express themselves in a way that is honest (Oosthuizen, 2019). For example, the use of rap music and its rhythmic structure in songwriting can serve as a means to express difficult life experiences (Oosthuizen, 2019). This structure can help adolescents organize their ideas in a format that is clear and understandable (Oosthuizen, 2019). Songwriting with rap music can start with improvisation that slowly gets morphed into a structured song. Indeed, in any form of songwriting, a structure may

help clients to manage stressful emotions and experiences (Oosthuizen, 2019). Choosing musical structures that adolescents identify with can help them to connect with the music, the therapist, and other clients (Oosthuizen, 2019). Within the songwriting process, the therapist can guide the client in finding ways of relating and being within music, which can then transfer outside of music therapy (Oosthuizen, 2019). The option to perform songs that are written in therapy, if there is a safe and confidential way to do so, can help to connect adolescents with a broader community, thereby creating support (Oosthuizen, 2019).

Chapter Summary

This chapter provided a Canadian contextualization of the mental health care system and examined the psychosocial strengths and needs of adolescents through the categories of emotional expression, performing identity, and being connected. It explored how adolescents may harness music's power, revealing that they tend to use music as a coping mechanism to match and meet their emotions (McFerran & Saarikallo, 2013), to understand themselves and their choices (Saarikallio, 2019), and to feel connected within a music therapy community (Rickson & McFerran, 2014). Music therapy work with adolescents involves receptive, re-creative, improvisational, and compositional methods. Furthermore, songwriting can meet the needs of adolescents receiving inpatient mental health care through assisting them in gaining greater understanding of their emotions (Geispel, 2019), examining their sense of self (Marese, 2020), and providing a framework for communication and connection (Oosthuizen, 2019). Chapter three explains the methodology of the current research.

Chapter 3: Methodology

This chapter outlines the research design utilized in creating a songwriting program intervention to be used with adolescents in inpatient mental health care. It describes how materials, data collection, data analysis, and ethical procedures were used in order to conceptualize the program.

Design

Fraser and Galinsky (2010) define intervention research as "the systematic study of purposive change strategies. It is characterized by both the design and development of interventions. Design involves the specification of an intervention" (p. 459). There are five steps to the intervention research method including (1) developing problem and program theories, (2) specifying program structures and processes, (3) refining and confirming in efficacy tests, (4) testing effectiveness in practice settings, and (5) disseminating program findings and materials (Fraser & Galinsky, 2010). This project used the first step and a half of the intervention research design by Fraser and Galinsky (2010), which included developing and identifying the problem and program theories in step one, and specifying and reviewing the program structure and processes in the first half of step two. This choice was made with time constraints in mind, as completing all the intervention research steps would be beyond the scope of a master's thesis. Practicality was an important consideration when choosing this methodology. The goal was to develop a songwriting program intervention addressing emotional expression needs of adolescents within inpatient mental health care. It is hoped that the final product will be accessible to music therapists working in this field.

The student-researcher reviewed the existing literature and combined ideas and perspectives into a strategy. This strategy was incorporated in the songwriting-based music therapy program intervention. The axiological assumptions were in the realm of normativism, in that value was subjective and derived from human experiences (Woolfolk & Murphy, 2004). The methodology assumptions of this intervention research project came from both dialogical and prescriptive perspectives. The program intervention was dialogical in the sense that there was no strict timeline, and methods were flexible; however, it was still prescriptive as it included a step-based process (Fraser & Galinsky, 2010).

Data Collection Procedures

The first one-and-a-half steps from Fraser and Galinsky's (2010) model included "[developing] the problem and program theories" (p. 463), and "[specifying the] program structure and processes" (p. 463). Data collection steps (Fraser & Galinsky, 2010) conducted by the student researcher were as follows:

1. To identify problems in relation to social and health concerns within the population, as well as within songwriting, based on the current literature, from databases such as *PsychInfo* and *PubMed*, journals such as *Journal of Psychotherapy* and *Journal of Music Therapy*, as well as books and dissertations.
2. To create a problem theory based on the information gathered.
3. To develop a program theory based on providing feedback for the issues.
4. To identify intervention level, setting, and agents according to what was proposed.
5. To develop a theory of change and a step-by-step process to address the problems at hand.
6. To develop a draft of the program intervention.
7. To specify important elements of the program as well as fidelity criteria.

Data Analysis Procedures

Data analysis was a continuous process in this research project as per the Fraser and Galinsky (2010) model. First, the student researcher analyzed the current literature to disifer risk and protection factors related to adolescent mental health. Then, the student researcher analyzed articles, books and dissertations using deductive coding in order to organize beneficial strategies based on the population's needs. This content analysis (Stemler, 2000) served as the basis for the development of the action strategies used to address risk and protection factors in the program intervention (Fraser & Galinsky, 2010).

Delimitations

To accommodate the scope of a master's thesis, this research used only the first step and a half of the Fraser and Galinsky (2010) design. When appropriate, the student-researcher chose to include older articles (pre-2000s) to provide important foundational or contextual information. The population was limited to adolescents receiving inpatient mental health care.

Chapter 4: Results

This chapter uses Fraser and Galinsky's (2010) intervention research model which involves the following tasks: (a) the identification of the problem theory of risk, promotive and protective factors, (b) the development of a program theory of malleable mediators, (c) the identification of the key intervention features, and (d) the proposition of program intervention procedures elaborated in phases. The program components are supported by evidence from relevant literature.

Problem Theory

Adolescence is a period influenced by "social, environmental, and cultural factors" (Patel et al., 2007, p. 1302). Most mental disorders have their onset in youth, which leads to a high risk of self-harm and suicide, as well as other health concerns in relation to education, substance abuse, violence, and sexual health (Patel et al., 2007). This section explores risk factors that contribute to the onset of mental health challenges, as well as protective factors to combat these risks.

Risk Factors

Risk factors include but are not limited to poverty and social disadvantage, parental home life, historical and cultural factors, and genetics.

Poverty and Social Disadvantage. Poverty and social disadvantage are two factors that are associated with the onset of mental illness (Patel & Kleinman, 2003). Research demonstrates a bidirectional relationship between mental health challenges and living in poverty as well as experiencing social disadvantage (Patel et al., 2007). Growing up in a poor household increases risk of food limitations, lack of nutrition, violence, poor education, and living in a neighbourhood with a limited social environment. All of these put youth at risk for developing mental health challenges (Patel et al., 2007). Similarly, having mental health challenges can lead to doing poorly in school, unemployment, and greater health care costs (Patel et al., 2007). This turns into a causal nexus, where parents under financial stress lose their sense of efficacy over their children (Fitch et al., 2011), and youth growing up in poverty are at greater risk for educational disadvantage (Harding, 2010), which may lead to mental health challenges (Weinreb et al., 2002). The educational disadvantage that these children may experience can increase the likelihood that they will experience financial distress later in life (Anakwenze & Zuberi, 2013).

Parental Home Life. Young people who live in households with a parent who has a mental illness are more likely to develop one themselves (Leinonen et al., 2003). Additionally, being a child in a family with marital violence, having parents with substance abuse issues, or witnessing general parental dissatisfaction are also risk factors for developing mental health challenges (Leinonen et al., 2003). Furthermore, violence and child abuse from guardian figures are strong risk factors to developing mental health challenges, as sexual violence most often is perpetrated by someone that the victim trusts, and violence most often occurs in the immediate community (Sansone et al., 2005).

Historical and Cultural Factors. Certain groups of people, including Indigenous peoples, migrants, internally displaced people, and refugees, are historically disadvantaged with how they are treated, thus often leading to mental health issues (Barwick et al., 2002). For example, according to the National Expert Commission (2013), the rate of suicide among Indigenous individuals in Canada is 2.1 times the overall national rate. High rates of unemployment, low income, low education levels, and overcrowded housing (Government of Canada, 2006), due to continued marginalization, have likely increased the risk in these populations. Cultural factors may also influence the onset of mental health challenges, including restricted autonomy and idealizing certain body types, both of which can instill a feeling of lost control (Patel & Andrew, 2001; Patel et al., 2007). The global fashion industry, which targets young people, may have influenced the rate of eating disorders in developing countries (Graham, 2004), and there is evidence of media promotion of beauty ideals influencing the amount of people suffering from eating disorders in societies that previously rarely experienced them (Becker et al., 2002).

Genetics. There is strong evidence for genetic and biological factors for some mental illnesses including depression, psychoses, and severe behavioural disorders (Patel et al., 2007). Additionally, having a neurological disorder such as epilepsy, learning disabilities, or developmental disorders (which often have a genetic component) increases the risk of developing mental health challenges (Kokkonen et al., 1998). The genetic factors of mental illness interact with a person's environment, which can alter the risk of developing mental health challenges. For example, beginning puberty while having parental conflicts can lead to low self-esteem and distancing from peers (Eley et al., 2004).

Promotive and Protective Factors

Research indicates that having a sense of connection, experiencing limited conflict, and being in an environment that encourages emotional expression protect against developing behavioural and emotional disorders (McGee et al., 1990). Having a strong social support system or being a part of a positive community can help reduce the impact of risk factors (Greening & Stoppelbein, 2002). Some cultural factors are also protective, for example parental involvement with children, as well as forming friendships with people within the same culture (Bhui et al., 2005). Parenting styles that are engaging and provide psychosocial stimulation, having strong adult role models, and being in a positive education system with limited bullying all foster an environment in which young people have their needs addressed (Jessor, 1998). Protective factors in youth can be categorized into personal, familial, and social. It is important to note that while in times of extreme stress, personal, social, and familial protective factors are helpful, other resources may be required to address the challenges adolescents may face (Wille et al., 2008).

Personal Resources. Personal resources can be explained as personality features (Wille et al., 2008). High self-efficacy, for example, is the belief in an individual's ability to manage stressful circumstances, which is considered a protective factor in tackling youth mental health needs (Schwarzer, 1994). Studies have shown a relationship between high self-efficacy and fewer mental health challenges (Schwarzer, 1994). This is different from the idea of optimism, as it is a belief in personal competence rather than general expectations (Scheier & Carver, 1985).

Familial Resources. Familial resources are an important protective factor in addressing youth mental health needs (Wille et al., 2008). Children are at a lesser risk for developing mental illness when they are raised in homes that are caring, that embrace autonomy, and that have frequent guardian involvement, as well as clear expectations (Lamborn et al., 1991). Familial resources may also relate to cultural protective factors, including parental involvement in their children's lives, as well as finding comfort in forming connections within the same cultural group (Bhui et al., 2005). Parental support and positive family climate and cohesion are important protective resources for youth (Wille et al., 2008), and supportive and positive parent-child relationships have been associated with lower levels of depression in adolescents (Juang & Silbereisen, 1999).

Social Resources. Social resources refer to social support systems outside the immediate family, which can include friends, teachers, clubs, and community organizations (Wille et al.,

2008). Access to social support systems gives adolescents a sense of relief by helping them develop coping mechanisms as well as personal competencies in handling stressful situations (Wille et al., 2008). High social support in general has been associated with lower mental health concerns in youth (Wille et al., 2008). The social and surrounding environment may also be a contributing protective factor, for example having supportive community and familial resources, and generally being in an environment that does not produce many stressors (Wille et al., 2008).

Music Therapy. A recent meta-analysis that included five studies examining impacts of reducing internalizing symptoms in children and adolescents, found significant results for those receiving music therapy versus those that did not (Geipel et al., 2018). Another study showed decreased distress for clients diagnosed with anxiety and/or depression after brief Healthy-Unhealthy Uses of Music Scale (HUMS)–based music therapy intervention, which was a guided discussion surrounding each item of the questionnaire (Saarikallio et al., 2015). Adolescents prefer opportunities for musical processing of emotions (Cheong-Clinch & McFerran, 2016), and generally prefer musical interventions over traditional cognitive techniques (Hence et al., 2018). Researchers have seen significant improvements among depressed adolescents, specifically those with suicidal and self-harm behaviours, who have received group music therapy, when compared to adolescents in control groups (Lin, 2010; Lee, 2006). Music therapy has also shown promise with adolescent trauma survivors who are resistant to cognitive therapies (Carr et al., 2012). Adolescents have a variety of needs that mainly focus on processing emotions, performing identity, and being connected (McFerran et al., 2019). Songwriting as a specific intervention helps to meet these three main needs because it is a communicative activity in therapy that promotes connection, identity expression, and emotional validation (Derrington, 2005).

Program Theory

This section involves developing a program theory of malleable mediators and identifying key intervention features (Fraser & Galinsky, 2010). Malleable mediators refer to conditional risk, for example life circumstances that can be mediated through support systems (Fraser & Galinsky, 2010). Key intervention features including target age, setting, materials, and assessment tools (Fraser & Galinsky, 2010) will also be discussed in this section.

Malleable Mediators

Psychological flexibility is the ability to adapt to demands, shift mindset in situations that compromise functioning, and maintain balance and awareness of behaviours that reflect personal

values (Kashdan & Rottenberg, 2010). Guiding youth in supporting their ability to deal with environmental stressors may lead to more positive mental health outcomes (Gloster et al., 2017). Interventions that promote the skill of psychological flexibility help youth to use that skills in their daily challenges (Gloster et al., 2017). Having a parent with a mental illness diagnosis puts the child at greater risk for developing one, however, having a second parent who is understanding of their partner's mental illness and supportive towards the child can mediate the potential impact (Hosman et al., 2009). Other factors that can help youth mediate the risks of mental illness include cognitive and social competence, positive self-esteem, self-reliance, and perceived social support (Beardslee & Podorefsky, 1988; Hosman et al., 2009). The specific belief in emotional malleability may also contribute as a mediator in mental health management, by influencing emotional regulation and psychopathology in adolescents (Kneeland et al., 2016). Similarly, adolescents' own belief in cognitive malleability may influence emotional regulation and well-being (Zhu et al., 2020). Therefore, addressing these malleable mediators in the context of songwriting is important in the development of the intervention program for adolescent inpatient mental health care.

Key Intervention Features. The following section will discuss the key features present in the proposed intervention program. These features include goals, target age, duration, intervention agents, intervention setting, materials, and assessment and evaluation questionnaires. The intervention outline will follow.

***Goals of the Program Intervention*.** The goals of this program intervention are to use therapeutic songwriting as a tool to address the client's psychosocial needs, including processing emotions, performing identity, and being connected, to provide songwriting resources to the client for use outside of music therapy, and to assist the client to create a song that reflects something they want to express or process.

Target Age. According to the CMHA, 10%–20% of youth are affected by a mental illness worldwide, and in Canada the number of 12- to 19-year-olds at risk for developing mental illness is 3.2 million (MHCC, 2013). Suicide is among the leading causes of death in 15- to 24-year-old Canadians, and this rate is the third-highest worldwide (MHCC, 2013). The MHCC states that investing in effective programs helps to provide treatment early, which makes a positive difference in overall well-being (MHCC, 2013). Furthermore, 70% of mental illnesses have their onset in childhood or adolescence (Government of Canada, 2006). In Ontario alone,

14% of high-school students have seriously contemplated suicide, with 4% having attempted it (Boak et al., 2016). The age range of adolescents treated in inpatient metal health care in Canada is usually between 12 and18 (Ontario Shores, n.d.), therefore that is the age targeted in this intervention. Adaptation to suit the specific strengths and needs of younger and older patients could be considered in future iterations of this program intervention.

Duration. According to Statistics Canada, the average length of stay in acute mental health care for Canadian adolescents is about 12 days (Johansen & Fines, 2015). Therefore, this intervention is aimed to meet the most crucial psychosocial needs of adolescents experiencing mental health challenges in a very short period. There would be one to three sessions in total for this program over the course of a client's stay. Each session would be self-contained as it is often unknown when a client will leave the facility, meaning that the client should not feel that the music therapy process is unfinished in the case of an early discharge.

Intervention Agents. A certified music therapist would be the main professional involved in the program, working closely with the interdisciplinary team throughout the program intervention process to establish some of the client's psychosocial needs and to communicate the client's progress. The music therapist will have knowledge of clients' psychopathologies, specifically as exhibited during adolescence. Given the intensity of inpatient mental health care, the music therapist would consult regularly with the interdisciplinary team and the crisis management professional if needed. The client partaking in the program would be a patient in an inpatient clinic and have consented to receive treatment.

Intervention Setting. This program intervention requires a reasonable amount of space for mobility and a private, average-sized room to ensure privacy during the actual therapy, for reasons of confidentiality and because clients have been found to make better progress with minimal interruptions (Baker, 2015). Baker (2015) speaks about setting in the context of "organizational structures, the physical space, the private space, and the organizational culture" (p.232). Therefore, beyond the physical space and the private space as previously addressed, it is important to understand that organizational structures and cultures will influence how clients react to the therapeutic environment (Baker, 2015). The music therapist must use their judgement when deciding what must be accommodated, and what changes may be made to ensure the best practices for clients' needs are addressed (Marese, 2020).

Materials. The music therapist can use materials for this intervention such as a guitar, a piano, small percussive instruments, and drums. A tablet with an internet connection and a speaker should be available for youth to utilize when sharing pre-recorded music. Though not required, a whiteboard would be useful for the purposes of brainstorming, as well as paper and pencils. A notepad and pen will be used for completing the pre and post intervention questionnaires. Should the client not want to, or be unable to write their answers, the therapist may verbally go through the questions and write down the client's responses. For youth who choose to record their song, as recording can allow for a reminder of connection and shared experience (Derrington, 2019), a portable computer, a USB microphone, a digital audio workstation (DAW), and a USB key for secure sharing will be necessary. Additionally, access to music-making apps such as Groovepad or Cove may be helpful tools to meet clients' needs and preferences.

Assessment and Evaluation Questionnaires. The Pediatric Symptom Checklist for Youth (PSC-Y; Murphy & Jellinek, 1988) will be used to measure psychosocial needs before and after the therapeutic songwriting process. The PSC-Y (Murphy & Jellinek, 1988) is a 35 item self-screening questionnaire that asks for information regarding psychosocial strengths and needs. This screening tool was originally designed for use in pediatric care but has since been used as a self-report system for adolescents to determine psychosocial strengths and needs (Gall et al., 2000). Filling out this questionnaire would be part of the assessment protocol administered by the music therapist, as it is an open access form for health care providers (please see the questionnaire in Appendix A). It is important to note that this questionnaire is a tool to gain information and cannot be used to diagnose. The questionnaire would be administered by the music therapist before the beginning of therapy, and after the program is complete or upon discharge. However, some of the questions will not be scored in the post-test due to the short nature of the intervention, including the questions about school grades dropping, being absent from school, having trouble with teachers, and spending more time alone. This assessment tool has shown validity in studies when replicated by teacher, parent, interviewer, and youth reports (Gall et al., 2000). If the questionnaire has been previously administered by other professionals in the team, the music therapist will consult the results in order to best plan for their session, and the client will still fill out the questionnaire for a second time after the intervention so that progress can be examined.

The Short Test of Musical Preferences Revised (STOMPR) (Rentfrow & Gosling, 2003), which includes 23 different musical genres, is a validated measure that was developed by psychology researchers, and will be used to assess the clients' musical preferences. The music therapist will administer the questionnaire as part of the assessment process to gain insight into the client's preferences (Please see Appendix B for a copy of the questionnaire).

Proposed Program Intervention Procedures

The proposed program intervention procedure will cover the course of up to three, 45- to 60-minute sessions, depending on the client's comfort levels, presenting issues, reasons for admission, progress, current severity of mental health challenges, and hospitalization time. The program involves a referral, an intake, a three-phase therapeutic process, and a post-intervention protocol.

Referral

Clients may be referred by a nurse, a social worker, a psychiatrist, a psychologist, or any other health care professionals as per hospital guidelines and procedures. In some instances, particularly in inpatient hospital units, the music therapist may run their own assessment without referral with consenting clients in order to determine whether this intervention would be indicated for them. In consultation with the interdisciplinary team, the music therapist will determine whether this program intervention is well-suited to address the patient's psychosocial needs of processing emotions, identity formation, and being connected. When possible, the patients will be consulted in order to know whether they feel songwriting would be a beneficial way to address their needs. If these needs are not apparent in a given client, if the client is not ready or not stable enough, or if the client does not benefit from music or verbal expression, then it may be counterindicated for them to attend. It is possible that some patients may be referred to this program, however the therapist decides that alternative methods of music therapy could be more beneficial. For example, if connection to others is the most indicated goal, perhaps group music therapy surrounding receptive and improvisational experiences may be more suitable (Doak, 2013). In most inpatient care facilities, clients provide consent to receive all forms of therapies; however, if this is not the case in the specific hospital, the consent form will be signed before beginning music therapy by either the client or their guardian as per hospital guidelines. The recording consent form will be given to the client or their guardian to sign during the intake.

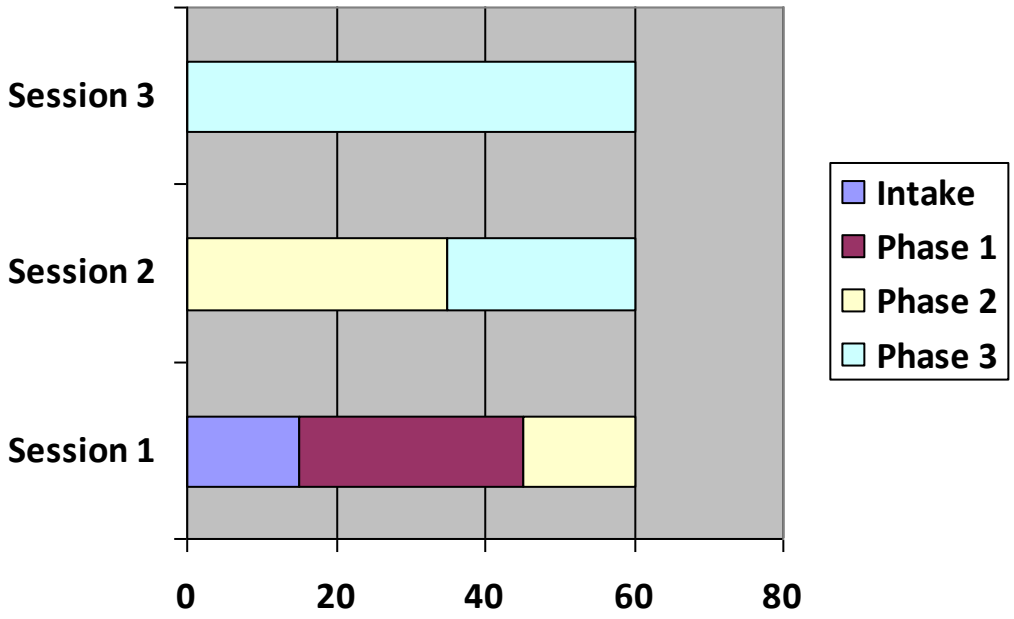
Music Therapy Intake

The music therapy intake process will take place during the first music therapy session. The client or their guardian, as per hospital guidelines and the age of consent where the program is being implemented, will be provided with the recording consent form. The music therapist will then administer the PSC-Y (Jellinek & Murphy, 1988) and STOMPR (Rentfrow & Gosling, 2003) questionnaires, which should collectively take around 10 to 15 minutes in total. During this process, the client may ask the therapist any questions they may have about the questionnaires as well as the music therapy program.

Phases

Figure 1

Overlap of Phases and Sessions



Note: The numbers refer to minutes of time for each phase per session for a 45- to 60-minute session.

Phase 1: Assessment. The first phase will be an assessment that will begin after the intake process and take about 20 to 30 minutes of the first music therapy session. (See Figure 1 for the overlap of phases and sessions.) This phase includes an opening experience and a referential improvisation in which the improvisation surrounds a theme or concept, in this case an emotion. This exercise is being used at the beginning of the program to ease the client into the

musical space in a way that is structured. There are three recommended options for opening experiences. Option one involves playing a client preferred song, since using adolescents' preferred music has been shown to be beneficial as a self-reflection tool (Cheong-Clinch, 2019). The client listens to or plays an instrument with the pre-recorded song or along to a live re-creation of the song played by the music therapist. Option two is a musical relaxation exercise, to help the client decompress (Grocke, & Wigram, 2007), and to gently lead the client into the musical space. This may involve a progressive muscle relaxation experience in which the music therapist plays on an instrument of choice, or puts on pre-recorded music based on client preferences and guides the client through tensing and relaxing different parts of their body. If this is too intimidating for the client, a music-assisted breathing exercise could be an alternative. Finally, option three is a song-sharing activity, where both the client and the music therapist share and listen to a song that they enjoy through an online platform, to promote the development of rapport and connection (Davis, 2012). Alternatively, the shared songs may be played live by the music therapist.

Following the opening experience, a referential improvisation occurs using the Cove app, which gives the option to not save any creations for privacy purposes. The therapist may also use a similar alternative app of their choosing. The Cove app gives the client a variety of emotions they can choose from, and then provides sounds and beats that reflect those emotions that the client can look through to create a musical improvisation. This referential improvisation will indicate a variety of feelings the client may be experiencing, followed by the creation of a melody that reflects those feelings. Alternatively, an acoustic method may be used. If using an acoustic version, the client can verbally state some emotions they are feeling, and the music therapist can lead them in a discussion about what instruments and sounds they associate with those emotions. The music therapist will then guide them in an improvisation based on these emotions and instruments the client chose. Alternatively, a combination of acoustic and technology methods could be used, where the client utilizes a beat-making app such as Groovepad to create an improvisational track based around a current feeling. The music therapist and/or client can play along to the track on a instrument of choice. The use of technology in music therapy often communicates to adolescents that the therapist respects and understands them by utilizing tools that they use in their daily lives (Epstein, 2010).

Both the opening experience and the referential improvisation give clients an opportunity for emotional expression through the exploration of the feeling referent. Identity exploration may be explored using the musical choice, and connection may occur through musicking with the music therapist during the improvisation (McFerran, 2010). The purpose of the opening experience and referential improvisation is to assess how the client is feeling in the current moment and to gain understanding on where they may want to go. The improvisation section of this phase is to help the client feel comfortable with the music therapist. Adolescents are often hesitant to sing (McFerran, 2010), so the referential improvisation will help to ease them into the musical space. Improvisation can often help with goals of identity formation (McFerran, 2010), and can naturally lead into the songwriting process (Doak, 2013).

Phase 2: Free Writing and Exploration. Phase 2 of the intervention begins in the last 15 minutes of the first music therapy session. (See Figure 1 for the overlap of phases and sessions.) In this phase, the client participates in free writing to music accompanied by the therapist, in a genre of their choice as expressed in the STOMPR questionnaire (Rentfrow & Gosling, 2003). Alternatively, the therapist may use a receptive method (Doak, 2013) by having the client write to an instrumental track in a genre of their choice, to begin the process of verbalising thoughts and feelings (McFerran, 2010). If the client chooses a track, the music therapist may improvise to it, or take some notes, to help the client feel they have some privacy during their writing. Should this be the only session the client is able to attend due to discharge or other factors, this first session will give the client songwriting tools that they can utilize outside of the session. The take-home resources from Session 1 include some potential lyrics from the free write and knowledge of music-making apps, such as Groovepad and Cove, that they may use for a songwriting framework. Should a client not have access to technology at home, the music therapist can encourage acapella songwriting at home, to a steady beat provided using body percussion. The music therapist can discuss these resources with the client. This will help the client feel that nothing was left unfinished.

The last 5 minutes of the session bring a closing experience with three possible options. To encourage the client to perform identity, they can choose a song in a preferred genre (Saarikallio, 2019), but this time the music therapist will ask them to pick a theme of closure, and have them play it with the music therapist. For the second option, the music therapist could end with a relaxation experience in which the client can choose to close their eyes or not, depending

of their comfort level, while the therapist improvises on a supportive instrument. The last option is for a song-sharing experience where the client shares and listens to a song with the theme of closure, with the option of having the music therapist play the song live. Before leaving the session, the client is encouraged to reflect outside of therapy on the words written during the free write and, if they would like, to highlight some key phrases as well as think of any backing instruments they may like to include as a part of their song. (See Appendix C, Table C1, for Sample Session Plan 1). The remainder of Phase 2 is completed in the first 20 to 30 minutes of the second music therapy session.

The second session starts with one of the opening experience options previously described, as well as a brief referential improvisation. The emotions indicated during the improvisation again serve as a referent if the client wants to write about current feelings. These together take about 10 minutes. Following the opening experience and referential improvisation, the music therapist leads the client in a second free-writing session for about 10 minutes to provide the client with a few more lyric options to examine. Afterwards, the music therapist goes through what the client wrote during the free write in the previous session, as well as the current session, and highlights key phrases the client may want to incorporate into their own song. During this process, the music therapist may initiate a discussion about the phrases, what the client wants the song to be about, and what comes to mind when reading aloud particular phrases, because lyric analysis helps to establish rapport in the therapeutic relationship, encourage discussion between the music therapist and client, and express client emotions (McFerran, 2010). This process takes about 10 to 15 minutes. Halfway through Session 2, the music therapist moves into Phase 3.

Phase 3: Structured Implementation. Putting the song together begins in the second music therapy session, and the song is completed in Session 3. After highlighting phrases, the music therapist goes through some chord progressions and genre style preferences with the client and tries to put some of the key phrases to music, with the client expressing whether they want certain phrases in the verses or chorus. Before the session ends, the music therapist writes out a general outline for the song. The song may be organized in a well-known structure the client is familiar with (Giepel, 2019), such as Verse, Chorus, Verse, Chorus, Bridge, Chorus. At the top of the score, the music therapist writes the genre, and within each category of the verse-chorus form, the music therapist may write out any phrases and chords discussed. If this is the last

session the client has, due to discharge or other circumstances, this outline is a resource the client takes home with them. The outline helps the client leave the hospital with something tangible that they can revisit in their own time and gives them a resource to help them continue the songwriting process if they wish. This part of Phase 3 takes about 10 to 20 min. If the client is able to attend the final session, the music therapist encourages the client to take some time outside of music therapy to reflect on what they have written so far, and to bring in any inspiration that may arise to their next and final music therapy session, such as writing or poetry. The second session ends with one of the closing experiences previously mentioned. (See Appendix C, Table C2, for Sample Session Plan 2.)

The third and final music therapy session begins with any of the opening experiences mentioned previously or any other ones the client would like to experience. This should take about 5 minutes. Following this opening, the client will complete most of the songwriting. To keep the focus on the client's song, the referential improvisation is not a part of the third session. The final part of the songwriting process involves working final lyrics and accompaniment into the song. The music therapist guides the client in implementing more phrases from the free write section, integrating other resources, such as previously written poems if the client brought any, as well as creating other lyrics inspired by these materials into verses of the song. These phrases are put to more chords and harmonic accompaniment, or a backing track from a beat-making app, chosen by the client in order to complete the melody. The process of putting the remaining lyrics and melody together addresses goals of understanding, acceptance, and development (McFerran, 2010). This process is an opportunity for adolescents to express emotions, develop a trusting therapeutic relationship, and reflect on personal experiences (McFerran, 2010). The completion of the song should take about 15 to 25 minutes.

Before the session closes, the client has the opportunity to record their song so that they may have their own copy, if they would like. About 10 minutes should be given for recording, in case there are multiple takes. This can be done using a USB mic in a laptop with any recording software. The song should be transferred onto a USB drive for safe transfer to the client. If the client does not want a recorded version, the music therapist writes out the lyrics of the song within their musical structure and chord progressions, so that the client has something to take away with them. After completing the recording or writing, the session ends with one of the previously mentioned closing experiences. The music therapist may ask about the client's

experience with songwriting to gain insight into their enjoyment, feelings that arose, and any reflection on the process. The combination of the conversation and the closing activity should take about 10 min. After the closing experience, the therapist will provide 5 to 10 minutes of time for the client to fill out the PSC-Y (Jellinek & Murphy, 1986) questionnaire. (See Appendix C, Table C3, for Sample Session Plan 3.)

Post-Program Intervention Considerations

After the music therapy program intervention is complete, it is likely that the client will have been discharged from the hospital. This is why it is important to give concrete resources after each session: it ensures the client has a sense of completion and it is a way to provide aftercare that the client can reflect on in their own time, and potentially utilize should they have more individual songwriting endeavours in their future. Coding from the PSC-Y questionnaires and any notes taken should be kept in the client's chart as per hospital policy and procedures. Additionally, should the music therapist assess that the client would benefit from further music therapy services, they should discuss community music therapy services or musical resources available to the client after leaving the hospital with the team. See Table 1 below for the detailed program intervention procedures.

Table 1

Proposed Program Intervention Procedures

Treatment Phase	Session Number	Number of Minutes	Procedures/Interventions
Referral	Pre-Intervention	N/A	• Music therapy consent form signed by client or guardian
Intake	1	10-15 min.	• Client or guardian is given recording consent forms to sign • Client fills out PSC-Y and STOMPR questionnaires
Phase 1. Assessment	1	20-30 min.	• Referential improvisation
Phase 2. Free Writing and Exploration	1 and 2	30-35 min.	• Free Writing 1 • Referential improvisation • Free writing 2 • Lyrical/musical outline
Phase 3. Structural Implementation	2 and 3	45-70 min	• Establishing song structure (form) • Revisiting lyrics and music • Recording and/or notating the song • Post-songwriting discussion • PSC-Y questionnaire
Post-Intervention Considerations	After Treatment	N/A	• Code PSC-Y questionnaires • Speaking to team about referring client to community music therapy resources

Note: Though not considered part of the phases, an opening and closing experience will be included in all three sessions.

Chapter Summary

This chapter explored risk and protective factors in relation to adolescents experiencing mental health challenges. Research showed the relationship between risk factors for mental health challenges and living in poverty (Patel et al., 2007), being a child in an unstable home (Leinonen et al., 2003), belonging to marginalized groups (Barwick et al., 2002), and genetic factors (Patel et al., 2007). Protective factors including personal factors such as self-efficacy (Schwarzer, 1994), familial factors such as parental support (Juang & Silbereisen, 1999), and social factors such as community networks (Wille et al., 2008) were reported as being crucial to help combat risk factors. Next, using these factors, the student researcher created a program theory, establishing the target age of 12 to 18, the target setting of inpatient adolescent mental health care, and the required materials. This was followed by a proposed therapeutic songwriting intervention protocol to be incorporated in this setting, which included referral, assessment and intake processes, a three-phase model, and a post-program intervention plan. The final chapter will speak to limitations of this program, future reccomendations, and concluding thoughts.

Chapter 5: Discussion

Given music therapy's unique contributions towards addressing psychosocial needs in adolescent inpatient mental health care, the purpose of this research was to develop a songwriting-based program intervention for use within this population. The student-researcher aimed to create a songwriting program intervention that utilized procedures that are effective with adolescents within a psychiatric inpatient context, according to the current literature. This proposed program was a way to complement the research which states that adolescent mental health care treatment improved when combined with opportunities for artistic expression (Erkkila, 2011). Due to the critical care nature of inpatient mental health care, this setting was chosen as a way for adolescents to have access to a creative outlet that can address specific psychosocial needs through music therapy, such as emotional processing, identity formation, and being connected as defined by McFerran et al. (2019). The following discussion addresses flexibility within the proposed intervention, realities of short-term music therapy, continuity of care, and therapeutic musicianship as well as awareness of youth mental health difficulties. The study's limitations, implications for practice, future research recommendations, and conclusion will follow.

Program Flexibility

Program flexibility was a very important component of the proposed intervention procedure. In a Canadian inpatient mental health setting, the average length of stay for adolescents is about 12 days (Johansen & Fines, 2015). It is important to note that this is an average, and some patients may be there for shorter or longer stays. The music therapist may not always be aware about the exact day of discharge, and it may happen suddenly. Therefore, it is important to make sure each music therapy session is complete in and of itself, so that the client does not feel as though things were left unfinished. The therapist must end each session with a feeling of closure and by leaving resources with the client. Though the full program is three sessions in length, it is important for the music therapist to know that not every client will receive all three sessions, and therefore they need to be flexible with their approach. Additionally, being flexible about which music resources to use is an important aspect of the program. Having a variety of music-making options in the form of physical instruments and technology will widen the range of genres and accessible equipment, such as beat-making apps for the client.

Realities of Short-Term Music Therapy

This intervention is a part of a short-term music therapy program, which comes with a few unfortunate realities. It is not possible to anticipate any long-term effects of a program like this. If this program is effective in addressing psychosocial needs of adolescents in inpatient mental health care, this cannot be generalized to long-term effects. Short-term music therapy may only have minimal effects in the long term (Porter et al., 2017). However, this research is meant to provide resources for adolescents in a setting that can often be isolating. This program seeks to provide options for adolescents to take home, which in turn may help them to understand their own protective factors outside the hospital setting. It is possible that adolescents will utilize their learned coping strategies when discharged. If the therapist sees positive short-term effects during the implementation of this intervention, it is worth examining the effectiveness of long-term therapeutic songwriting by creating a program for adolescent clients who've been recently released from an inpatient mental health setting.

Continuity of Care

This program intervention is quite brief due to the short-term nature of inpatient mental health care. Any clients the music therapist sees may benefit from continuation of music therapy outside the hospital setting. Therefore, the music therapist should speak with the team about music therapy resources within the community that they can refer the client to, should the therapist believe the client could benefit from continuing the therapeutic process. Providing continuity of care options may foster clients' access to music resources outside the hospital, which may assist them in the next part of their recovery journey. Referral to outpatient music therapy services may be particularly indicated when the client expresses or the music therapist feels that the client may further benefit from songwriting or other music therapy methods. Music may serve as a welcomed anchor as clients experience the transition between inpatient to outpatient care. The inpatient mental health setting is quite medical, and this music therapy program emphasises the incorporation of resources the client may use on their own time. Therefore when no longer in a medical setting, it may be beneficial for them to continue with these resources in a way that is safe and accessible.

Music Beyond Therapy

After every music therapy session, the client will walk away with resources they can utilize on their own time, in order to continue with some form of care. In Session 1, this involves

information about music technology apps that the client can used for songwriting, and potential lyrics from the free write to turn to, should they continue the songwriting process. Session 2 has a song outline including music and some basic lyrics to expand on. Finally, in Session 3 a possible outcome is a completed song in writing, a recording, or both as per the client's preference. The client can revisit the song they have created to remember emotions they experienced and parts of themselves they expressed, as well as the connection with the therapeutic process (Derrington, 2019). It is important to note that these emotions may be difficult to reconnect with, therefore, recommending music therapy follow-up through outpatient services (when possible) may be beneficial. Additionally, with the resources gained through the songwriting process, the client has options if they want to participate in future songwriting endeavours led or guided by a music therapist in a community centre. Three sessions may be too short in some cases to build self-confidence, and without follow-up care, this program may not benefit every adolescent in a mental health setting. Rolvsjord (2009) speaks to the concept of empowerment, and continued empowerment, which inherently argues for "more resource-oriented practises and collaborative approaches that require the professional to journey beyond the role of the expert-therapist" (p. 108). Therefore, providing music as a health resource beyond the therapy to the client, based on strengths explored in session, will be an important aspect to the program. This can be accomplished through music therapy follow-up in external mental health services.

Awareness of Youth Psychosocial Strengths and Needs

The music therapist must be aware of specific challenges, strengths, and needs within adolescent mental health care. In order to address needs like emotional expression, performing identity, and being connected (McFerran et al., 2019), it is important to understand how these needs come into play for adolescents experiencing mental health challenges.The therapist must be aware of common reasons adolescents may find themselves in an inpatient setting, such as mood disorders, suicidal ideation, and addiction (Johansen & Fines, 2015).

Therapist Musical Knowledge

The music therapist must be able to effectively play and be knowledgeable about various musical styles and genres and be up to date on current music trends to cater to the preferences of adolescents. Having access to musical instruments and technology will give clients more options when creating their song. Finally, when using electronic music technology to explore genres

created by specific cultures, it is important for music therapists to seek out cultural competencies to avoid appropriation in music therapy sessions (Hadley & Norris, 2016).

Limitations

Limitations to this research included the student researcher not being able to access all the available resources, one example being the library not always having access to certain publications and unavalability of interloan services at times. Additionally, though Canadian mental health contextualization was given at the beginning of Chapter 2, most of the research found was not conducted in Canada. Therefore, this type of intervention may yield different results depending on the culture and country it is being implemented in. To create a program intervention, the student researcher looked through various models, methods, and techniques that may not have been implemented in practice or tested using research protocols. The musical preferences questionnaire was not developed by music therapists, which may limit the scope of understanding from a music therapy lens. This is the student-researcher's first time doing this kind of research, which limits their knowledge and understanding of this kind of project. It is also important to note that the student-researcher has limited experience working in adolescent inpatient mental health care.

Implications for Practice

The context of inpatient mental health care can be experienced as a highly medicalized environment due to patients' need to be hospitalized as well as the needs for diagnostic clarification, medication stabilization, and symptom-management-based psychotherapy (Ontario Shores, n.d.). This research was meant to bring forth the music therapy discipline as an allied profession in mental health that allows clients to uncover their strengths and be sure their psychosocial needs are met. Inpatient care can be very isolating, due to often being removed from family and friends, having to follow strict rules, and feeling the stigma that surrounds mental health settings (Lindgren et al., 2018). Bringing a sense of connection to inpatients through the songwriting intervention program may be beneficial. This program and tangible resources could be used by music therapists working with youth. Additionally, it may help promote the hiring of music therapists in inpatient mental health care, so that they can provide this program for clients. Though this program has been specifically designed for inpatient care, it can be adapted for use in other mental health settings and cultural contexts.

Future Research Implications

A future study could look at completing the intervention research steps and implementing the program in an inpatient unit. Doing so would show the impact of the program intervention, as well as ways in which it can be improved to better meet the needs of clients. Though this intervention was particularly designed for inpatient adolescent mental health care, future studies could examine how it can be adapted into other adolescent mental health care settings such as outpatient and community settings, and in schools. If there are promising findings in short-term results of this intervention, long-term effects could be explored with recently discharged clients, or in community mental health settings. Research could also explore preferred songwriting techniques to best meet the needs of adolescents in a variety of settings. In a recent study, Guittard (2019) spoke directly with music therapists working in youth mental health care, and they expressed the importance of group music therapy as an option to address emotional expression, identity through self-awareness, and connection through interpersonal skills. Therefore, perhaps a group songwriting adaptation of this intervention could be explored. There are many opportunities for future research to develop the intervention further and see the effects of implementation in an inpatient adolescent mental health care setting.

Conclusion

This research addressed the psychosocial strengths and needs of adolescents, including emotional processing, identity formation, and being connected, through the development of a therapeutic songwriting program intervention. The student-researcher explored how music therapy is used with adolescents, as well as ways to use music therapy, specifically songwriting, when addressing psychosocial needs of youth in inpatient mental health care. Risk and protective factors were analyzed to develop a program theory of age, duration, agents, setting, and materials. The proposed program intervention included a referral, intake, and assessment, and a three-phase model, followed by a post-intervention procedure. The student-researcher was inspired to look into this topic due to their personal relationship with mental illness, as well as the lack of resources they had as a teenager. The student-researcher hopes to work in an adolescent mental health care setting in the future in order to advocate for the well-being of youth and promote understanding through the reduction of stigma. It is the student-researcher's intention to continue exploring therapeutic songwriting with adolescents in their future career endeavours.

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Appendix A: Pediatric Symptom Checklist - Youth Self Report Version (PSC-Y)

Murphy & Jellinek, 1988: *reproduced with permission from the authors*

A Survey From Your Healthcare Provider – PSC-Y

Name:	Date:		
Please mark under the heading that best fits you or circle Yes or No	Never O	Sometimes I	Often 2
1. Complain of aches or pains			
2. Spend more time alone			
3. Tire easily, little energy			
4. Fidgety, unable to sit still			
5. Have trouble with teacher			
6. Less interested in school			
7. Act as if driven by motor			
8. Daydream too much			
9. Distract easily			
10. Are afraid of new situations			
11. Feel sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			

	15. Less interested in friends			
	16. Fight with other children			
	17. Absent from school			
	18. School grades dropping			
	19. Down on yourself			
	20. Visit doctor with doctor finding nothing wrong			
	21. Have trouble sleeping			
	22. Worry a lot			
	23. Want to be with parent more than before			
	24. Feel that you are bad			
	25. Take unnecessary risks			
	26. Get hurt frequently			
	27. Seem to be having less fun			
	28. Act younger than children your age			
	29. Do not listen to rules			
	30. Do not show feelings			
	31. Do not understand other people's feelings			
	32. Tease others			
	33. Blame others for your troubles			

	34. Take things that do not belong to you			
	35. Refuse to share			
	36. During the past three months, have you thought of killing yourself?		Yes	No
	37. Have you ever tried to kill yourself?		Yes	No

FOR OFFICE USE ONLY

TS _____

Plan for Follow-up C] Annual screening Return visit w/ PCP C] Referred to counselor

C] Parent declined C] Already in treatment C] Referred to other professional

Q 36 or Q 37=Y	30

Source: Pediatric Symptom Checklist — Youth Report (PSC-Y) Maryland/psc-y/123.10/1000

Administering, Scoring and Interpreting the PSC-Y Screening Questionnaire

Administering

- The youth self-report version of the Pediatric Symptom Checklist (PSC-Y) can be used with patients between the ages of 11 and 18 and takes less than five minutes to complete and score.
- The PSC-Y can be administered and scored by a nurse, medical technician, physical assistant, physician or other office staff.
- Patients should be left alone to complete the PSC-Y in a private area, such as an exam room or private area of the waiting room.
- Patients should be informed of their confidentiality rights before the PSC-Y is administered.
- It is recommended that parents are informed that a mental health checkup will be administered as part of the exam.
- The American Academy of Pediatrics and United States Preventive Service Task Force recommend that depression screening be conducted annually.

Scoring

Each item on the PSC-Y is scored as follows:

Never = 0

Sometimes = 1

Often = 2

To calculate the score, add all of the item scores together: Total Score = (range 0–70). If items are left blank, they are scored as 0.

If four or more items are left blank, the questionnaire is considered invalid. Note if either suicide question has been endorsed (Questions 36 and 37). Score is positive if:

total score >/= 30

OR

Recent suicidal ideation is reported (Q36)

OR

Past suicide attempt is reported (Q37)

Interpreting the Screening Results

- Patients that score positively on their PSC-Y should be evaluated by their primary care provider (PCP) to determine if the symptoms endorsed on the questionnaire are significant, causing impairment and warrant a referral to a mental health specialist or follow-up treatment by the PCP.
- For patients who score negatively on the PSC-Y, it is recommended that the PCP briefly review the symptoms marked as "sometimes" and "often" with the patient.
- The questionnaire indicates only the likelihood that a youth is at risk for a significant mental health problem or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

The symbols on the questionnaire and below represent the different problem areas that are covered on the PSC-Y and lists out the items that correspond with problem areas. Though this does not affect the overall score, the purpose of this breakdown is to help guide the discussion with and evaluation of patients after screening and allows the PCP to focus on the main problem areas identified by the PSC-Y.

Individual Problem Areas (For Interpretation Only)			
Internalizing Problems (i.e. Depression or Anxiety)	Attention Problems (i.e. ADHD)	Externalizing Problems (e.g. Conduct Disorder, Oppositional	Suicidality (if either question is endorsed, further

		Defiant Disorder)	assess for suicidal thinking and behavior and depression)
• Feel sad, unhappy • Worry a lot • Feel hopeless • Seem to be having less fun • Down on yourself	• Fidgety, unable to sit still • Distract easily • Act as if driven by motor • Daydream too much • Have trouble concentrating	• Fight with other children • Tease others • Do not listen to rules • Do not understand other people's feelings • Blame others for your troubles • Take things that do not belong to you	• Recent suicide ideation • Prior suicide attempt
Non-Categorizing Items			
• Complain of aches or pains • Spend more time alone • Tire easily, little energy • Do not show feelings • Have trouble with teacher	• Less interested at school • Are afraid of new situations • Are irritable, angry • Less interested in friends • Absent from school	• School grades dropping • Visit doctor with doctor finding nothing wrong • Have trouble sleeping • Feel that you are bad	• Want to be with parent more than before • Take unnecessary risks • Get hurt frequently • Act younger than children your age

Appendix B : Short Test of Musical Preferences-Revised (STOMPR)

Rentfrow & Gosling, 2003: *reproduced with permission from the authors*

Please indicate your basic preference for each of the following genres using the scale provided.

1	2	3	4	5	6	7
Dislike Strongly	Dislike Moderately	Dislike a Little	Neither like nor dislike	Like a Little	Like Moderately	Like Strongly

1. _____ Alternative
2. _____ Bluegrass
3. _____ Blues
4. _____ Classical
5. _____ Country
6. _____ Dance/Electronica
7. _____ Folk
8. _____ Funk
9. _____ Gospel
10. _____ Heavy Metal
11. _____ World
12. _____ Jazz
13. _____ New Age
14. _____ Oldies
15. _____ Opera
16. _____ Pop
17. _____ Punk
18. _____ Rap/hip-hop
19. _____ Reggae
20. _____ Religious
21. _____ Rock
22. _____ Soul/R&B
23. _____ Soundtracks/theme song

Scoring instructions for the STOMPR

Scoring for the four dimensions reported in: Rentfrow, P. J., & Gosling, S. D. (2003). The do re mi's of everyday life: The structure and personality correlates of music preferences. *Journal of Personality and Social Psychology, 84*(6), 1236–1256. https://doi.org/10.1037/0022-3514.84.6.1236

Compute the average score for each dimension using the items listed next to each label.

Reflective & Complex: 2, 3, 4, 7, 11, 12, 13, 15
Intense & Rebellious: 1, 10, 17, 21
Upbeat & Conventional: 5, 9, 14, 16, 20, 23
Energetic & Rhythmic: 6, 8, 18, 19, 22

Scale Reliabilities:

Reflective & Complex: alpha = .81
Intense & Rebellious: alpha = .74
Upbeat & Conventional: alpha = .70
Energetic & Rhythmic: alpha = .71

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Scoring for the five dimensions reported in: Rentfrow, P. J., & Gosling, S. D. (2011). The structure of musical preferences: A five-factor model. *Journal of Personality and Social Psychology, 100*, 1139–1157. https://doi.org/ 10.1037/a0022406

Compute the average score for each dimension using the items listed next to each label.

Mellow: 6, 13, 11
Unpretentious: 16, 5, 20
Sophisticated: 3, 12, 2, 7, 4, 9, 15
Intense: 21, 17, 1, 10
Contemporary: 18, 22, 8, 19

Note: The soundtrack and oldies genres don't load on a single factor. So you can remove those two genres from the STOMP-R or simply not score them.

Scale Reliabilities:

Mellow: alpha = .55
Unpretentious: alpha = .57
Sophisticated: alpha = .82
Intense: alpha = .74
Contemporary: alpha = .72
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Appendix C: Sample Session Plans

Goals of the Program Intervention

1. To use therapeutic songwriting as a tool to address psychosocial needs of the client, including processing emotions, performing identity, and being connected
2. To provide songwriting resources to the client for use outside of music therapy
3. To create a song that reflects something that the client wants to process.

Table C1

Sample Session Plan 1

Procedures/Interventions	**Observations**
Music Therapy Intake Client fills out PSC-Y form and STOMPR form, administered by music therapist.	Briefly take notes on PSC-Y form on particular needs to address in the session. Take note of musical preferences indicated in the STOMPR form.
Opening Experience Option 1: Re-create acoustically or listen to client's choice of song. Option 2: Music therapist guides the client in progressive muscle relaxation/musial relaxation while improvising on a supportive instrument. Option 3: Client and music therapist each share and listen to a song they enjoy, to promote connection.	Take note of the client's emotional availability/disposition to enter the music therapy space and observe any emotional reactions, or relationship with personal identity if the client chooses a song to re-create or share.
Referential Improvisation Use the Cove app, other similar app, acoustic methods, or a combination of both. Client states current emotions and	Take note of emotions the client is expressing as well as comfort level in music creation and therapeutic connection.

creates music with the music therapist in reference to these emotions.	
Free Writing Client writes freely to instrumental of preferred genre. Music therapist can either play in the preferred genre or play a recording of an instrumental while improvising on an instrument of choice.	Observe the client's comfort in writing and take note of themes that emerge surrounding emotional processing, performing identity, and being connected.
Closing Experience Option 1: Re-create a song of client's choosing under the theme of closure. Option 2: Musical relaxation where the client listens to a calming track, or to the music therapist improvising on an instrument. Option 3: Client shares and listens to a song with the theme of closure.	Observe the client's response to the session ending as well as any emotional processes around closure that may arise.
Afterwards, the therapist briefly reviews the resources used in session with the client, including technological resources, and the results of the free writing for the client to take home with them.	

Note: The therapist establishes vocabulary, procedural, and relationship givens (Gardstrom, 2007) based on emotions indicated by the client during referential improvisation.

Table C2

Sample Session Plan 2

Procedures/Interventions	Observations
Opening Experience Option 1: Re-create acoustically or listen to client's choice of song. Option 2: Music therapist guides the client in progressive muscle relaxation/musical relaxation while improvising on a supportive instrument. Option 3: Client and music therapist each share and listen to a song they enjoy.	Take note on the client's disposition to enter the music therapy space and observe any emotional reactions, or relationship with personal identity if client chooses a song to re-create or share.
Referential Improvisation Use Cove app, other similar app, acoustic methods, or a combination of both. Client states current emotions and creates music with the music therapist in reference to these emotions.	Take note of emotions the client is expressing as well as comfort level in music creation and therapeutic connection.
Free Writing Client writes to an instrumental of their preferred genre. Music therapist can either play in the preferred genre or play a recording of an instrumental while improvising on an instrument of choice.	Observe client's comfort with writing and take note of themes that emerge surrounding emotional processing, performing identity, and being connected.
Lyrical Highlighting and Analysis Music therapist guides the client in highlighting key phrases from both free writing sessions, as well as doing some analysis around the feelings behind the words.	Observe preferred phrases and emotions the client expresses around the phrases. Observe client's desire to share and connect with the therapist.

Song Outlining Music therapist guides the client in creating a song framework with genre and chosen phrases written under client's category (e.g., verse, chorus, bridge), as well as backing music, or basic beat (e.g., in Groovepad) options that the client is drawn to. Begin putting some phrases to melody.	Observe the client's work with the song structure, lyric, and melodic implementation. Observe how identity and emotions come up in the lyric and music choices.
Closing Experience Option 1: Re-create a song of client's choice under the theme of closure. Option 2: Musical relaxation where the client listens to a calming track, or to the therapist improvising on an instrument. Option 3: Client shares and listens to a song with the theme of closure.	Observe the client's response to session ending as well as any emotional processes around closure that may arise.
Afterwards, the music therapist briefly reviews the take-away resources, which include the song outline.	

Table C3

Sample Session Plan 3

Procedures/Interventions	**Observations**
Opening Experience Option 1: Re-create acoustically or listen to client's choice of song. Option 2: Music therapist guides the client in progressive muscle relaxation while improvising on piano or guitar. Option 3: Client and music therapist each share and listen to a song they enjoy.	Take notes on the client's disposition to enter the music therapy space and observe any emotional reactions, or relationship with personal identity if client chooses a song to re-create or share.
Songwriting Guide the client in implementing more phrases from the free writing section into verses of the song, and incorporating other resources if the client brought in any, as well as other lyrics that may naturally come up. These phrases are put to chords, or a backing track from a beat making app, that were chosen by the client to develop a melody.	Observe the client's disposition to participate in the process. Take note of emotional reactions, relation to the lyrics, relationship with lyrical identity, and comfort in the connection of the therapeutic relationship.
Recording If the client chooses to, record the song with them using a USB mic and a recording software of choice. Transfer file to a USB key to give to the client. Alternatively, the music therapist can write out the whole song, with musical elements for the client to take home with them.	Observe the client's connection to the song, completed lyrics, and recording or writing process in relation to themselves, the therapeutic process, and their emotional processes.

Discussion Talk with the client about their experience with the songwriting process, and any reflections they would like to share.	Observe reactions, reflections, and general thoughts that may emerge surrounding emotions, identity, and connection.
Closing Experience Option 1: Re-create a song of the client's choosing under the theme of closure. Option 2: Musical relaxation where the client listens to a calming track, or to the therapist improvising on an instrument. Option 3: Client shares and listens to a song with the theme of closure.	Observe the client's response to the session ending and the program ending, as well as any emotional processes around closure that may arise.
PSC-Y Form Have the client fill out this form for the second time, administered by the music therapist.	Observe any changes that arise in comparison to the pre-intervention form.